

1.1 moves to amend H.F. No. 2414 as follows:

1.2 Delete everything after the enacting clause and insert:

1.3 "ARTICLE 1

1.4 CHILDREN AND FAMILIES

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

1.7 Subd. 13b. **Homeless.** "Homeless" means a self-declared housing status as defined in
1.8 the McKinney-Vento Homeless Assistance Act and United States Code, title 42, section
1.9 11302, paragraph (a).

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

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

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

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

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

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

2.1 (4) a legal nonlicensed child care provider as defined under section 119B.011, subdivision
 2.2 16, providing legal child care services. A ~~legally unlicensed family~~ legal nonlicensed child
 2.3 care provider must be at least 18 years of age, and not a member of the MFIP assistance
 2.4 unit or a member of the family receiving child care assistance to be authorized under this
 2.5 chapter.

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

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

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

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

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

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

2.27 (b) The commissioner shall:

2.28 (1) provide technical assistance and training to support child care providers to ensure
 2.29 proper billing and attendance records are submitted for reimbursement under this chapter;
 2.30 and

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

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

3.2 Subd. 7. **Child care market rate survey.** ~~Biennially,~~ The commissioner shall conduct
3.3 the next survey of prices charged by child care providers in Minnesota in state fiscal year
3.4 2021 and every three years thereafter to determine the 75th percentile for like-care
3.5 arrangements in county price clusters.

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

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

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

3.11 (1) identity of adults;

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

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

3.15 (4) age;

3.16 (5) immigration status, if related to eligibility;

3.17 (6) Social Security number, if given;

3.18 (7) counted income;

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

3.20 (9) residence; and

3.21 (10) inconsistent information, if related to eligibility.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5.4 (c) The receiving county must:

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

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

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

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

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

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

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

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

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

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

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

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

5.30 (7) families who are participating in programs as required in tribal contracts under section
 5.31 119B.02, subdivision 2, or 256.01, subdivision 2;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7.24 (1) the child's school schedule;

7.25 (2) the custody schedule; or

7.26 (3) the provider's availability.

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

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

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

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

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

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

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

8.18 Subdivision 1. **Subsidy restrictions.** (a) Beginning ~~February 3, 2014~~, September 20,
 8.19 2019, the maximum rate paid for child care assistance in any county or county price cluster
 8.20 under the child care fund shall be the greater of the 25th percentile of the ~~2011~~ 2018 child
 8.21 care provider rate survey under section 119B.02, subdivision 7, or the maximum rate effective
 8.22 ~~November 28, 2011~~ February 3, 2014. For a child care provider located within the boundaries
 8.23 of a city located in two or more of the counties of Benton, Sherburne, and Stearns, the
 8.24 maximum rate paid for child care assistance shall be equal to the maximum rate paid in the
 8.25 county with the highest maximum reimbursement rates or the provider's charge, whichever
 8.26 is less. The commissioner may: (1) assign a county with no reported provider prices to a
 8.27 similar price cluster; and (2) consider county level access when determining final price
 8.28 clusters.

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

8.31 (c) The department shall monitor the effect of this paragraph on provider rates. The
 8.32 county shall pay the provider's full charges for every child in care up to the maximum

9.1 established. The commissioner shall determine the maximum rate for each type of care on
9.2 an hourly, full-day, and weekly basis, including special needs and disability care.

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

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

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

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

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

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

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

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

9.19 (i) ~~Notwithstanding Minnesota Rules, part 3400.0130, subpart 7, maximum registration~~
9.20 ~~fees in effect on January 1, 2013, shall remain in effect.~~ The maximum registration fee paid
9.21 for child care assistance in any county or county price cluster under the child care fund shall
9.22 be the greater of the 25th percentile of the 2018 child care provider rate survey under section
9.23 119B.02, subdivision 7, or the registration fee in effect February 3, 2014. Maximum
9.24 registration fees must be set for licensed family child care and for child care centers. For a
9.25 child care provider located within the boundaries of a city located in two or more of the
9.26 counties of Benton, Sherburne, and Stearns, the maximum registration fee paid for child
9.27 care assistance shall be equal to the maximum registration fee paid in the county with the
9.28 highest maximum registration fee or the provider's charge, whichever is less.

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

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

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

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

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

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

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

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

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

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

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

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

11.1 (3) establishes an overpayment for failure to comply with section 119B.125, subdivision
 11.2 6;

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

11.5 (5) initiates an administrative fraud disqualification hearing; or

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

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

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

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

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

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

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

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

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

11.20 Subd. 1b. **Joint fair hearings.** ~~When a provider requests a fair hearing under subdivision~~
 11.21 ~~1a, the family in whose case the overpayment was created must be made a party to the fair~~
 11.22 ~~hearing. All other issues raised by the family must be resolved in the same proceeding.~~
 11.23 ~~When a family requests a fair hearing and claims that the county should have assigned~~
 11.24 ~~responsibility for an overpayment to a provider, the provider must be made a party to the~~
 11.25 ~~fair hearing. The human services judge assigned to a fair hearing may join a family or a~~
 11.26 ~~provider as a party to the fair hearing whenever joinder of that party is necessary to fully~~
 11.27 ~~and fairly resolve overpayment issues raised in the appeal.~~

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

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

12.3 Subd. 1c. **Notice to providers.** (a) Before taking an action appealable under subdivision
12.4 1a, paragraph (b), a county agency or the commissioner must mail written notice to the
12.5 provider against whom the action is being taken. Unless otherwise specified under chapter
12.6 119B or 245E or Minnesota Rules, chapter 3400, a county agency or the commissioner must
12.7 mail the written notice at least 15 calendar days before the adverse action's effective date.

12.8 (b) The notice shall state (1) the factual basis for the department's determination, (2) the
12.9 action the department intends to take, (3) the dollar amount of the monetary recovery or
12.10 recoupment, if known, and (4) the provider's right to appeal the department's proposed
12.11 action.

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

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

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

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

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

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

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

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

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

12.30 Subdivision 1. **Applicability.** A provider has the right to an administrative review under
12.31 this section if (1) a payment was suspended under chapter 245E, or (2) the provider's

13.1 authorization was denied or revoked under section 119B.13, subdivision 6, paragraph (d),
13.2 clause (1) or (2).

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

13.6 (b) The notice must:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15.4 (b) Grant recipients must sign a contract agreeing to remain in their current position for
 15.5 12 months.

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

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

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

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

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

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

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

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

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

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

15.30 (d) The commissioner shall recover the cost of obtaining background study data required
 15.31 under section 524.5-118 through a fee of \$50 per study for an individual who has not lived

16.1 outside Minnesota for the past ten years, and a fee of \$100 for an individual who has resided
16.2 outside of Minnesota for any period during the ten years preceding the background study.
16.3 The commissioner shall recover, from the individual, any additional fees charged by other
16.4 states' licensing agencies that are associated with these data requests. Fees under subdivision
16.5 3 also apply when criminal history data from the National Criminal Records Repository is
16.6 required.

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

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

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

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

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

- 17.1 (1) be one of the existing tribes with reservation land in Minnesota;
- 17.2 (2) have a tribal court with jurisdiction over child custody proceedings;
- 17.3 (3) have a substantial number of children for whom determinations of maltreatment have
17.4 occurred;
- 17.5 (4)(i) have capacity to respond to reports of abuse and neglect under section 626.556;
17.6 or (ii) have codified the tribe's screening, investigation, and assessment of reports of child
17.7 maltreatment procedures, if authorized to use an alternative method by the commissioner
17.8 under paragraph (a);
- 17.9 (5) provide a wide range of services to families in need of child welfare services; and
- 17.10 (6) have a tribal-state title IV-E agreement in effect.
- 17.11 (d) Grants awarded under this section may be used for the nonfederal costs of providing
17.12 child welfare services to American Indian children on the tribe's reservation, including costs
17.13 associated with:
- 17.14 (1) assessment and prevention of child abuse and neglect;
- 17.15 (2) family preservation;
- 17.16 (3) facilitative, supportive, and reunification services;
- 17.17 (4) out-of-home placement for children removed from the home for child protective
17.18 purposes; and
- 17.19 (5) other activities and services approved by the commissioner that further the goals of
17.20 providing safety, permanency, and well-being of American Indian children.
- 17.21 (e) When a tribe has initiated a project and has been approved by the commissioner to
17.22 assume child welfare responsibilities for American Indian children of that tribe under this
17.23 section, the affected county social service agency is relieved of responsibility for responding
17.24 to reports of abuse and neglect under section 626.556 for those children during the time
17.25 within which the tribal project is in effect and funded. The commissioner shall work with
17.26 tribes and affected counties to develop procedures for data collection, evaluation, and
17.27 clarification of ongoing role and financial responsibilities of the county and tribe for child
17.28 welfare services prior to initiation of the project. Children who have not been identified by
17.29 the tribe as participating in the project shall remain the responsibility of the county. Nothing
17.30 in this section shall alter responsibilities of the county for law enforcement or court services.

18.1 (f) Participating tribes may conduct children's mental health screenings under section
18.2 245.4874, subdivision 1, paragraph (a), clause (12), for children who are eligible for the
18.3 initiative and living on the reservation and who meet one of the following criteria:

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

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

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

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

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

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

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

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

18.31 Subd. 5. **MFIP transitional standard.** (a) The MFIP transitional standard is based on
18.32 the number of persons in the assistance unit eligible for both food and cash assistance. The

19.1 amount of the transitional standard is published annually by the Department of Human
19.2 Services.

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

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

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

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

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

19.13 ~~(1) 80 percent of the allocation as determined in subdivision 1 must be paid to counties~~
19.14 ~~on or before July 10 of each year;~~

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

19.26 ~~(3) ten percent of the allocation shall be withheld until the commissioner determines~~
19.27 ~~that the county has met the performance outcome threshold of 90 percent based on~~
19.28 ~~face-to-face visits by the case manager. In order to receive the performance allocation, the~~
19.29 ~~total number of visits made by caseworkers on a monthly basis to children in foster care~~
19.30 ~~and children receiving child protection services while residing in their home must be at least~~
19.31 ~~90 percent of the total number of such visits that would occur if every child were visited~~
19.32 ~~once per month. The commissioner shall make such determinations in January of each year~~
19.33 ~~and payments to counties meeting the performance outcome threshold shall occur in February~~

20.1 ~~of each year. Any withheld funds from this appropriation for counties that do not meet this~~
 20.2 ~~requirement shall be reallocated by the commissioner to those counties meeting the~~
 20.3 ~~requirement. For 2015, the commissioner shall only apply the standard for monthly foster~~
 20.4 ~~care visits.~~

20.5 ~~(e) The commissioner shall work with stakeholders and the Human Services Performance~~
 20.6 ~~Council under section 402A.16 to develop recommendations for specific outcome measures~~
 20.7 ~~that counties should meet in order to receive funds withheld under paragraph (b), and include~~
 20.8 ~~in those recommendations a determination as to whether the performance measures under~~
 20.9 ~~paragraph (b) should be modified or phased out. The commissioner shall report the~~
 20.10 ~~recommendations to the legislative committees having jurisdiction over child protection~~
 20.11 ~~issues by January 1, 2018.~~

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

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

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

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

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

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

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

21.4 (b) A child is in foster care under this definition regardless of whether the facility is
21.5 licensed and payments are made for the cost of care. Nothing in this definition creates any
21.6 authority to place a child in a home or facility that is required to be licensed which is not
21.7 licensed. "Foster care" does not include placement in any of the following facilities: hospitals,
21.8 inpatient chemical dependency treatment facilities where the child is the recipient of the
21.9 treatment, facilities that are primarily for delinquent children, any corrections facility or
21.10 program within a particular correction's facility not meeting requirements for title IV-E
21.11 facilities as determined by the commissioner, facilities to which a child is committed under
21.12 the provision of chapter 253B, forestry camps, or jails. Foster care is intended to provide
21.13 for a child's safety or to access treatment. Foster care must not be used as a punishment or
21.14 consequence for a child's behavior.

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

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

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

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

21.30 (b) Unless there is reason to believe that the child would endanger self or others or not
21.31 return for a court hearing, or that the child's health or welfare would be immediately
21.32 endangered, the child shall be released to the custody of a parent, guardian, custodian, or
21.33 other suitable person, subject to reasonable conditions of release including, but not limited

22.1 to, a requirement that the child undergo a chemical use assessment as provided in section
22.2 260C.157, subdivision 1.

22.3 (c) If the court determines there is reason to believe that the child would endanger self
22.4 or others or not return for a court hearing, or that the child's health or welfare would be
22.5 immediately endangered if returned to the care of the parent or guardian who has custody
22.6 and from whom the child was removed, the court shall order the child into foster care as
22.7 defined in section 260C.007, subdivision 18, under the legal responsibility of the responsible
22.8 social services agency or responsible probation or corrections agency for the purposes of
22.9 protective care as that term is used in the juvenile court rules or into the home of a
22.10 noncustodial parent and order the noncustodial parent to comply with any conditions the
22.11 court determines to be appropriate to the safety and care of the child, including cooperating
22.12 with paternity establishment proceedings in the case of a man who has not been adjudicated
22.13 the child's father. The court shall not give the responsible social services legal custody and
22.14 order a trial home visit at any time prior to adjudication and disposition under section
22.15 260C.201, subdivision 1, paragraph (a), clause (3), but may order the child returned to the
22.16 care of the parent or guardian who has custody and from whom the child was removed and
22.17 order the parent or guardian to comply with any conditions the court determines to be
22.18 appropriate to meet the safety, health, and welfare of the child.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

24.8 (i) If the county attorney has filed a petition under section 260C.307, the court shall
24.9 schedule a trial under section 260C.163 within 90 days of the filing of the petition except
24.10 when the county attorney determines that the criminal case shall proceed to trial first under
24.11 section 260C.503, subdivision 2, paragraph (c).

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

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

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

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

25.2 **Subdivision 1. Placement.** (a) An agency with legal responsibility for a child under
25.3 section 260C.178, subdivision 1, paragraph (c), or legal custody of a child under section
25.4 260C.201, subdivision 1, paragraph (a), clause (3), may colocate a child with a parent who
25.5 is receiving services in a licensed residential family-based substance use disorder treatment
25.6 program for up to 12 months.

25.7 (b) During the child's placement under paragraph (a), the agency: (1) may visit the child
25.8 as the agency deems necessary and appropriate; (2) shall continue to have access to
25.9 information under section 260C.208; and (3) shall continue to provide appropriate services
25.10 to both the parent and the child.

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

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

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

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

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

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

26.7 (d) The court shall make findings regarding the reasonable efforts of the agency to
26.8 finalize the child's return home as the permanency disposition order in the child's best
26.9 interests. The court may continue the child's foster care placement colocated with a parent
26.10 in a licensed residential family-based substance use disorder treatment program for up to
26.11 12 months. When a child has been in foster care placement for 12 months, but the duration
26.12 of the colocation with a parent in a licensed residential family-based substance use disorder
26.13 treatment program is less than 12 months, the court may continue the colocation with the
26.14 total time spent in foster care not exceeding 15 out of the most recent 22 months. If the
26.15 court finds that the agency fails to make reasonable efforts to finalize the child's return home
26.16 as the permanency disposition order in the child's best interests, the court may order additional
26.17 efforts to support the child remaining in the care of the parent.

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

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

26.28 (g) If a parent leaves or is discharged from a licensed residential family-based substance
26.29 use disorder treatment program without completing the program and the child is colocated
26.30 with a parent and the child has been in foster care for more than six months but less than
26.31 12 months, the court must conduct a permanency progress review hearing under section
26.32 260C.204 no later than 30 days after the day the parent leaves or is discharged.

26.33 (h) If a parent leaves or is discharged from a licensed residential family-based substance
26.34 use disorder treatment program without completing the program and the child is colocated

27.1 with a parent and the child has been in foster care for more than 12 months, the court shall
27.2 begin permanency proceedings under sections 260C.503 to 260C.521.

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

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

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

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

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

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

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

27.21 (i) a child-placing agency; or

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

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

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

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

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

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

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

28.12 (vi) shall prepare a report for the court when the trial home visit is terminated whether
28.13 by the agency or court order which describes the child's circumstances during the trial home
28.14 visit and recommends appropriate orders, if any, for the court to enter to provide for the
28.15 child's safety and stability. In the event a trial home visit is terminated by the agency by
28.16 removing the child to foster care without prior court order or authorization, the court shall
28.17 conduct a hearing within ten days of receiving notice of the termination of the trial home
28.18 visit by the agency and shall order disposition under this subdivision or ~~conduct a permanency~~
28.19 ~~hearing under subdivision 11 or 11a~~ commence permanency proceedings under sections
28.20 260C.503 to 260C.515. The time period for the hearing may be extended by the court for
28.21 good cause shown and if it is in the best interests of the child as long as the total time the
28.22 child spends in foster care without a permanency hearing does not exceed 12 months;

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

29.1 professional, the court may order that the diagnosing professional not provide the treatment
29.2 to the child if it finds that such an order is in the child's best interests; or

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

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

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

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

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

29.18 (i) a reputable person of good moral character. No person may receive custody of two
29.19 or more unrelated children unless licensed to operate a residential program under sections
29.20 245A.01 to 245A.16; or

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

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

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

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

29.29 (7) if the court believes that it is in the best interests of the child or of public safety that
29.30 the child's driver's license or instruction permit be canceled, the court may order the
29.31 commissioner of public safety to cancel the child's license or permit for any period up to
29.32 the child's 18th birthday. If the child does not have a driver's license or permit, the court

30.1 may order a denial of driving privileges for any period up to the child's 18th birthday. The
30.2 court shall forward an order issued under this clause to the commissioner, who shall cancel
30.3 the license or permit or deny driving privileges without a hearing for the period specified
30.4 by the court. At any time before the expiration of the period of cancellation or denial, the
30.5 court may, for good cause, order the commissioner of public safety to allow the child to
30.6 apply for a license or permit, and the commissioner shall so authorize;

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

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

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

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

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

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

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

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

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

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

31.9 (3) when legal custody of the child is transferred, the appropriateness of the particular
31.10 placement made or to be made by the placing agency using the factors in section 260C.212,
31.11 subdivision 2, paragraph (b), or the appropriateness of a child colocated with a parent in a
31.12 licensed residential family-based substance use disorder treatment program under section
31.13 260C.190;

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

31.16 (i) to prevent the child's placement and to reunify the child with the parent or guardian
31.17 from whom the child was removed at the earliest time consistent with the child's safety.
31.18 The court's findings must include a brief description of what preventive and reunification
31.19 efforts were made and why further efforts could not have prevented or eliminated the
31.20 necessity of removal or that reasonable efforts were not required under section 260.012 or
31.21 260C.178, subdivision 1;

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

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

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

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

32.9 (5) if the child has been adjudicated as a child in need of protection or services because
32.10 the child is in need of special services or care to treat or ameliorate a mental disability or
32.11 emotional disturbance as defined in section 245.4871, subdivision 15, the written findings
32.12 shall also set forth:

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

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

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

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

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

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

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

33.2 Subd. 6. **Case plan.** (a) For each disposition ordered where the child is placed away
33.3 from a parent or guardian, the court shall order the responsible social services agency to
33.4 prepare a written out-of-home placement plan according to the requirements of section
33.5 260C.212, subdivision 1. When a foster child is colocated with a parent in a licensed
33.6 residential family-based substance use disorder treatment program under section 260C.190,
33.7 the case plan must specify the recommendation for the colocation before the child is colocated
33.8 with the parent.

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

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

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

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

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

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

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

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

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

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

34.4 (2) the medical needs of the child;

34.5 (3) the educational needs of the child;

34.6 (4) the developmental needs of the child;

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

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

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

34.10 (8) the child's interests and talents;

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

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

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

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

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

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

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

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

35.9 Subdivision 1. **Generally.** When a parent requests assistance from an agency and both
 35.10 the parent and agency agree that a child's placement in foster care and colocation with a
 35.11 parent in a licensed residential family-based substance use treatment facility as defined by
 35.12 section 260C.007, subdivision 22a, is in the child's best interests, the agency must specify
 35.13 the recommendation for the placement in the child's case plan. After the child's case plan
 35.14 includes the recommendation, the agency and the parent may enter into a written voluntary
 35.15 placement agreement on a form approved by the commissioner.

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

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

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

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

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

35.27 (iv) a statement regarding the child's eligibility for membership or enrollment in an
 35.28 Indian tribe and the agency's compliance with applicable provisions of sections 260.751 to
 35.29 260.835;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

37.13 (i) If the court finds continuing the voluntary foster care arrangement is not in the child's
37.14 best interests or that the agency or the parent is not appropriately planning for the child, the
37.15 court shall notify the agency, the parent, the licensed residential family-based substance
37.16 use disorder treatment program, a child 12 years of age or older, and the county attorney of
37.17 the court's determination and the basis for the court's determination. The court shall set the
37.18 matter for hearing and appoint a guardian ad litem for the child under section 260C.163,
37.19 subdivision 5.

37.20 Subd. 3. **Termination.** The voluntary placement agreement terminates at the parent's
37.21 discharge from the licensed residential family-based substance use disorder treatment
37.22 program, or upon receipt of a written and dated request from the parent, unless the request
37.23 specifies a later date. If the child's voluntary foster care placement meets the calculated time
37.24 to require a permanency proceeding under section 260C.503, subdivision 3, paragraph (a),
37.25 and the child is not returned home, the agency must file a petition according to section
37.26 260C.141 or 260C.505.

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

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

37.31 (b) The responsible social services agency shall file a copy of the notification required
37.32 in subdivision 3 with the court. If the responsible social services agency does not file the

38.1 notice by the time the child is 17-1/2 years of age, the court shall require the responsible
38.2 social services agency to file the notice.

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

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

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

38.16 (2) health insurance, including eligibility for medical assistance as defined in section
38.17 256B.055, subdivision 17;

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

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

38.21 (5) workforce supports and employment services;

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

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

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

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

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

39.2 Subdivision 1. **Required permanency proceedings.** (a) Except for children in foster
39.3 care pursuant to chapter 260D, where the child is in foster care or in the care of a noncustodial
39.4 or nonresident parent, the court shall commence proceedings to determine the permanent
39.5 status of a child by holding the admit-deny hearing required under section 260C.507 not
39.6 later than 12 months after the child is placed in foster care or in the care of a noncustodial
39.7 or nonresident parent. Permanency proceedings for children in foster care pursuant to chapter
39.8 260D shall be according to section 260D.07.

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

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

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

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

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

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

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

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

39.27 Subd. 10. **Duties of local welfare agency and local law enforcement agency upon**
39.28 **receipt of report; mandatory notification between police or sheriff and agency.** (a) The
39.29 police department or the county sheriff shall immediately notify the local welfare agency
39.30 or agency responsible for child protection reports under this section orally and in writing
39.31 when a report is received. The local welfare agency or agency responsible for child protection
39.32 reports shall immediately notify the local police department or the county sheriff orally and

40.1 in writing when a report is received. The county sheriff and the head of every local welfare
40.2 agency, agency responsible for child protection reports, and police department shall each
40.3 designate a person within their agency, department, or office who is responsible for ensuring
40.4 that the notification duties of this paragraph are carried out. When the alleged maltreatment
40.5 occurred on tribal land, the local welfare agency or agency responsible for child protection
40.6 reports and the local police department or the county sheriff shall immediately notify the
40.7 tribe's social services agency and tribal law enforcement orally and in writing when a report
40.8 is received.

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

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

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

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

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

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

40.30 If the report alleges neglect, physical abuse, or sexual abuse by a parent, guardian, or
40.31 individual functioning within the family unit as a person responsible for the child's care, or
40.32 sexual abuse by a person with a significant relationship to the child when that person resides
40.33 in the child's household or by a sibling, the local welfare agency shall immediately conduct
40.34 a family assessment or investigation as identified in clauses (1) to (4). In conducting a family

41.1 assessment or investigation, the local welfare agency shall gather information on the existence
41.2 of substance abuse and domestic violence and offer services for purposes of preventing
41.3 future child maltreatment, safeguarding and enhancing the welfare of the abused or neglected
41.4 minor, and supporting and preserving family life whenever possible. If the report alleges a
41.5 violation of a criminal statute involving sexual abuse, physical abuse, or neglect or
41.6 endangerment, under section 609.378, the local law enforcement agency and local welfare
41.7 agency shall coordinate the planning and execution of their respective investigation and
41.8 assessment efforts to avoid a duplication of fact-finding efforts and multiple interviews.
41.9 Each agency shall prepare a separate report of the results of its investigation or assessment.
41.10 In cases of alleged child maltreatment resulting in death, the local agency may rely on the
41.11 fact-finding efforts of a law enforcement investigation to make a determination of whether
41.12 or not maltreatment occurred. When necessary the local welfare agency shall seek authority
41.13 to remove the child from the custody of a parent, guardian, or adult with whom the child is
41.14 living. In performing any of these duties, the local welfare agency shall maintain appropriate
41.15 records.

41.16 If the family assessment or investigation indicates there is a potential for abuse of alcohol
41.17 or other drugs by the parent, guardian, or person responsible for the child's care, the local
41.18 welfare agency shall conduct a chemical use assessment pursuant to Minnesota Rules, part
41.19 9530.6615.

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

41.28 (d) Authority of the local welfare agency responsible for assessing or investigating the
41.29 child abuse or neglect report, the agency responsible for assessing or investigating the report,
41.30 and of the local law enforcement agency for investigating the alleged abuse or neglect
41.31 includes, but is not limited to, authority to interview, without parental consent, the alleged
41.32 victim and any other minors who currently reside with or who have resided with the alleged
41.33 offender. The interview may take place at school or at any facility or other place where the
41.34 alleged victim or other minors might be found or the child may be transported to, and the
41.35 interview conducted at, a place appropriate for the interview of a child designated by the

42.1 local welfare agency or law enforcement agency. The interview may take place outside the
42.2 presence of the alleged offender or parent, legal custodian, guardian, or school official. For
42.3 family assessments, it is the preferred practice to request a parent or guardian's permission
42.4 to interview the child prior to conducting the child interview, unless doing so would
42.5 compromise the safety assessment. Except as provided in this paragraph, the parent, legal
42.6 custodian, or guardian shall be notified by the responsible local welfare or law enforcement
42.7 agency no later than the conclusion of the investigation or assessment that this interview
42.8 has occurred. Notwithstanding rule 32 of the Minnesota Rules of Procedure for Juvenile
42.9 Courts, the juvenile court may, after hearing on an ex parte motion by the local welfare
42.10 agency, order that, where reasonable cause exists, the agency withhold notification of this
42.11 interview from the parent, legal custodian, or guardian. If the interview took place or is to
42.12 take place on school property, the order shall specify that school officials may not disclose
42.13 to the parent, legal custodian, or guardian the contents of the notification of intent to interview
42.14 the child on school property, as provided under this paragraph, and any other related
42.15 information regarding the interview that may be a part of the child's school record. A copy
42.16 of the order shall be sent by the local welfare or law enforcement agency to the appropriate
42.17 school official.

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

42.34 Except where the alleged offender is believed to be a school official or employee, the
42.35 time and place, and manner of the interview on school premises shall be within the discretion

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

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

43.16 (g) Before making an order under paragraph (f), the court shall issue an order to show
43.17 cause, either upon its own motion or upon a verified petition, specifying the basis for the
43.18 requested interviews and fixing the time and place of the hearing. The order to show cause
43.19 shall be served personally and shall be heard in the same manner as provided in other cases
43.20 in the juvenile court. The court shall consider the need for appointment of a guardian ad
43.21 litem to protect the best interests of the child. If appointed, the guardian ad litem shall be
43.22 present at the hearing on the order to show cause.

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

43.32 (i) The local welfare agency responsible for conducting a family assessment or
43.33 investigation shall collect available and relevant information to determine child safety, risk
43.34 of subsequent child maltreatment, and family strengths and needs and share not public
43.35 information with an Indian's tribal social services agency without violating any law of the

44.1 state that may otherwise impose duties of confidentiality on the local welfare agency in
44.2 order to implement the tribal state agreement. The local welfare agency or the agency
44.3 responsible for investigating the report shall collect available and relevant information to
44.4 ascertain whether maltreatment occurred and whether protective services are needed.
44.5 Information collected includes, when relevant, information with regard to the person reporting
44.6 the alleged maltreatment, including the nature of the reporter's relationship to the child and
44.7 to the alleged offender, and the basis of the reporter's knowledge for the report; the child
44.8 allegedly being maltreated; the alleged offender; the child's caretaker; and other collateral
44.9 sources having relevant information related to the alleged maltreatment. As a part of
44.10 determining whether child protective services are needed, the local welfare agency
44.11 responsible for conducting the family assessment or investigation shall submit a request to
44.12 the commissioner of human services to collect child abuse and neglect records maintained
44.13 in each state other than Minnesota where the alleged offender has resided in the preceding
44.14 five years. The commissioner shall send out-of-state child abuse and neglect records inquiries
44.15 to the relevant states within three business days of receiving the request from the local
44.16 welfare agency. The commissioner shall forward the results of these inquiries to the local
44.17 welfare agency responsible for conducting the family assessment or investigation as they
44.18 are received. The commissioner shall inform the local welfare agency if the commissioner
44.19 does not receive a response from all states with records required to be searched within 20
44.20 business days. The local welfare agency or the agency responsible for investigating the
44.21 report may make a determination of no maltreatment early in an investigation, and close
44.22 the case and retain immunity, if the collected information shows no basis for a full
44.23 investigation.

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

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

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

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

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

45.11 Nothing in this paragraph precludes the local welfare agency, the local law enforcement
45.12 agency, or the agency responsible for assessing or investigating the report from collecting
45.13 other relevant information necessary to conduct the assessment or investigation.

45.14 Notwithstanding sections 13.384 or 144.291 to 144.298, the local welfare agency has access
45.15 to medical data and records for purposes of clause (3). Notwithstanding the data's
45.16 classification in the possession of any other agency, data acquired by the local welfare
45.17 agency or the agency responsible for assessing or investigating the report during the course
45.18 of the assessment or investigation are private data on individuals and must be maintained
45.19 in accordance with subdivision 11. Data of the commissioner of education collected or
45.20 maintained during and for the purpose of an investigation of alleged maltreatment in a school
45.21 are governed by this section, notwithstanding the data's classification as educational,
45.22 licensing, or personnel data under chapter 13.

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

45.27 (j) Upon receipt of a report, the local welfare agency shall conduct a face-to-face contact
45.28 with the child reported to be maltreated and with the child's primary caregiver sufficient to
45.29 complete a safety assessment and ensure the immediate safety of the child. The face-to-face
45.30 contact with the child and primary caregiver shall occur immediately if sexual abuse or
45.31 substantial child endangerment is alleged and within five calendar days for all other reports.
45.32 If the alleged offender was not already interviewed as the primary caregiver, the local welfare
45.33 agency shall also conduct a face-to-face interview with the alleged offender in the early
45.34 stages of the assessment or investigation. At the initial contact, the local child welfare agency
45.35 or the agency responsible for assessing or investigating the report must inform the alleged

46.1 offender of the complaints or allegations made against the individual in a manner consistent
 46.2 with laws protecting the rights of the person who made the report. The interview with the
 46.3 alleged offender may be postponed if it would jeopardize an active law enforcement
 46.4 investigation.

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

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

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

46.12 (l) In conducting an assessment or investigation involving a school facility as defined
 46.13 in subdivision 2, paragraph (c), the commissioner of education shall collect available and
 46.14 relevant information and use the procedures in paragraphs (j) and (k), and subdivision 3d,
 46.15 except that the requirement for face-to-face observation of the child and face-to-face interview
 46.16 of the alleged offender is to occur in the initial stages of the assessment or investigation
 46.17 provided that the commissioner may also base the assessment or investigation on investigative
 46.18 reports and data received from the school facility and local law enforcement, to the extent
 46.19 those investigations satisfy the requirements of paragraphs (j) and (k), and subdivision 3d.

46.20 Sec. 40. **TITLE.**

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

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

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

47.1 Sec. 42. INSTRUCTION TO COMMISSIONER.

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

47.11 Sec. 43. CHILD WELFARE TRAINING ACADEMY.

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

47.16 Subd. 2. Administration. (a) The Child Welfare Training Academy must be administered
47.17 through five regional hubs in northwest, northeast, southwest, southeast, and central
47.18 Minnesota. Each hub must deliver training targeted to the needs of the hub's particular
47.19 region, taking into account varying demographics, resources, and practice outcomes.

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

47.24 (c) Content of training delivered by the Child Welfare Training Academy must be
47.25 informed using multidisciplinary approaches and must include the voices and expertise of
47.26 stakeholders, including but not limited to child welfare professionals, resource parents,
47.27 biological parents and caregivers, and community members. Content must be structured to
47.28 reflect the variety of communities served by child welfare and must recognize the racial
47.29 disparities and disproportionality that exist in the system. Content must also be informed
47.30 with attention to both child safety and the evidence-based understanding that maintaining
47.31 family relationships is key to child well-being.

47.32 (d) Each child welfare worker and supervisor must complete a certification, including
47.33 a competency-based knowledge test and a skills demonstration, at the completion of the

48.1 worker's or supervisor's initial training and biennially thereafter. The commissioner shall
48.2 develop ongoing training requirements and a method for tracking certifications.

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

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

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

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

48.12 (a) The commissioner of human services shall conduct a child welfare caseload study
48.13 to collect data on (1) the number of child welfare workers in Minnesota, and (2) the amount
48.14 of time that child welfare workers spend on different components of child welfare work.
48.15 The study must be completed by October 1, 2020.

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

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

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

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

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

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

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

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

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

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

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

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

49.11 (1) by September 30, 2020, and September 30, 2021, report to the commissioner of
 49.12 human services the purposes for which the money was used during the past fiscal year,
 49.13 including a description of projects supported by the financing, an account of loans made
 49.14 during the calendar year, the financing program's assets and liabilities, and an explanation
 49.15 of administrative expenses; and

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

49.19 Sec. 46. **REPEALER.**

49.20 (a) Minnesota Statutes 2018, sections 119B.16, subdivision 2; and 245E.06, subdivisions
 49.21 2, 4, and 5, and Minnesota Rules, part 3400.0185, subpart 5, are repealed effective February
 49.22 26, 2021.

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

49.24 **ARTICLE 2**

49.25 **OPERATIONS**

49.26 Section 1. Minnesota Statutes 2018, section 13.46, subdivision 3, is amended to read:

49.27 Subd. 3. **Investigative data.** (a) Data on persons, including data on vendors of services,
 49.28 licensees, and applicants that is collected, maintained, used, or disseminated by the welfare
 49.29 system in an investigation, authorized by statute, and relating to the enforcement of rules
 49.30 or law are confidential data on individuals pursuant to section 13.02, subdivision 3, or

50.1 protected nonpublic data not on individuals pursuant to section 13.02, subdivision 13, and
50.2 shall not be disclosed except:

50.3 (1) pursuant to section 13.05;

50.4 (2) pursuant to statute or valid court order;

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

50.7 (4) to an agent of the welfare system or an investigator acting on behalf of a county,
50.8 state, or federal government, including a law enforcement officer or attorney in the
50.9 investigation or prosecution of a criminal, civil, or administrative proceeding, unless the
50.10 commissioner of human services determines that disclosure may compromise a Department
50.11 of Human Services ongoing investigation; or

50.12 ~~(4)~~ (5) to provide notices required or permitted by statute.

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

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

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

50.24 Sec. 2. Minnesota Statutes 2018, section 15C.02, is amended to read:

50.25 **15C.02 LIABILITY FOR CERTAIN ACTS.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

52.5 Sec. 3. Minnesota Statutes 2018, section 119B.02, subdivision 6, is amended to read:

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

52.10 (b) For purposes of this paragraph, "child care assistance program payment data" means
52.11 data for a specified time period showing (1) that a child care assistance program payment
52.12 under this chapter was made, and (2) the amount of child care assistance payments made
52.13 to a child care center. Child care assistance program payment data may include the number
52.14 of families and children on whose behalf payments were made for the specified time period.
52.15 Any child care assistance program payment data that may identify a specific child care
52.16 assistance recipient or benefit paid on behalf of a specific child care assistance recipient,
52.17 as determined by the commissioner, is private data on individuals as defined in section
52.18 13.02, subdivision 12. Data related to a child care assistance payment is public if the data
52.19 relates to a child care assistance payment made to a licensed child care center or a child
52.20 care center exempt from licensure and:

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

52.23 (2) when the commissioner or county agency either:

52.24 (i) disqualified the center from receipt of a payment from the child care assistance
52.25 program under this chapter for wrongfully obtaining child care assistance under section
52.26 256.98, subdivision 8, paragraph (c);

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

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

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

53.1 Sec. 4. Minnesota Statutes 2018, section 119B.09, subdivision 7, is amended to read:

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

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

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

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

53.20 Sec. 5. Minnesota Statutes 2018, section 119B.125, subdivision 6, is amended to read:

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

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

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

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

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

54.3 (c) A county or the commissioner may deny or revoke a provider's authorization as a
54.4 child care provider to any applicant, rescind authorization of any provider, to receive child
54.5 care assistance payments under section 119B.13, subdivision 6, paragraph (d), pursue a
54.6 fraud disqualification under section 256.98, take an action against the provider under chapter
54.7 245E, or establish an attendance record overpayment claim in the system under paragraph
54.8 (d) against a current or former provider, when the county or the commissioner knows or
54.9 has reason to believe that the provider has not complied with the record-keeping requirement
54.10 in this subdivision. A provider's failure to produce attendance records as requested on more
54.11 than one occasion constitutes grounds for disqualification as a provider.

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

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

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

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

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

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

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

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

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

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

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

55.16 (4) the provider is operating after:

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

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

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

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

55.23 (6) the provider gives false child care price information; or

55.24 (7) the provider fails to report decreases in a child's attendance as required under section
 55.25 119B.125, subdivision 9.

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

55.29 (f) A county's payment policies must be included in the county's child care plan under
 55.30 section 119B.08, subdivision 3. If payments are made by the state, in addition to being in
 55.31 compliance with this subdivision, the payments must be made in compliance with section
 55.32 16A.124.

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

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

56.3 Subd. 7. **Absent days.** (a) Licensed child care providers and license-exempt centers
56.4 must not be reimbursed for more than 25 full-day absent days per child, excluding holidays,
56.5 in a ~~fiscal~~ calendar year, or for more than ten consecutive full-day absent days. "Absent
56.6 day" means any day that the child is authorized and scheduled to be in care with a licensed
56.7 provider or license-exempt center, and the child is absent from the care for the entire day.

56.8 Legal nonlicensed family child care providers must not be reimbursed for absent days. If a
56.9 child attends for part of the time authorized to be in care in a day, but is absent for part of
56.10 the time authorized to be in care in that same day, the absent time must be reimbursed but
56.11 the time must not count toward the absent days limit. Child care providers must only be
56.12 reimbursed for absent days if the provider has a written policy for child absences and charges
56.13 all other families in care for similar absences.

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

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

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

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

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

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

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

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

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

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

57.20 Sec. 8. Minnesota Statutes 2018, section 144.057, subdivision 3, is amended to read:

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

58.1 Sec. 9. Minnesota Statutes 2018, section 245.095, is amended to read:

58.2 **245.095 LIMITS ON RECEIVING PUBLIC FUNDS.**

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

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

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

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

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

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

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

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

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

58.29 Sec. 10. Minnesota Statutes 2018, section 245A.02, subdivision 3, is amended to read:

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

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

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

59.4 Sec. 11. Minnesota Statutes 2018, section 245A.02, is amended by adding a subdivision
 59.5 to read:

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

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

59.11 Sec. 12. Minnesota Statutes 2018, section 245A.02, subdivision 8, is amended to read:

59.12 **Subd. 8. License.** "License" means a certificate issued by the commissioner under section
 59.13 245A.04 authorizing the license holder to provide a specified program for a specified period
 59.14 of time and in accordance with the terms of the license and the rules of the commissioner.

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

59.16 Sec. 13. Minnesota Statutes 2018, section 245A.02, subdivision 9, is amended to read:

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

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

59.23 Sec. 14. Minnesota Statutes 2018, section 245A.02, is amended by adding a subdivision
 59.24 to read:

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

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

60.1 Sec. 15. Minnesota Statutes 2018, section 245A.02, subdivision 12, is amended to read:

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

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

60.7 Sec. 16. Minnesota Statutes 2018, section 245A.02, subdivision 14, is amended to read:

60.8 Subd. 14. **Residential program.** (a) Except as provided in paragraph (b), "residential
 60.9 program" means a program that provides 24-hour-a-day care, supervision, food, lodging,
 60.10 rehabilitation, training, education, habilitation, or treatment outside a person's own home,
 60.11 including a program in an intermediate care facility for four or more persons with
 60.12 developmental disabilities; and chemical dependency or chemical abuse programs that are
 60.13 located in a hospital or nursing home and receive public funds for providing chemical abuse
 60.14 or chemical dependency treatment services under chapter 254B. Residential programs
 60.15 include home and community-based services for persons with disabilities or persons age
 60.16 65 and older that are provided in or outside of a person's own home under chapter 245D.

60.17 (b) For a residential program under chapter 245D, "residential program" means a single
 60.18 or multifamily dwelling that is under the control, either directly or indirectly, of the service
 60.19 provider licensed under chapter 245D and in which at least one person receives services
 60.20 under chapter 245D, including residential supports and services under section 245D.03,
 60.21 subdivision 1, paragraph (c), clause (3); out-of-home crisis respite services under section
 60.22 245D.03, subdivision 1, paragraph (c), clause (1), item (ii); and out-of-home respite services
 60.23 under section 245D.03, subdivision 1, paragraph (b), clause (1). A residential program does
 60.24 not include out-of-home respite services when a case manager has determined that an
 60.25 unlicensed site meets the assessed needs of the person. A residential program also does not
 60.26 include multifamily dwellings where persons receive integrated community supports, even
 60.27 if authorization to provide these supports is granted under chapter 245D and approved in
 60.28 the federal waiver.

60.29 Sec. 17. Minnesota Statutes 2018, section 245A.02, subdivision 18, is amended to read:

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

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

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

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

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

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

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

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

61.20 Sec. 18. Minnesota Statutes 2018, section 245A.03, subdivision 1, is amended to read:

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

61.24 (1) operate a residential or a nonresidential program;

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

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

61.29 (4) advertise a residential or nonresidential program.

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

62.1 Sec. 19. Minnesota Statutes 2018, section 245A.03, subdivision 3, is amended to read:

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

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

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

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

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

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

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

62.23 Sec. 20. Minnesota Statutes 2018, section 245A.04, subdivision 1, is amended to read:

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

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

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

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

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

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

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

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

64.8 ~~(e) The applicant must be able to demonstrate competent knowledge of the applicable~~
 64.9 ~~requirements of this chapter and chapter 245C, and the requirements of other licensing~~
 64.10 ~~statutes and rules applicable to the program or services for which the applicant is seeking~~
 64.11 ~~to be licensed. Effective January 1, 2013, The commissioner may limit communication~~
 64.12 ~~during the application process to the authorized agent or the controlling individuals identified~~
 64.13 ~~on the license application and for whom a background study was initiated under chapter~~
 64.14 ~~245C.~~ The commissioner may require the applicant, except for child foster care, to
 64.15 demonstrate competence in the applicable licensing requirements by successfully completing
 64.16 a written examination. The commissioner may develop a prescribed written examination
 64.17 format.

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

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

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

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

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

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

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

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

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

65.6 (3) the first, middle, and last name, and address for all individuals who will be controlling
 65.7 individuals, including all officers, owners, and managerial officials as defined in section
 65.8 245A.02, subdivision 5a, and the date that the background study was initiated by the applicant
 65.9 for each controlling individual; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

66.12 (iii) recovery of payments made for the service;

66.13 (iv) disenrollment in the public payment program; or

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

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

66.16 Sec. 21. Minnesota Statutes 2018, section 245A.04, subdivision 2, is amended to read:

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

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

67.1 Sec. 22. Minnesota Statutes 2018, section 245A.04, subdivision 4, is amended to read:

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

67.5 (1) an inspection of the physical plant;

67.6 (2) an inspection of records and documents;

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

67.8 ~~(4)~~ (3) observation of the program in operation; and

67.9 ~~(5)~~ (4) an inspection for the health, safety, and fire standards in licensing requirements
67.10 for a child care license holder.

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

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

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

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

68.1 requirement at issue, and explain why the license holder believes the county licenser's
 68.2 interpretation is inaccurate. The commissioner and the county must include the license
 68.3 holder in all correspondence regarding the disputed interpretation, and must provide an
 68.4 opportunity for the license holder to contribute relevant information that may impact the
 68.5 commissioner's decision. The commissioner or county licenser must not issue a correction
 68.6 order related to the disputed licensing requirement until the commissioner has provided
 68.7 clarification to the license holder about the licensing requirement.

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

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

68.16 **EFFECTIVE DATE.** The amendments to paragraphs (a) and (b) are effective January
 68.17 1, 2020.

68.18 Sec. 23. Minnesota Statutes 2018, section 245A.04, subdivision 6, is amended to read:

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

68.25 (1) the program's operation;

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

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

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

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

69.1 (b) The commissioner shall also evaluate the results of the study required in subdivision
 69.2 3 and determine whether a risk of harm to the persons served by the program exists. In
 69.3 conducting this evaluation, the commissioner shall apply the disqualification standards set
 69.4 forth in chapter 245C.

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

69.6 Sec. 24. Minnesota Statutes 2018, section 245A.04, subdivision 7, is amended to read:

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

69.11 (1) the name of the license holder;

69.12 (2) the address of the program;

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

69.14 (4) the type of license;

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

69.16 and

69.17 (6) any special conditions of licensure.

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

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

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

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

69.26 (c) A decision by the commissioner to issue a license does not guarantee that any person
 69.27 or persons will be placed or cared for in the licensed program. ~~A license shall not be~~
 69.28 ~~transferable to another individual, corporation, partnership, voluntary association, other~~
 69.29 ~~organization, or controlling individual or to another location.~~

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

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

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

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

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

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

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

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

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

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

70.28 ~~(h)~~ (g) Notwithstanding paragraph ~~(g)~~ (f), when a revocation is based on the
 70.29 disqualification of a controlling individual or license holder, and the controlling individual
 70.30 or license holder is ordered under section 245C.17 to be immediately removed from direct
 70.31 contact with persons receiving services or is ordered to be under continuous, direct
 70.32 supervision when providing direct contact services, the program may continue to operate
 70.33 only if the program complies with the order and submits documentation demonstrating

71.1 compliance with the order. If the disqualified individual fails to submit a timely request for
 71.2 reconsideration, or if the disqualification is not set aside and no variance is granted, the
 71.3 order to immediately remove the individual from direct contact or to be under continuous,
 71.4 direct supervision remains in effect pending the outcome of a hearing and final order from
 71.5 the commissioner.

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

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

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

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

71.20 Sec. 25. Minnesota Statutes 2018, section 245A.04, is amended by adding a subdivision
 71.21 to read:

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

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

71.28 (1) to the license holder's authorized agent as defined in section 245A.02, subdivision
 71.29 3b;

71.30 (2) to the license holder's controlling individual as defined in section 245A.02, subdivision
 71.31 5a;

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

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

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

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

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

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

72.11 Sec. 26. Minnesota Statutes 2018, section 245A.04, is amended by adding a subdivision
 72.12 to read:

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

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

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

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

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

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

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

73.1 Sec. 27. Minnesota Statutes 2018, section 245A.04, subdivision 10, is amended to read:

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

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

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

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

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

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

73.18 Sec. 28. **[245A.043] LICENSE APPLICATION AFTER CHANGE OF OWNERSHIP.**

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

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

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

73.27 (2) the license holder merges with another organization;

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

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

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

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

74.5 Subd. 3. **Change of ownership process.** (a) When a change in ownership is proposed
74.6 and the party intends to assume operation without an interruption in service longer than 60
74.7 days after acquiring the program or service, the license holder must provide the commissioner
74.8 with written notice of the proposed change on a form provided by the commissioner at least
74.9 60 days before the anticipated date of the change in ownership. For purposes of this
74.10 subdivision and subdivision 4, "party" means the party that intends to operate the service
74.11 or program.

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

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

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

74.30 (e) If a licensing inspection of the program or service was conducted within the previous
74.31 12 months and the existing license holder's record demonstrates substantial compliance with
74.32 the applicable licensing requirements, the commissioner may waive the party's inspection
74.33 required by section 245A.04, subdivision 4. The party must submit to the commissioner (1)
74.34 proof that the premises was inspected by a fire marshal or that the fire marshal deemed an

75.1 inspection was not warranted, and (2) proof that the premises was inspected for compliance
75.2 with the building code or no inspection was deemed warranted.

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

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

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

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

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

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

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

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

76.1 Sec. 29. Minnesota Statutes 2018, section 245A.05, is amended to read:

76.2 **245A.05 DENIAL OF APPLICATION.**

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

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

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

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

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

76.12 (5) has an individual living in the household who received a background study under
76.13 section 245C.03, subdivision 1, paragraph (a), clause (2), who has a disqualification that
76.14 has not been set aside under section 245C.22, and no variance has been granted;

76.15 (6) is associated with an individual who received a background study under section
76.16 245C.03, subdivision 1, paragraph (a), clause (6), who may have unsupervised access to
76.17 children or vulnerable adults, and who has a disqualification that has not been set aside
76.18 under section 245C.22, and no variance has been granted; ~~or~~

76.19 (7) fails to comply with section 245A.04, subdivision 1, paragraph (f) or (g);~~;~~

76.20 (8) fails to demonstrate competent knowledge as required by section 245A.04, subdivision
76.21 6;

76.22 (9) has a history of noncompliance as a license holder or controlling individual with
76.23 applicable laws or rules, including but not limited to this chapter and chapters 119B and
76.24 245C;

76.25 (10) is prohibited from holding a license according to section 245.095; or

76.26 (11) for family child foster care, has nondisqualifying background study information,
76.27 as described in section 245C.05, subdivision 4, that reflects on the individual's ability to
76.28 safely provide care to foster children.

76.29 (b) An applicant whose application has been denied by the commissioner must be given
76.30 notice of the denial, which must state the reasons for the denial in plain language. Notice
76.31 must be given by certified mail or personal service. The notice must state the reasons the

77.1 application was denied and must inform the applicant of the right to a contested case hearing
77.2 under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The applicant may
77.3 appeal the denial by notifying the commissioner in writing by certified mail or personal
77.4 service. If mailed, the appeal must be postmarked and sent to the commissioner within 20
77.5 calendar days after the applicant received the notice of denial. If an appeal request is made
77.6 by personal service, it must be received by the commissioner within 20 calendar days after
77.7 the applicant received the notice of denial. Section 245A.08 applies to hearings held to
77.8 appeal the commissioner's denial of an application.

77.9 **EFFECTIVE DATE.** This section is effective January 1, 2020, except paragraph (a),
77.10 clause (11), is effective March 1, 2020.

77.11 Sec. 30. **[245A.055] CLOSING A LICENSE.**

77.12 Subdivision 1. **Inactive programs.** The commissioner shall close a license if the
77.13 commissioner determines that a licensed program has not been serving any client for a
77.14 consecutive period of 12 months or longer. The license holder is not prohibited from
77.15 reapplying for a license if the license holder's license was closed under this chapter.

77.16 Subd. 2. **Reconsideration of closure.** If a license is closed, the commissioner must
77.17 notify the license holder of closure by certified mail or personal service. If mailed, the notice
77.18 of closure must be mailed to the last known address of the license holder and must inform
77.19 the license holder why the license was closed and that the license holder has the right to
77.20 request reconsideration of the closure. If the license holder believes that the license was
77.21 closed in error, the license holder may ask the commissioner to reconsider the closure. The
77.22 license holder's request for reconsideration must be made in writing and must include
77.23 documentation that the licensed program has served a client in the previous 12 months. The
77.24 request for reconsideration must be postmarked and sent to the commissioner within 20
77.25 calendar days after the license holder receives the notice of closure. A timely request for
77.26 reconsideration stays imposition of the license closure until the commissioner issues a
77.27 decision on the request for reconsideration.

77.28 Subd. 3. **Reconsideration final.** The commissioner's disposition of a request for
77.29 reconsideration is final and not subject to appeal under chapter 14.

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

78.1 Sec. 31. Minnesota Statutes 2018, section 245A.07, subdivision 1, is amended to read:

78.2 Subdivision 1. **Sanctions; appeals; license.** (a) In addition to making a license conditional
78.3 under section 245A.06, the commissioner may suspend or revoke the license, impose a fine,
78.4 or secure an injunction against the continuing operation of the program of a license holder
78.5 who does not comply with applicable law or rule or who has nondisqualifying background
78.6 study information, as described in section 245C.05, subdivision 4, that reflects on the license
78.7 holder's ability to safely provide care to foster children. When applying sanctions authorized
78.8 under this section, the commissioner shall consider the nature, chronicity, or severity of the
78.9 violation of law or rule and the effect of the violation on the health, safety, or rights of
78.10 persons served by the program.

78.11 (b) If a license holder appeals the suspension or revocation of a license and the license
78.12 holder continues to operate the program pending a final order on the appeal, the commissioner
78.13 shall issue the license holder a temporary provisional license. Unless otherwise specified
78.14 by the commissioner, variances in effect on the date of the license sanction under appeal
78.15 continue under the temporary provisional license. If a license holder fails to comply with
78.16 applicable law or rule while operating under a temporary provisional license, the
78.17 commissioner may impose additional sanctions under this section and section 245A.06, and
78.18 may terminate any prior variance. If a temporary provisional license is set to expire, a new
78.19 temporary provisional license shall be issued to the license holder upon payment of any fee
78.20 required under section 245A.10. The temporary provisional license shall expire on the date
78.21 the final order is issued. If the license holder prevails on the appeal, a new nonprovisional
78.22 license shall be issued for the remainder of the current license period.

78.23 (c) If a license holder is under investigation and the license issued under this chapter is
78.24 due to expire before completion of the investigation, the program shall be issued a new
78.25 license upon completion of the reapplication requirements and payment of any applicable
78.26 license fee. Upon completion of the investigation, a licensing sanction may be imposed
78.27 against the new license under this section, section 245A.06, or 245A.08.

78.28 (d) Failure to reapply or closure of a license issued under this chapter by the license
78.29 holder prior to the completion of any investigation shall not preclude the commissioner
78.30 from issuing a licensing sanction under this section, or section 245A.06, ~~or 245A.08~~ at the
78.31 conclusion of the investigation.

78.32 **EFFECTIVE DATE.** Paragraph (a) is effective March 1, 2020. Paragraphs (c) and (d)
78.33 are effective January 1, 2020.

79.1 Sec. 32. Minnesota Statutes 2018, section 245A.07, subdivision 2, is amended to read:

79.2 Subd. 2. **Temporary immediate suspension.** (a) The commissioner shall act immediately
79.3 to temporarily suspend a license issued under this chapter if:

79.4 (1) the license holder's actions or failure to comply with applicable law or rule, or the
79.5 actions of other individuals or conditions in the program, pose an imminent risk of harm to
79.6 the health, safety, or rights of persons served by the program; ~~or~~

79.7 (2) while the program continues to operate pending an appeal of an order of revocation,
79.8 the commissioner identifies one or more subsequent violations of law or rule which may
79.9 adversely affect the health or safety of persons served by the program; or

79.10 (3) the license holder is criminally charged in state or federal court with an offense that
79.11 involves fraud or theft against a program administered by the commissioner.

79.12 (b) No state funds shall be made available or be expended by any agency or department
79.13 of state, county, or municipal government for use by a license holder regulated under this
79.14 chapter while a license issued under this chapter is under immediate suspension. A notice
79.15 stating the reasons for the immediate suspension and informing the license holder of the
79.16 right to an expedited hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to
79.17 1400.8612, must be delivered by personal service to the address shown on the application
79.18 or the last known address of the license holder. The license holder may appeal an order
79.19 immediately suspending a license. The appeal of an order immediately suspending a license
79.20 must be made in writing by certified mail ~~or~~, personal service, or other means expressly set
79.21 forth in the commissioner's order. If mailed, the appeal must be postmarked and sent to the
79.22 commissioner within five calendar days after the license holder receives notice that the
79.23 license has been immediately suspended. If a request is made by personal service, it must
79.24 be received by the commissioner within five calendar days after the license holder received
79.25 the order. A license holder and any controlling individual shall discontinue operation of the
79.26 program upon receipt of the commissioner's order to immediately suspend the license.

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

79.28 Sec. 33. Minnesota Statutes 2018, section 245A.07, subdivision 2a, is amended to read:

79.29 Subd. 2a. **Immediate suspension expedited hearing.** (a) Within five working days of
79.30 receipt of the license holder's timely appeal, the commissioner shall request assignment of
79.31 an administrative law judge. The request must include a proposed date, time, and place of
79.32 a hearing. A hearing must be conducted by an administrative law judge within 30 calendar
79.33 days of the request for assignment, unless an extension is requested by either party and

80.1 granted by the administrative law judge for good cause. The commissioner shall issue a
80.2 notice of hearing by certified mail or personal service at least ten working days before the
80.3 hearing. The scope of the hearing shall be limited solely to the issue of whether the temporary
80.4 immediate suspension should remain in effect pending the commissioner's final order under
80.5 section 245A.08, regarding a licensing sanction issued under subdivision 3 following the
80.6 immediate suspension. For suspensions under subdivision 2, paragraph (a), clause (1), the
80.7 burden of proof in expedited hearings under this subdivision shall be limited to the
80.8 commissioner's demonstration that reasonable cause exists to believe that the license holder's
80.9 actions or failure to comply with applicable law or rule poses, or the actions of other
80.10 individuals or conditions in the program poses an imminent risk of harm to the health, safety,
80.11 or rights of persons served by the program. "Reasonable cause" means there exist specific
80.12 articulable facts or circumstances which provide the commissioner with a reasonable
80.13 suspicion that there is an imminent risk of harm to the health, safety, or rights of persons
80.14 served by the program. When the commissioner has determined there is reasonable cause
80.15 to order the temporary immediate suspension of a license based on a violation of safe sleep
80.16 requirements, as defined in section 245A.1435, the commissioner is not required to
80.17 demonstrate that an infant died or was injured as a result of the safe sleep violations. For
80.18 suspensions under subdivision 2, paragraph (a), clause (2), the burden of proof in expedited
80.19 hearings under this subdivision shall be limited to the commissioner's demonstration by a
80.20 preponderance of the evidence that, since the license was revoked, the license holder
80.21 committed additional violations of law or rule which may adversely affect the health or
80.22 safety of persons served by the program.

80.23 (b) The administrative law judge shall issue findings of fact, conclusions, and a
80.24 recommendation within ten working days from the date of hearing. The parties shall have
80.25 ten calendar days to submit exceptions to the administrative law judge's report. The record
80.26 shall close at the end of the ten-day period for submission of exceptions. The commissioner's
80.27 final order shall be issued within ten working days from the close of the record. When an
80.28 appeal of a temporary immediate suspension is withdrawn or dismissed, the commissioner
80.29 shall issue a final order affirming the temporary immediate suspension within ten calendar
80.30 days of the commissioner's receipt of the withdrawal or dismissal. Within 90 calendar days
80.31 after a final order affirming an immediate suspension, the commissioner shall make a
80.32 determination regarding whether a final licensing sanction shall be issued under subdivision
80.33 3. The license holder shall continue to be prohibited from operation of the program during
80.34 this 90-day period.

81.1 (c) When the final order under paragraph (b) affirms an immediate suspension, and a
 81.2 final licensing sanction is issued under subdivision 3 and the license holder appeals that
 81.3 sanction, the license holder continues to be prohibited from operation of the program pending
 81.4 a final commissioner's order under section 245A.08, subdivision 5, regarding the final
 81.5 licensing sanction.

81.6 (d) For suspensions under subdivision 2, paragraph (a), clause (3), the burden of proof
 81.7 in expedited hearings under this subdivision shall be limited to the commissioner's
 81.8 demonstration by a preponderance of the evidence that a criminal complaint and warrant
 81.9 or summons was issued for the license holder that was not dismissed, and that the criminal
 81.10 charge is an offense that involves fraud or theft against a program administered by the
 81.11 commissioner.

81.12 Sec. 34. Minnesota Statutes 2018, section 245A.07, subdivision 3, is amended to read:

81.13 Subd. 3. **License suspension, revocation, or fine.** (a) The commissioner may suspend
 81.14 or revoke a license, or impose a fine if:

81.15 (1) a license holder fails to comply fully with applicable laws or rules including but not
 81.16 limited to the requirements of this chapter and chapter 245C;

81.17 (2) a license holder, a controlling individual, or an individual living in the household
 81.18 where the licensed services are provided or is otherwise subject to a background study has
 81.19 a been disqualified and the disqualification which has was not been set aside under section
 81.20 245C.22 and no variance has been granted;

81.21 (3) a license holder knowingly withholds relevant information from or gives false or
 81.22 misleading information to the commissioner in connection with an application for a license,
 81.23 in connection with the background study status of an individual, during an investigation,
 81.24 or regarding compliance with applicable laws or rules; ~~or~~

81.25 (4) ~~after July 1, 2012, and upon request by the commissioner, a license holder fails to~~
 81.26 ~~submit the information required of an applicant under section 245A.04, subdivision 1,~~
 81.27 ~~paragraph (f) or (g);~~ a license holder is excluded from any program administered by the
 81.28 commissioner under section 245.095; or

81.29 (5) revocation is required under section 245A.04, subdivision 7, paragraph (d).

81.30 A license holder who has had a license issued under this chapter suspended, revoked,
 81.31 or has been ordered to pay a fine must be given notice of the action by certified mail or
 81.32 personal service. If mailed, the notice must be mailed to the address shown on the application

82.1 or the last known address of the license holder. The notice must state in plain language the
82.2 reasons the license was suspended or revoked, or a fine was ordered.

82.3 (b) If the license was suspended or revoked, the notice must inform the license holder
82.4 of the right to a contested case hearing under chapter 14 and Minnesota Rules, parts
82.5 1400.8505 to 1400.8612. The license holder may appeal an order suspending or revoking
82.6 a license. The appeal of an order suspending or revoking a license must be made in writing
82.7 by certified mail or personal service. If mailed, the appeal must be postmarked and sent to
82.8 the commissioner within ten calendar days after the license holder receives notice that the
82.9 license has been suspended or revoked. If a request is made by personal service, it must be
82.10 received by the commissioner within ten calendar days after the license holder received the
82.11 order. Except as provided in subdivision 2a, paragraph (c), if a license holder submits a
82.12 timely appeal of an order suspending or revoking a license, the license holder may continue
82.13 to operate the program as provided in section 245A.04, subdivision 7, paragraphs ~~(g)~~ (f)
82.14 and ~~(h)~~ (g), until the commissioner issues a final order on the suspension or revocation.

82.15 (c)(1) If the license holder was ordered to pay a fine, the notice must inform the license
82.16 holder of the responsibility for payment of fines and the right to a contested case hearing
82.17 under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The appeal of an
82.18 order to pay a fine must be made in writing by certified mail or personal service. If mailed,
82.19 the appeal must be postmarked and sent to the commissioner within ten calendar days after
82.20 the license holder receives notice that the fine has been ordered. If a request is made by
82.21 personal service, it must be received by the commissioner within ten calendar days after
82.22 the license holder received the order.

82.23 (2) The license holder shall pay the fines assessed on or before the payment date specified.
82.24 If the license holder fails to fully comply with the order, the commissioner may issue a
82.25 second fine or suspend the license until the license holder complies. If the license holder
82.26 receives state funds, the state, county, or municipal agencies or departments responsible for
82.27 administering the funds shall withhold payments and recover any payments made while the
82.28 license is suspended for failure to pay a fine. A timely appeal shall stay payment of the fine
82.29 until the commissioner issues a final order.

82.30 (3) A license holder shall promptly notify the commissioner of human services, in writing,
82.31 when a violation specified in the order to forfeit a fine is corrected. If upon reinspection the
82.32 commissioner determines that a violation has not been corrected as indicated by the order
82.33 to forfeit a fine, the commissioner may issue a second fine. The commissioner shall notify
82.34 the license holder by certified mail or personal service that a second fine has been assessed.
82.35 The license holder may appeal the second fine as provided under this subdivision.

83.1 (4) Fines shall be assessed as follows:

83.2 (i) the license holder shall forfeit \$1,000 for each determination of maltreatment of a
83.3 child under section 626.556 or the maltreatment of a vulnerable adult under section 626.557
83.4 for which the license holder is determined responsible for the maltreatment under section
83.5 626.556, subdivision 10e, paragraph (i), or 626.557, subdivision 9c, paragraph (c);

83.6 (ii) if the commissioner determines that a determination of maltreatment for which the
83.7 license holder is responsible is the result of maltreatment that meets the definition of serious
83.8 maltreatment as defined in section 245C.02, subdivision 18, the license holder shall forfeit
83.9 \$5,000;

83.10 (iii) for a program that operates out of the license holder's home and a program licensed
83.11 under Minnesota Rules, parts 9502.0300 to ~~9502.0495~~ 9502.0445, the fine assessed against
83.12 the license holder shall not exceed \$1,000 for each determination of maltreatment;

83.13 (iv) the license holder shall forfeit \$200 for each occurrence of a violation of law or rule
83.14 governing matters of health, safety, or supervision, including but not limited to the provision
83.15 of adequate staff-to-child or adult ratios, and failure to comply with background study
83.16 requirements under chapter 245C; and

83.17 (v) the license holder shall forfeit \$100 for each occurrence of a violation of law or rule
83.18 other than those subject to a \$5,000, \$1,000, or \$200 fine in items (i) to (iv).

83.19 For purposes of this section, "occurrence" means each violation identified in the
83.20 commissioner's fine order. Fines assessed against a license holder that holds a license to
83.21 provide home and community-based services, as identified in section 245D.03, subdivision
83.22 1, and a community residential setting or day services facility license under chapter 245D
83.23 where the services are provided, may be assessed against both licenses for the same
83.24 occurrence, but the combined amount of the fines shall not exceed the amount specified in
83.25 this clause for that occurrence.

83.26 (5) When a fine has been assessed, the license holder may not avoid payment by closing,
83.27 selling, or otherwise transferring the licensed program to a third party. In such an event, the
83.28 license holder will be personally liable for payment. In the case of a corporation, each
83.29 controlling individual is personally and jointly liable for payment.

83.30 (d) Except for background study violations involving the failure to comply with an order
83.31 to immediately remove an individual or an order to provide continuous, direct supervision,
83.32 the commissioner shall not issue a fine under paragraph (c) relating to a background study
83.33 violation to a license holder who self-corrects a background study violation before the

84.1 commissioner discovers the violation. A license holder who has previously exercised the
 84.2 provisions of this paragraph to avoid a fine for a background study violation may not avoid
 84.3 a fine for a subsequent background study violation unless at least 365 days have passed
 84.4 since the license holder self-corrected the earlier background study violation.

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

84.6 Sec. 35. Minnesota Statutes 2018, section 245A.10, subdivision 4, is amended to read:

84.7 Subd. 4. **License or certification fee for certain programs.** (a) Child care centers shall
 84.8 pay an annual nonrefundable license fee based on the following schedule:

84.9	84.10	Child Care Center License Fee
84.11	1 to 24 persons	\$200
84.12	25 to 49 persons	\$300
84.13	50 to 74 persons	\$400
84.14	75 to 99 persons	\$500
84.15	100 to 124 persons	\$600
84.16	125 to 149 persons	\$700
84.17	150 to 174 persons	\$800
84.18	175 to 199 persons	\$900
84.19	200 to 224 persons	\$1,000
84.20	225 or more persons	\$1,100

84.21 (b)(1) A program licensed to provide one or more of the home and community-based
 84.22 services and supports identified under chapter 245D to persons with disabilities or age 65
 84.23 and older, shall pay an annual nonrefundable license fee based on revenues derived from
 84.24 the provision of services that would require licensure under chapter 245D during the calendar
 84.25 year immediately preceding the year in which the license fee is paid, according to the
 84.26 following schedule:

84.27	License Holder Annual Revenue	License Fee
84.28	less than or equal to \$10,000	\$200 <u>\$240</u>
84.29	greater than \$10,000 but less than or	
84.30	equal to \$25,000	\$300 <u>\$360</u>
84.31	greater than \$25,000 but less than or	
84.32	equal to \$50,000	\$400 <u>\$480</u>
84.33	greater than \$50,000 but less than or	
84.34	equal to \$100,000	\$500 <u>\$600</u>
84.35	greater than \$100,000 but less than or	
84.36	equal to \$150,000	\$600 <u>\$720</u>

85.1	greater than \$150,000 but less than or	
85.2	equal to \$200,000	\$800 <u>\$960</u>
85.3	greater than \$200,000 but less than or	
85.4	equal to \$250,000	\$1,000 <u>\$1,200</u>
85.5	greater than \$250,000 but less than or	
85.6	equal to \$300,000	\$1,200 <u>\$1,440</u>
85.7	greater than \$300,000 but less than or	
85.8	equal to \$350,000	\$1,400 <u>\$1,680</u>
85.9	greater than \$350,000 but less than or	
85.10	equal to \$400,000	\$1,600 <u>\$1,920</u>
85.11	greater than \$400,000 but less than or	
85.12	equal to \$450,000	\$1,800 <u>\$2,160</u>
85.13	greater than \$450,000 but less than or	
85.14	equal to \$500,000	\$2,000 <u>\$2,400</u>
85.15	greater than \$500,000 but less than or	
85.16	equal to \$600,000	\$2,250 <u>\$2,700</u>
85.17	greater than \$600,000 but less than or	
85.18	equal to \$700,000	\$2,500 <u>\$3,000</u>
85.19	greater than \$700,000 but less than or	
85.20	equal to \$800,000	\$2,750 <u>\$3,300</u>
85.21	greater than \$800,000 but less than or	
85.22	equal to \$900,000	\$3,000 <u>\$3,600</u>
85.23	greater than \$900,000 but less than or	
85.24	equal to \$1,000,000	\$3,250 <u>\$3,900</u>
85.25	greater than \$1,000,000 but less than or	
85.26	equal to \$1,250,000	\$3,500 <u>\$4,200</u>
85.27	greater than \$1,250,000 but less than or	
85.28	equal to \$1,500,000	\$3,750 <u>\$4,500</u>
85.29	greater than \$1,500,000 but less than or	
85.30	equal to \$1,750,000	\$4,000 <u>\$4,800</u>
85.31	greater than \$1,750,000 but less than or	
85.32	equal to \$2,000,000	\$4,250 <u>\$5,100</u>
85.33	greater than \$2,000,000 but less than or	
85.34	equal to \$2,500,000	\$4,500 <u>\$5,400</u>
85.35	greater than \$2,500,000 but less than or	
85.36	equal to \$3,000,000	\$4,750 <u>\$5,700</u>
85.37	greater than \$3,000,000 but less than or	
85.38	equal to \$3,500,000	\$5,000 <u>\$6,000</u>
85.39	greater than \$3,500,000 but less than or	
85.40	equal to \$4,000,000	\$5,500 <u>\$6,600</u>
85.41	greater than \$4,000,000 but less than or	
85.42	equal to \$4,500,000	\$6,000 <u>\$7,200</u>
85.43	greater than \$4,500,000 but less than or	
85.44	equal to \$5,000,000	\$6,500 <u>\$7,800</u>
85.45	greater than \$5,000,000 but less than or	
85.46	equal to \$7,500,000	\$7,000 <u>\$9,000</u>

86.1	greater than \$7,500,000 but less than or	
86.2	equal to \$10,000,000	\$8,500 <u>\$13,500</u>
86.3	greater than \$10,000,000 but less than or	
86.4	equal to \$12,500,000	\$10,000 <u>\$18,000</u>
86.5	greater than \$12,500,000 but less than or	
86.6	equal to \$15,000,000	\$14,000 <u>\$22,500</u>
86.7	greater than \$15,000,000 but less than or	
86.8	<u>equal to \$17,500,000</u>	\$18,000 <u>\$27,000</u>
86.9	<u>greater than \$17,500,000 but less than or</u>	
86.10	<u>equal to \$20,000,000</u>	<u>\$31,500</u>
86.11	<u>greater than \$20,000,000 but less than or</u>	
86.12	<u>equal to \$25,000,000</u>	<u>\$36,000</u>
86.13	<u>greater than \$25,000,000 but less than or</u>	
86.14	<u>equal to \$30,000,000</u>	<u>\$45,000</u>
86.15	<u>greater than \$30,000,000 but less than or</u>	
86.16	<u>equal to \$35,000,000</u>	<u>\$54,000</u>
86.17	<u>greater than \$35,000,000 but less than or</u>	
86.18	<u>equal to \$40,000,000</u>	<u>\$63,000</u>
86.19	<u>greater than \$40,000,000</u>	<u>\$72,000</u>

86.20 (2) If requested, the license holder shall provide the commissioner information to verify
 86.21 the license holder's annual revenues or other information as needed, including copies of
 86.22 documents submitted to the Department of Revenue.

86.23 (3) At each annual renewal, a license holder may elect to pay the highest renewal fee,
 86.24 and not provide annual revenue information to the commissioner.

86.25 (4) A license holder that knowingly provides the commissioner incorrect revenue amounts
 86.26 for the purpose of paying a lower license fee shall be subject to a civil penalty in the amount
 86.27 of double the fee the provider should have paid.

86.28 ~~(5) Notwithstanding clause (1), a license holder providing services under one or more~~
 86.29 ~~licenses under chapter 245B that are in effect on May 15, 2013, shall pay an annual license~~
 86.30 ~~fee for calendar years 2014, 2015, and 2016, equal to the total license fees paid by the license~~
 86.31 ~~holder for all licenses held under chapter 245B for calendar year 2013. For calendar year~~
 86.32 ~~2017 and thereafter, the license holder shall pay an annual license fee according to clause~~
 86.33 ~~(1).~~

86.34 (c) A chemical dependency treatment program licensed under chapter 245G, to provide
 86.35 chemical dependency treatment shall pay an annual nonrefundable license fee based on the
 86.36 following schedule:

86.37	Licensed Capacity	License Fee
86.38	1 to 24 persons	\$600

87.1	25 to 49 persons	\$800
87.2	50 to 74 persons	\$1,000
87.3	75 to 99 persons	\$1,200
87.4	100 or more persons	\$1,400

87.5 (d) A chemical dependency program licensed under Minnesota Rules, parts 9530.6510
 87.6 to 9530.6590, to provide detoxification services shall pay an annual nonrefundable license
 87.7 fee based on the following schedule:

87.8	Licensed Capacity	License Fee
87.9	1 to 24 persons	\$760
87.10	25 to 49 persons	\$960
87.11	50 or more persons	\$1,160

87.12 (e) Except for child foster care, a residential facility licensed under Minnesota Rules,
 87.13 chapter 2960, to serve children shall pay an annual nonrefundable license fee based on the
 87.14 following schedule:

87.15	Licensed Capacity	License Fee
87.16	1 to 24 persons	\$1,000
87.17	25 to 49 persons	\$1,100
87.18	50 to 74 persons	\$1,200
87.19	75 to 99 persons	\$1,300
87.20	100 or more persons	\$1,400

87.21 (f) A residential facility licensed under Minnesota Rules, parts 9520.0500 to 9520.0670,
 87.22 to serve persons with mental illness shall pay an annual nonrefundable license fee based on
 87.23 the following schedule:

87.24	Licensed Capacity	License Fee
87.25	1 to 24 persons	\$2,525
87.26	25 or more persons	\$2,725

87.27 (g) A residential facility licensed under Minnesota Rules, parts 9570.2000 to 9570.3400,
 87.28 to serve persons with physical disabilities shall pay an annual nonrefundable license fee
 87.29 based on the following schedule:

87.30	Licensed Capacity	License Fee
87.31	1 to 24 persons	\$450
87.32	25 to 49 persons	\$650
87.33	50 to 74 persons	\$850

88.1 75 to 99 persons \$1,050

88.2 100 or more persons \$1,250

88.3 (h) A program licensed to provide independent living assistance for youth under section
88.4 245A.22 shall pay an annual nonrefundable license fee of \$1,500.

88.5 (i) A private agency licensed to provide foster care and adoption services under Minnesota
88.6 Rules, parts 9545.0755 to 9545.0845, shall pay an annual nonrefundable license fee of \$875.

88.7 (j) A program licensed as an adult day care center licensed under Minnesota Rules, parts
88.8 9555.9600 to 9555.9730, shall pay an annual nonrefundable license fee based on the
88.9 following schedule:

88.10	Licensed Capacity	License Fee
88.11	1 to 24 persons	\$500
88.12	25 to 49 persons	\$700
88.13	50 to 74 persons	\$900
88.14	75 to 99 persons	\$1,100
88.15	100 or more persons	\$1,300

88.16 (k) A program licensed to provide treatment services to persons with sexual psychopathic
88.17 personalities or sexually dangerous persons under Minnesota Rules, parts 9515.3000 to
88.18 9515.3110, shall pay an annual nonrefundable license fee of \$20,000.

88.19 (l) A mental health center or mental health clinic requesting certification for purposes
88.20 of insurance and subscriber contract reimbursement under Minnesota Rules, parts 9520.0750
88.21 to 9520.0870, shall pay a certification fee of \$1,550 per year. If the mental health center or
88.22 mental health clinic provides services at a primary location with satellite facilities, the
88.23 satellite facilities shall be certified with the primary location without an additional charge.

88.24 Sec. 36. Minnesota Statutes 2018, section 245A.14, subdivision 4, is amended to read:

88.25 Subd. 4. **Special family day care homes.** Nonresidential child care programs serving
88.26 14 or fewer children that are conducted at a location other than the license holder's own
88.27 residence shall be licensed under this section and the rules governing family day care or
88.28 group family day care if:

88.29 (a) the license holder is the primary provider of care and the nonresidential child care
88.30 program is conducted in a dwelling that is located on a residential lot;

88.31 (b) the license holder is an employer who may or may not be the primary provider of
88.32 care, and the purpose for the child care program is to provide child care services to children
88.33 of the license holder's employees;

89.1 (c) the license holder is a church or religious organization;

89.2 (d) the license holder is a community collaborative child care provider. For purposes of
89.3 this subdivision, a community collaborative child care provider is a provider participating
89.4 in a cooperative agreement with a community action agency as defined in section 256E.31;

89.5 (e) the license holder is a not-for-profit agency that provides child care in a dwelling
89.6 located on a residential lot and the license holder maintains two or more contracts with
89.7 community employers or other community organizations to provide child care services.
89.8 The county licensing agency may grant a capacity variance to a license holder licensed
89.9 under this paragraph to exceed the licensed capacity of 14 children by no more than five
89.10 children during transition periods related to the work schedules of parents, if the license
89.11 holder meets the following requirements:

89.12 (1) the program does not exceed a capacity of 14 children more than a cumulative total
89.13 of four hours per day;

89.14 (2) the program meets a one to seven staff-to-child ratio during the variance period;

89.15 (3) all employees receive at least an extra four hours of training per year than required
89.16 in the rules governing family child care each year;

89.17 (4) the facility has square footage required per child under Minnesota Rules, part
89.18 9502.0425;

89.19 (5) the program is in compliance with local zoning regulations;

89.20 (6) the program is in compliance with the applicable fire code as follows:

89.21 (i) if the program serves more than five children older than 2-1/2 years of age, but no
89.22 more than five children 2-1/2 years of age or less, the applicable fire code is educational
89.23 occupancy, as provided in Group E Occupancy under the Minnesota State Fire Code ~~2003~~
89.24 2015, Section 202; or

89.25 (ii) if the program serves more than five children 2-1/2 years of age or less, the applicable
89.26 fire code is Group I-4 Occupancies, as provided in the Minnesota State Fire Code ~~2003~~
89.27 2015, Section 202, unless the rooms in which the children are cared for are located on a
89.28 level of exit discharge and each of these child care rooms has an exit door directly to the
89.29 exterior, then the applicable fire code is Group E occupancies, as provided in the Minnesota
89.30 State Fire Code 2015, Section 202; and

89.31 (7) any age and capacity limitations required by the fire code inspection and square
89.32 footage determinations shall be printed on the license; or

90.1 (f) the license holder is the primary provider of care and has located the licensed child
 90.2 care program in a commercial space, if the license holder meets the following requirements:

90.3 (1) the program is in compliance with local zoning regulations;

90.4 (2) the program is in compliance with the applicable fire code as follows:

90.5 (i) if the program serves more than five children older than 2-1/2 years of age, but no
 90.6 more than five children 2-1/2 years of age or less, the applicable fire code is educational
 90.7 occupancy, as provided in Group E Occupancy under the Minnesota State Fire Code ~~2003~~
 90.8 2015, Section 202; or

90.9 (ii) if the program serves more than five children 2-1/2 years of age or less, the applicable
 90.10 fire code is Group I-4 Occupancies, as provided under the Minnesota State Fire Code ~~2003~~
 90.11 2015, Section 202;

90.12 (3) any age and capacity limitations required by the fire code inspection and square
 90.13 footage determinations are printed on the license; and

90.14 (4) the license holder prominently displays the license issued by the commissioner which
 90.15 contains the statement "This special family child care provider is not licensed as a child
 90.16 care center."

90.17 (g) The commissioner may approve two or more licenses under paragraphs (a) to (f) to
 90.18 be issued at the same location or under one contiguous roof, if each license holder is able
 90.19 to demonstrate compliance with all applicable rules and laws. Each license holder must
 90.20 operate the license holder's respective licensed program as a distinct program and within
 90.21 the capacity, age, and ratio distributions of each license.

90.22 (h) The commissioner may grant variances to this section to allow a primary provider
 90.23 of care, a not-for-profit organization, a church or religious organization, an employer, or a
 90.24 community collaborative to be licensed to provide child care under paragraphs (e) and (f)
 90.25 if the license holder meets the other requirements of the statute.

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

90.27 Sec. 37. Minnesota Statutes 2018, section 245A.14, subdivision 8, is amended to read:

90.28 Subd. 8. **Experienced aides; child care centers.** (a) An individual employed as an aide
 90.29 at a child care center may work with children without being directly supervised for an
 90.30 amount of time that does not exceed 25 percent of the child care center's daily hours if:

90.31 (1) a teacher is in the facility;

91.1 ~~(2) the individual has received within the last three years first aid training that meets the~~
 91.2 ~~requirements under section 245A.40, subdivision 3, and CPR training that meets the~~
 91.3 ~~requirements under section 245A.40, subdivision 4;~~

91.4 ~~(3)~~ (2) the individual is at least 20 years old; and

91.5 ~~(4)~~ (3) the individual has at least 4,160 hours of child care experience as a staff member
 91.6 in a licensed child care center or as the license holder of a family day care home, 120 days
 91.7 of which must be in the employment of the current company.

91.8 (b) A child care center that uses experienced aides under this subdivision must notify
 91.9 parents or guardians by posting the notification in each classroom that uses experienced
 91.10 aides, identifying which staff member is the experienced aide. Records of experienced aide
 91.11 usage must be kept on site and given to the commissioner upon request.

91.12 (c) A child care center may not use the experienced aide provision for one year following
 91.13 two determined experienced aide violations within a one-year period.

91.14 (d) A child care center may use one experienced aide per every four full-time child care
 91.15 classroom staff.

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

91.17 Sec. 38. Minnesota Statutes 2018, section 245A.14, is amended by adding a subdivision
 91.18 to read:

91.19 Subd. 16. **Valid driver's license.** Notwithstanding any law to the contrary, when a
 91.20 licensed child care center provides transportation for children or contracts to provide
 91.21 transportation for children, a person who has a current, valid driver's license appropriate to
 91.22 the vehicle driven may transport the child.

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

91.24 Sec. 39. Minnesota Statutes 2018, section 245A.14, is amended by adding a subdivision
 91.25 to read:

91.26 Subd. 17. **Reusable water bottles or cups.** Notwithstanding any law to the contrary, a
 91.27 licensed child care center may provide drinking water to a child in a reusable water bottle
 91.28 or reusable cup if the center develops and ensures implementation of a written policy that
 91.29 at a minimum includes the following procedures:

92.1 (1) each day the water bottle or cup is used, the child care center cleans and sanitizes
 92.2 the water bottle or cup using procedures that comply with the Food Code under Minnesota
 92.3 Rules, chapter 4626;

92.4 (2) a water bottle or cup is assigned to a specific child and labeled with the child's first
 92.5 and last name;

92.6 (3) water bottles and cups are stored in a manner that reduces the risk of a child using
 92.7 the wrong water bottle or cup; and

92.8 (4) a water bottle or cup is used only for water.

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

92.10 Sec. 40. Minnesota Statutes 2018, section 245A.145, subdivision 1, is amended to read:

92.11 Subdivision 1. **Policies and procedures.** ~~(a) All licensed child care providers~~ The
 92.12 Department of Human Services must develop policies and procedures for reporting suspected
 92.13 child maltreatment that fulfill the requirements in section 626.556 and ~~must develop policies~~
 92.14 ~~and procedures for reporting complaints about the operation of a child care program. The~~
 92.15 ~~policies and procedures must include the telephone numbers of the local county child~~
 92.16 ~~protection agency for reporting suspected maltreatment; the county licensing agency for~~
 92.17 ~~family and group family child care providers; and the state licensing agency for child care~~
 92.18 ~~centers.~~ provide the policies and procedures to all licensed child care providers. The policies
 92.19 and procedures must be written in plain language.

92.20 (b) The policies and procedures required in paragraph (a) must:

92.21 (1) be provided to the parents of all children at the time of enrollment in the child care
 92.22 program; and

92.23 (2) be made available upon request.

92.24 Sec. 41. Minnesota Statutes 2018, section 245A.145, subdivision 2, is amended to read:

92.25 Subd. 2. **Licensing agency phone number displayed.** ~~By July 1, 2002,~~ A new or
 92.26 renewed child care license must include the licensing agency's telephone number and a
 92.27 statement that informs parents who have concerns questions about their child's care that
 92.28 they may call the licensing agency. ~~The commissioner shall print the telephone number for~~
 92.29 ~~the licensing agency in bold and large font on the license issued to child care providers.~~

93.1 Sec. 42. **[245A.149] SUPERVISION OF FAMILY CHILD CARE LICENSE**

93.2 **HOLDER'S OWN CHILD.**

93.3 Notwithstanding Minnesota Rules, part 9502.0365, subpart 5, an individual may supervise
 93.4 the family child care license holder's own child both inside and outside of the licensed space,
 93.5 and is exempt from the requirements of this chapter and Minnesota Rules, chapter 9502, if
 93.6 the individual:

93.7 (1) is related to the license holder, as defined in section 245A.02, subdivision 13;

93.8 (2) is not a designated caregiver, helper, or substitute for the licensed program; and

93.9 (3) is involved only in the care of the license holder's own child.

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

93.11 Sec. 43. Minnesota Statutes 2018, section 245A.151, is amended to read:

93.12 **245A.151 FIRE MARSHAL INSPECTION.**

93.13 When licensure under this chapter or certification under chapter 245H requires an
 93.14 inspection by a fire marshal to determine compliance with the State Fire Code under section
 93.15 299F.011, a local fire code inspector approved by the state fire marshal may conduct the
 93.16 inspection. If a community does not have a local fire code inspector or if the local fire code
 93.17 inspector does not perform the inspection, the state fire marshal must conduct the inspection.
 93.18 A local fire code inspector or the state fire marshal may recover the cost of these inspections
 93.19 through a fee of no more than \$50 per inspection charged to the applicant or license holder
 93.20 or license-exempt child care center certification holder. The fees collected by the state fire
 93.21 marshal under this section are appropriated to the commissioner of public safety for the
 93.22 purpose of conducting the inspections.

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

93.24 Sec. 44. Minnesota Statutes 2018, section 245A.16, subdivision 1, is amended to read:

93.25 Subdivision 1. **Delegation of authority to agencies.** (a) County agencies and private
 93.26 agencies that have been designated or licensed by the commissioner to perform licensing
 93.27 functions and activities under section 245A.04 and background studies for family child care
 93.28 under chapter 245C; to recommend denial of applicants under section 245A.05; to issue
 93.29 correction orders, to issue variances, and recommend a conditional license under section
 93.30 245A.06; or to recommend suspending or revoking a license or issuing a fine under section
 93.31 245A.07, shall comply with rules and directives of the commissioner governing those

94.1 functions and with this section. The following variances are excluded from the delegation
94.2 of variance authority and may be issued only by the commissioner:

94.3 (1) dual licensure of family child care and child foster care, dual licensure of child and
94.4 adult foster care, and adult foster care and family child care;

94.5 (2) adult foster care maximum capacity;

94.6 (3) adult foster care minimum age requirement;

94.7 (4) child foster care maximum age requirement;

94.8 (5) variances regarding disqualified individuals except that, before the implementation
94.9 of NETStudy 2.0, county agencies may issue variances under section 245C.30 regarding
94.10 disqualified individuals when the county is responsible for conducting a consolidated
94.11 reconsideration according to sections 245C.25 and 245C.27, subdivision 2, clauses (a) and
94.12 (b), of a county maltreatment determination and a disqualification based on serious or
94.13 recurring maltreatment;

94.14 (6) the required presence of a caregiver in the adult foster care residence during normal
94.15 sleeping hours; ~~and~~

94.16 (7) variances to requirements relating to chemical use problems of a license holder or a
94.17 household member of a license holder; and

94.18 (8) variances to section 245A.53 for a time-limited period. If the commissioner grants
94.19 a variance under this clause, the license holder must provide notice of the variance to all
94.20 parents and guardians of the children in care.

94.21 Except as provided in section 245A.14, subdivision 4, paragraph (e), a county agency must
94.22 not grant a license holder a variance to exceed the maximum allowable family child care
94.23 license capacity of 14 children.

94.24 (b) Before the implementation of NETStudy 2.0, county agencies must report information
94.25 about disqualification reconsiderations under sections 245C.25 and 245C.27, subdivision
94.26 2, paragraphs (a) and (b), and variances granted under paragraph (a), clause (5), to the
94.27 commissioner at least monthly in a format prescribed by the commissioner.

94.28 (c) For family child care programs, the commissioner shall require a county agency to
94.29 conduct one unannounced licensing review at least annually.

94.30 (d) For family adult day services programs, the commissioner may authorize licensing
94.31 reviews every two years after a licensee has had at least one annual review.

94.32 (e) A license issued under this section may be issued for up to two years.

95.1 (f) During implementation of chapter 245D, the commissioner shall consider:

95.2 (1) the role of counties in quality assurance;

95.3 (2) the duties of county licensing staff; and

95.4 (3) the possible use of joint powers agreements, according to section 471.59, with counties
95.5 through which some licensing duties under chapter 245D may be delegated by the
95.6 commissioner to the counties.

95.7 Any consideration related to this paragraph must meet all of the requirements of the corrective
95.8 action plan ordered by the federal Centers for Medicare and Medicaid Services.

95.9 (g) Licensing authority specific to section 245D.06, subdivisions 5, 6, 7, and 8, or
95.10 successor provisions; and section 245D.061 or successor provisions, for family child foster
95.11 care programs providing out-of-home respite, as identified in section 245D.03, subdivision
95.12 1, paragraph (b), clause (1), is excluded from the delegation of authority to county and
95.13 private agencies.

95.14 (h) A county agency shall report to the commissioner, in a manner prescribed by the
95.15 commissioner, the following information for a licensed family child care program:

95.16 (1) the results of each licensing review completed, including the date of the review, and
95.17 any licensing correction order issued; ~~and~~

95.18 (2) any death, serious injury, or determination of substantiated maltreatment; and

95.19 (3) any fires that require the service of a fire department within 48 hours of the fire. The
95.20 information under this clause must also be reported to the State Fire Marshal within 48
95.21 hours of the fire.

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

95.23 Sec. 45. Minnesota Statutes 2018, section 245A.16, is amended by adding a subdivision
95.24 to read:

95.25 **Subd. 9. Licensed family child foster care.** (a) Before recommending to deny a license
95.26 under section 245A.05 or revoke a license under section 245A.07 for nondisqualifying
95.27 background study information received under section 245C.05, subdivision 4, paragraph
95.28 (a), clause (3), for licensed family child foster care a county agency or private agency that
95.29 has been designated or licensed by the commissioner must review the following:

95.30 (1) the type of crime;

95.31 (2) the number of crimes;

- 96.1 (3) the nature of the offenses;
- 96.2 (4) the age of the individual at the time of conviction;
- 96.3 (5) the length of time that has elapsed since the last conviction;
- 96.4 (6) the relationship of the crime and the capacity to care for a child;
- 96.5 (7) evidence of rehabilitation;
- 96.6 (8) information or knowledge from community members regarding the individual's
 96.7 capacity to provide foster care;
- 96.8 (9) a statement from the study subject;
- 96.9 (10) a statement from the license holder; and
- 96.10 (11) other aggravating and mitigating factors.
- 96.11 (b) The county or private licensing agency must send a summary of the review completed
 96.12 according to paragraph (a), on a form developed by the commissioner, to the commissioner
 96.13 and include any recommendation for licensing action.
- 96.14 **EFFECTIVE DATE.** This section is effective March 1, 2020.

96.15 Sec. 46. Minnesota Statutes 2018, section 245A.18, subdivision 2, is amended to read:

96.16 Subd. 2. **Child passenger restraint systems; training requirement.** (a) Programs
 96.17 licensed by the Department of Human Services under Minnesota Rules, chapter 2960, that
 96.18 serve a child or children under nine years of age must document training that fulfills the
 96.19 requirements in this subdivision.

96.20 (b) Before a license holder, staff person, or caregiver transports a child or children under
 96.21 age nine in a motor vehicle, the person transporting the child must satisfactorily complete
 96.22 training on the proper use and installation of child restraint systems in motor vehicles.
 96.23 Training completed under this section may be used to meet initial or ongoing training under
 96.24 Minnesota Rules, part 2960.3070, subparts 1 and 2.

96.25 ~~For all providers licensed prior to July 1, 2006, the training required in this subdivision~~
 96.26 ~~must be obtained by December 31, 2007.~~

96.27 (c) Training required under this section must be at least one hour in length, completed
 96.28 at orientation or initial training, and repeated at least once every five years. At a minimum,
 96.29 the training must address the proper use of child restraint systems based on the child's size,
 96.30 weight, and age, and the proper installation of a car seat or booster seat in the motor vehicle
 96.31 used by the license holder to transport the child or children.

97.1 (d) Training under paragraph (c) must be provided by individuals who are certified and
 97.2 approved by the Department of Public Safety, Office of Traffic Safety. License holders may
 97.3 obtain a list of certified and approved trainers through the Department of Public Safety
 97.4 website or by contacting the agency.

97.5 ~~(e) Child care providers that only transport school age children as defined in section~~
 97.6 ~~245A.02, subdivision 16, in school buses as defined in section 169.011, subdivision 71,~~
 97.7 ~~paragraphs (e) to (f), are exempt from this subdivision.~~

97.8 Sec. 47. Minnesota Statutes 2018, section 245A.40, is amended to read:

97.9 **245A.40 CHILD CARE CENTER TRAINING REQUIREMENTS.**

97.10 Subdivision 1. **Orientation.** (a) The child care center license holder must ensure that
 97.11 ~~every the director, staff person and volunteer is~~ persons, substitutes, and unsupervised
 97.12 volunteers are given orientation training and successfully ~~completes~~ complete the training
 97.13 before starting assigned duties. ~~The orientation training in this subdivision applies to~~
 97.14 ~~volunteers who will have direct contact with or access to children and who are not under~~
 97.15 ~~the direct supervision of a staff person. Completion of the orientation must be documented~~
 97.16 ~~in the individual's personnel record.~~ The orientation training must include information about:

97.17 (1) the center's philosophy, child care program, and procedures for maintaining health
 97.18 and safety according to section 245A.41 and Minnesota Rules, part 9503.0140, and handling
 97.19 emergencies and accidents according to Minnesota Rules, part 9503.0110;

97.20 (2) specific job responsibilities;

97.21 (3) the behavior guidance standards in Minnesota Rules, part 9503.0055; ~~and~~

97.22 (4) the reporting responsibilities in section 626.556, and Minnesota Rules, part
 97.23 9503.0130-₂;

97.24 (5) the center's drug and alcohol policy under section 245A.04, subdivision 1, paragraph
 97.25 (c);

97.26 (6) the center's risk reduction plan as required under section 245A.66, subdivision 2;

97.27 (7) at least one-half hour of training on the standards under section 245A.1435 and on
 97.28 reducing the risk of sudden unexpected infant death as required in subdivision 5, if applicable;

97.29 (8) at least one-half hour of training on the risk of abusive head trauma as required for
 97.30 the director and staff under subdivision 5a, if applicable; and

98.1 (9) training required by a child's individual child care program plan as required under
98.2 Minnesota Rules, part 9503.0065, subpart 3, if applicable.

98.3 (b) In addition to paragraph (a), before having unsupervised direct contact with a child,
98.4 the director and staff persons within the first 90 days of employment, and substitutes and
98.5 unsupervised volunteers within 90 days after the first date of direct contact with a child,
98.6 must complete:

98.7 (1) pediatric first aid, in accordance with subdivision 3; and

98.8 (2) pediatric cardiopulmonary resuscitation, in accordance with subdivision 4.

98.9 (c) In addition to paragraph (b), the director and staff persons within the first 90 days
98.10 of employment, and substitutes and unsupervised volunteers within 90 days from the first
98.11 date of direct contact with a child, must complete training in child development, in accordance
98.12 with subdivision 2.

98.13 (d) The license holder must ensure that documentation, as required in subdivision 10,
98.14 identifies the number of hours completed for each topic with a minimum training time
98.15 identified, if applicable, and that all required content is included.

98.16 (e) Training in this subdivision must not be used to meet in-service training requirements
98.17 in subdivision 7.

98.18 (f) Training completed within the previous 12 months under paragraphs (a), clauses (7)
98.19 and (8), and (c) are transferable to another child care center.

98.20 Subd. 1a. **Definitions.** (a) For the purposes of this section, the following terms have the
98.21 meanings given.

98.22 (b) "Substitute" means an adult who is temporarily filling a position as a director, teacher,
98.23 assistant teacher, or aide in a licensed child care center for less than 240 hours total in a
98.24 calendar year due to the absence of a regularly employed staff person.

98.25 (c) "Staff person" means an employee of a child care center who provides direct contact
98.26 services to children.

98.27 (d) "Unsupervised volunteer" means an individual who:

98.28 (1) assists in the care of a child in care;

98.29 (2) is not under the continuous direct supervision of a staff person; and

98.30 (3) is not employed by the child care center.

99.1 Subd. 2. **Child development and learning training.** (a) ~~For purposes of child care~~
 99.2 ~~centers, The director and all staff hired after July 1, 2006, persons, substitutes, and~~
 99.3 ~~unsupervised volunteers shall complete and document at least two hours of child development~~
 99.4 ~~and learning training within the first 90 days of employment. The director and staff persons,~~
 99.5 ~~not including substitutes, must complete at least two hours of training on child development~~
 99.6 ~~and learning. The training for substitutes and unsupervised volunteers is not required to be~~
 99.7 ~~of a minimum length. For purposes of this subdivision, "child development and learning~~
 99.8 ~~training" means any training in Knowledge and Competency Area I: Child Development~~
 99.9 ~~and Learning, which is training in understanding how children develop physically,~~
 99.10 ~~cognitively, emotionally, and socially and learn as part of the children's family, culture, and~~
 99.11 ~~community. Training completed under this subdivision may be used to meet the in-service~~
 99.12 ~~training requirements under subdivision 7.~~

99.13 (b) Notwithstanding paragraph (a), individuals are exempt from this requirement if they:

99.14 (1) have taken a three-credit college course on early childhood development within the
 99.15 past five years;

99.16 (2) have received a baccalaureate or master's degree in early childhood education or
 99.17 school-age child care within the past five years;

99.18 (3) are licensed in Minnesota as a prekindergarten teacher, an early childhood educator,
 99.19 a kindergarten to sixth grade teacher with a prekindergarten specialty, an early childhood
 99.20 special education teacher, or an elementary teacher with a kindergarten endorsement; or

99.21 (4) have received a baccalaureate degree with a Montessori certificate within the past
 99.22 five years.

99.23 (c) The director and staff persons, not including substitutes, must complete at least two
 99.24 hours of child development and learning training every second calendar year.

99.25 (d) Substitutes and unsupervised volunteers must complete child development and
 99.26 learning training every second calendar year. There is no minimum number of training hours
 99.27 required.

99.28 (e) Except for training required under paragraph (a), training completed under this
 99.29 subdivision may be used to meet the in-service training requirements under subdivision 7.

99.30 Subd. 3. **First aid.** (a) ~~All teachers and assistant teachers in a child care center governed~~
 99.31 ~~by Minnesota Rules, parts 9503.0005 to 9503.0170, and at least one staff person during~~
 99.32 ~~field trips and when transporting children in care, must satisfactorily complete pediatric~~
 99.33 ~~first aid training within 90 days of the start of work, unless the training has been completed~~

100.1 ~~within the previous two years. Unless training has been completed within the previous two~~
 100.2 ~~years, the director, staff persons, substitutes, and unsupervised volunteers must satisfactorily~~
 100.3 ~~complete pediatric first aid training prior to having unsupervised direct contact with a child,~~
 100.4 ~~but not to exceed the first 90 days of employment.~~

100.5 ~~(b) Notwithstanding paragraph (a), which allows 90 days to complete training, at least~~
 100.6 ~~one staff person who has satisfactorily completed pediatric first aid training must be present~~
 100.7 ~~at all times in the center, during field trips, and when transporting children in care. Pediatric~~
 100.8 ~~first aid training must be repeated at least every second calendar year. First aid training~~
 100.9 ~~under this subdivision must be provided by an individual approved as a first aid instructor~~
 100.10 ~~and must not be used to meet in-service training requirements under subdivision 7.~~

100.11 ~~(e) The pediatric first aid training must be repeated at least every two years, documented~~
 100.12 ~~in the person's personnel record and indicated on the center's staffing chart, and provided~~
 100.13 ~~by an individual approved as a first aid instructor. This training may be less than eight hours.~~

100.14 **Subd. 4. Cardiopulmonary resuscitation.** ~~(a) All teachers and assistant teachers in a~~
 100.15 ~~child care center governed by Minnesota Rules, parts 9503.0005 to 9503.0170, and at least~~
 100.16 ~~one staff person during field trips and when transporting children in care, must satisfactorily~~
 100.17 ~~complete training in cardiopulmonary resuscitation (CPR) that includes CPR techniques~~
 100.18 ~~for infants and children and in the treatment of obstructed airways. The CPR training must~~
 100.19 ~~be completed within 90 days of the start of work, unless the training has been completed~~
 100.20 ~~within the previous two years. The CPR training must have been provided by an individual~~
 100.21 ~~approved to provide CPR instruction, must be repeated at least once every two years, and~~
 100.22 ~~must be documented in the staff person's records.~~

100.23 ~~(b) Notwithstanding paragraph (a), which allows 90 days to complete training, at least~~
 100.24 ~~one staff person who has satisfactorily completed cardiopulmonary resuscitation training~~
 100.25 ~~must be present at all times in the center, during field trips, and when transporting children~~
 100.26 ~~in care.~~

100.27 ~~(c) CPR training may be provided for less than four hours.~~

100.28 ~~(d) Persons providing CPR training must use CPR training that has been developed:~~

100.29 ~~(1) by the American Heart Association or the American Red Cross and incorporates~~
 100.30 ~~psychomotor skills to support the instruction; or~~

100.31 ~~(2) using nationally recognized, evidence-based guidelines for CPR and incorporates~~
 100.32 ~~psychomotor skills to support the instruction.~~

101.1 (a) Unless training has been completed within the previous two years, the director, staff
 101.2 persons, substitutes, and unsupervised volunteers must satisfactorily complete pediatric
 101.3 cardiopulmonary resuscitation (CPR) training that meets the requirements of this subdivision.
 101.4 Pediatric CPR training must be completed prior to having unsupervised direct contact with
 101.5 a child, but not to exceed the first 90 days of employment.

101.6 (b) Pediatric CPR training must be provided by an individual approved to provide
 101.7 pediatric CPR instruction.

101.8 (c) The Pediatric CPR training must:

101.9 (1) cover CPR techniques for infants and children and the treatment of obstructed airways;

101.10 (2) include instruction, hands-on practice, and an in-person, observed skills assessment
 101.11 under the direct supervision of a CPR instructor; and

101.12 (3) be developed by the American Heart Association, the American Red Cross, or another
 101.13 organization that uses nationally recognized, evidence-based guidelines for CPR.

101.14 (d) Pediatric CPR training must be repeated at least once every second calendar year.

101.15 (e) Pediatric CPR training in this subdivision must not be used to meet in-service training
 101.16 requirements under subdivision 7.

101.17 **Subd. 5. Sudden unexpected infant death and abusive head trauma training.** (a)
 101.18 Before caring for infants, the director, staff persons, substitutes, and unsupervised volunteers
 101.19 must receive training on the standards under section 245A.1435 and on reducing the risk
 101.20 of sudden unexpected infant death during orientation and each calendar year thereafter.

101.21 (b) Sudden unexpected infant death reduction training required under this subdivision
 101.22 must be at least one-half hour in length. At a minimum, the training must address the risk
 101.23 factors related to sudden unexpected infant death, means of reducing the risk of sudden
 101.24 unexpected infant death in child care, and license holder communication with parents
 101.25 regarding reducing the risk of sudden unexpected infant death.

101.26 (c) Except if completed during orientation, training taken under this subdivision may
 101.27 be used to meet the in-service training requirements under subdivision 7.

101.28 **Subd. 5a. Abusive head trauma training.** ~~(a) License holders must document that~~
 101.29 ~~before staff persons and volunteers care for infants, they are instructed on the standards in~~
 101.30 ~~section 245A.1435 and receive training on reducing the risk of sudden unexpected infant~~
 101.31 ~~death. In addition, license holders must document that before staff persons care for infants~~
 101.32 ~~or children under school age, they receive training on the risk of abusive head trauma from~~

102.1 ~~shaking infants and young children. The training in this subdivision may be provided as~~
 102.2 ~~orientation training under subdivision 1 and in-service training under subdivision 7. (a)~~
 102.3 Before caring for children under school age, the director, staff persons, substitutes, and
 102.4 unsupervised volunteers must receive training on the risk of abusive head trauma during
 102.5 orientation and each calendar year thereafter.

102.6 ~~(b) Sudden unexpected infant death reduction training required under this subdivision~~
 102.7 ~~must be at least one-half hour in length and must be completed at least once every year. At~~
 102.8 ~~a minimum, the training must address the risk factors related to sudden unexpected infant~~
 102.9 ~~death, means of reducing the risk of sudden unexpected infant death in child care, and license~~
 102.10 ~~holder communication with parents regarding reducing the risk of sudden unexpected infant~~
 102.11 ~~death.~~

102.12 ~~(e)~~ (b) Abusive head trauma training under this subdivision must be at least one-half
 102.13 hour in length ~~and must be completed at least once every year.~~ At a minimum, the training
 102.14 must address the risk factors related to shaking infants and young children, means to reduce
 102.15 the risk of abusive head trauma in child care, and license holder communication with parents
 102.16 regarding reducing the risk of abusive head trauma.

102.17 (c) Except if completed during orientation, training taken under this subdivision may
 102.18 be used to meet the in-service training requirements under subdivision 7.

102.19 (d) The commissioner shall make available for viewing a video presentation on the
 102.20 dangers associated with shaking infants and young children, which may be used in
 102.21 conjunction with the annual training required under paragraph ~~(e)~~ (a).

102.22 **Subd. 6. Child passenger restraint systems; training requirement.** ~~(a) A license~~
 102.23 ~~holder must comply with all seat belt and child passenger restraint system requirements~~
 102.24 ~~under section 169.685. (b) Child care centers that serve a child or children under nine years~~
 102.25 ~~of age must document training that fulfills the requirements in this subdivision.~~

102.26 ~~(1)~~ (a) Before a license holder transports a child or children under age ~~nine~~ eight in a
 102.27 motor vehicle, the person placing the child or children in a passenger restraint must
 102.28 satisfactorily complete training on the proper use and installation of child restraint systems
 102.29 in motor vehicles. ~~Training completed under this subdivision may be used to meet orientation~~
 102.30 ~~training under subdivision 1 and in-service training under subdivision 7.~~

102.31 ~~(2)~~ (b) Training required under this subdivision must be ~~at least one hour in length,~~
 102.32 ~~completed at orientation, and repeated at least once every five years.~~ At a minimum, the
 102.33 training must address the proper use of child restraint systems based on the child's size,

103.1 weight, and age, and the proper installation of a car seat or booster seat in the motor vehicle
 103.2 used by the license holder to transport the child or children.

103.3 ~~(3)~~ (c) Training required under this subdivision must be provided by individuals who
 103.4 are certified and approved by the Department of Public Safety, Office of Traffic Safety.
 103.5 License holders may obtain a list of certified and approved trainers through the Department
 103.6 of Public Safety website or by contacting the agency.

103.7 ~~(4)~~ (d) Child care providers that only transport school-age children as defined in section
 103.8 245A.02, subdivision 16, in child care buses as defined in section 169.448, subdivision 1,
 103.9 paragraph (e), are exempt from this subdivision.

103.10 (e) Training completed under this subdivision may be used to meet in-service training
 103.11 requirements under subdivision 7. Training completed within the previous five years is
 103.12 transferable upon a staff person's change in employment to another child care center.

103.13 Subd. 7. **In-service.** ~~(a) A license holder must ensure that the center director and all staff~~
 103.14 ~~who have direct contact with a child complete annual in-service training. In-service training~~
 103.15 ~~requirements must be met by a staff person's participation in the following training areas:~~
 103.16 staff persons, substitutes, and unsupervised volunteers complete in-service training each
 103.17 calendar year.

103.18 (b) The center director and staff persons who work more than 20 hours per week must
 103.19 complete 24 hours of in-service training each calendar year. Staff persons who work 20
 103.20 hours or less per week must complete 12 hours of in-service training each calendar year.
 103.21 Substitutes and unsupervised volunteers must complete the requirements of paragraphs (e)
 103.22 to (h) and do not otherwise have a minimum number of hours of training to complete.

103.23 (c) The number of in-service training hours may be prorated for individuals not employed
 103.24 for an entire year.

103.25 (d) Each year, in-service training must include:

103.26 (1) the center's procedures for maintaining health and safety according to section 245A.41
 103.27 and Minnesota Rules, part 9503.0140, and handling emergencies and accidents according
 103.28 to Minnesota Rules, part 9503.0110;

103.29 (2) the reporting responsibilities under section 626.556 and Minnesota Rules, part
 103.30 9503.0130;

103.31 (3) at least one-half hour of training on the standards under section 245A.1435 and on
 103.32 reducing the risk of sudden unexpected infant death as required under subdivision 5, if
 103.33 applicable; and

104.1 (4) at least one-half hour of training on the risk of abusive head trauma from shaking
104.2 infants and young children as required under subdivision 5a, if applicable.

104.3 (e) Each year, or when a change is made, whichever is more frequent, in-service training
104.4 must be provided on: (1) the center's risk reduction plan under section 245A.66, subdivision
104.5 2; and (2) a child's individual child care program plan as required under Minnesota Rules,
104.6 part 9503.0065, subpart 3.

104.7 (f) At least once every two calendar years, the in-service training must include:

104.8 (1) child development and learning training under subdivision 2;

104.9 (2) pediatric first aid that meets the requirements of subdivision 3;

104.10 (3) pediatric cardiopulmonary resuscitation training that meets the requirements of
104.11 subdivision 4;

104.12 (4) cultural dynamics training to increase awareness of cultural differences; and

104.13 (5) disabilities training to increase awareness of differing abilities of children.

104.14 (g) At least once every five years, in-service training must include child passenger
104.15 restraint training that meets the requirements of subdivision 6, if applicable.

104.16 (h) The remaining hours of the in-service training requirement must be met by completing
104.17 training in the following content areas of the Minnesota Knowledge and Competency
104.18 Framework:

104.19 (1) Content area I: child development and learning;

104.20 (2) Content area II: developmentally appropriate learning experiences;

104.21 (3) Content area III: relationships with families;

104.22 (4) Content area IV: assessment, evaluation, and individualization;

104.23 (5) Content area V: historical and contemporary development of early childhood
104.24 education;

104.25 (6) Content area VI: professionalism; and

104.26 (7) Content area VII: health, safety, and nutrition; and

104.27 (8) Content area VIII: application through clinical experiences.

104.28 ~~(b)~~ (i) For purposes of this subdivision, the following terms have the meanings given
104.29 them.

105.1 (1) "Child development and learning training" ~~has the meaning given it in subdivision~~
 105.2 ~~2, paragraph (a).~~ means training in understanding how children develop physically,
 105.3 cognitively, emotionally, and socially and learn as part of the children's family, culture, and
 105.4 community.

105.5 (2) "Developmentally appropriate learning experiences" means creating positive learning
 105.6 experiences, promoting cognitive development, promoting social and emotional development,
 105.7 promoting physical development, and promoting creative development.

105.8 (3) "Relationships with families" means training on building a positive, respectful
 105.9 relationship with the child's family.

105.10 (4) "Assessment, evaluation, and individualization" means training in observing,
 105.11 recording, and assessing development; assessing and using information to plan; and assessing
 105.12 and using information to enhance and maintain program quality.

105.13 (5) "Historical and contemporary development of early childhood education" means
 105.14 training in past and current practices in early childhood education and how current events
 105.15 and issues affect children, families, and programs.

105.16 (6) "Professionalism" means training in knowledge, skills, and abilities that promote
 105.17 ongoing professional development.

105.18 (7) "Health, safety, and nutrition" means training in establishing health practices, ensuring
 105.19 safety, and providing healthy nutrition.

105.20 (8) "Application through clinical experiences" means clinical experiences in which a
 105.21 person applies effective teaching practices using a range of educational programming models.

105.22 ~~(e) The director and all program staff persons must annually complete a number of hours~~
 105.23 ~~of in-service training equal to at least two percent of the hours for which the director or~~
 105.24 ~~program staff person is annually paid, unless one of the following is applicable.~~

105.25 ~~(1) A teacher at a child care center must complete one percent of working hours of~~
 105.26 ~~in-service training annually if the teacher:~~

105.27 ~~(i) possesses a baccalaureate or master's degree in early childhood education or school-age~~
 105.28 ~~care;~~

105.29 ~~(ii) is licensed in Minnesota as a prekindergarten teacher, an early childhood educator,~~
 105.30 ~~a kindergarten to sixth grade teacher with a prekindergarten specialty, an early childhood~~
 105.31 ~~special education teacher, or an elementary teacher with a kindergarten endorsement; or~~

105.32 ~~(iii) possesses a baccalaureate degree with a Montessori certificate.~~

106.1 ~~(2) A teacher or assistant teacher at a child care center must complete one and one-half~~
 106.2 ~~percent of working hours of in-service training annually if the individual is:~~

106.3 ~~(i) a registered nurse or licensed practical nurse with experience working with infants;~~

106.4 ~~(ii) possesses a Montessori certificate, a technical college certificate in early childhood~~
 106.5 ~~development, or a child development associate certificate; or~~

106.6 ~~(iii) possesses an associate of arts degree in early childhood education, a baccalaureate~~
 106.7 ~~degree in child development, or a technical college diploma in early childhood development.~~

106.8 ~~(d) The number of required training hours may be prorated for individuals not employed~~
 106.9 ~~full time or for an entire year.~~

106.10 ~~(e) The annual in-service training must be completed within the calendar year for which~~
 106.11 ~~it was required. In-service training completed by staff persons is transferable upon a staff~~
 106.12 ~~person's change in employment to another child care program.~~

106.13 ~~(f) (j) The license holder must ensure that, when a staff person completes in-service~~
 106.14 ~~training, the training is documented in the staff person's personnel record. The documentation~~
 106.15 ~~must include the date training was completed, the goal of the training and topics covered,~~
 106.16 ~~trainer's name and organizational affiliation, trainer's signed statement that training was~~
 106.17 ~~successfully completed, documentation, as required in subdivision 10, includes the number~~
 106.18 ~~of total training hours required to be completed, name of the training, the Minnesota~~
 106.19 ~~Knowledge and Competency Framework content area, number of hours completed, and the~~
 106.20 ~~director's approval of the training.~~

106.21 ~~(k) In-service training completed by a staff person that is not specific to that child care~~
 106.22 ~~center is transferable upon a staff person's change in employment to another child care~~
 106.23 ~~program.~~

106.24 ~~Subd. 8. **Cultural dynamics and disabilities training for child care providers.** (a)~~
 106.25 ~~The training required of licensed child care center staff must include training in the cultural~~
 106.26 ~~dynamics of early childhood development and child care. The cultural dynamics and~~
 106.27 ~~disabilities training and skills development of child care providers must be designed to~~
 106.28 ~~achieve outcomes for providers of child care that include, but are not limited to:~~

106.29 ~~(1) an understanding and support of the importance of culture and differences in ability~~
 106.30 ~~in children's identity development;~~

106.31 ~~(2) understanding the importance of awareness of cultural differences and similarities~~
 106.32 ~~in working with children and their families;~~

107.1 ~~(3) understanding and support of the needs of families and children with differences in~~
 107.2 ~~ability;~~

107.3 ~~(4) developing skills to help children develop unbiased attitudes about cultural differences~~
 107.4 ~~and differences in ability;~~

107.5 ~~(5) developing skills in culturally appropriate caregiving; and~~

107.6 ~~(6) developing skills in appropriate caregiving for children of different abilities.~~

107.7 ~~(b) Curriculum for cultural dynamics and disability training shall be approved by the~~
 107.8 ~~commissioner.~~

107.9 ~~(c) The commissioner shall amend current rules relating to the training of the licensed~~
 107.10 ~~child care center staff to require cultural dynamics training. Timelines established in the~~
 107.11 ~~rule amendments for complying with the cultural dynamics training requirements must be~~
 107.12 ~~based on the commissioner's determination that curriculum materials and trainers are available~~
 107.13 ~~statewide.~~

107.14 ~~(d) For programs caring for children with special needs, the license holder shall ensure~~
 107.15 ~~that any additional staff training required by the child's individual child care program plan~~
 107.16 ~~required under Minnesota Rules, part 9503.0065, subpart 3, is provided.~~

107.17 ~~Subd. 9. **Ongoing health and safety training.** A staff person's orientation training on~~
 107.18 ~~maintaining health and safety and handling emergencies and accidents, as required in~~
 107.19 ~~subdivision 1, must be repeated at least once each calendar year by each staff person. The~~
 107.20 ~~completion of the annual training must be documented in the staff person's personnel record.~~

107.21 ~~Subd. 10. **Documentation.** All training must be documented and maintained on site in~~
 107.22 ~~each personnel record. In addition to any requirements for each training provided in this~~
 107.23 ~~section, documentation for each staff person must include the staff person's first date of~~
 107.24 ~~direct contact and first date of unsupervised contact with a child in care.~~

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

107.26 Sec. 48. Minnesota Statutes 2018, section 245A.41, is amended to read:

107.27 **245A.41 CHILD CARE CENTER HEALTH AND SAFETY REQUIREMENTS.**

107.28 Subdivision 1. **Allergy prevention and response.** (a) Before admitting a child for care,
 107.29 the license holder must obtain documentation of any known allergy from the child's parent
 107.30 or legal guardian or the child's source of medical care. If a child has a known allergy, the
 107.31 license holder must maintain current information about the allergy in the child's record and
 107.32 develop an individual child care program plan as specified in Minnesota Rules, part

108.1 9503.0065, subpart 3. The individual child care program plan must include but not be limited
108.2 to a description of the allergy, specific triggers, avoidance techniques, symptoms of an
108.3 allergic reaction, and procedures for responding to an allergic reaction, including medication,
108.4 dosages, and a doctor's contact information.

108.5 (b) The license holder must ensure that each staff person who is responsible for carrying
108.6 out the individual child care program plan review and follow the plan. Documentation of a
108.7 staff person's review must be kept on site.

108.8 (c) At least ~~annually~~ once each calendar year or following any changes made to
108.9 allergy-related information in the child's record, the license holder must update the child's
108.10 individual child care program plan and inform each staff person who is responsible for
108.11 carrying out the individual child care program plan of the change. The license holder must
108.12 keep on site documentation that a staff person was informed of a change.

108.13 (d) A child's allergy information must be available at all times including on site, when
108.14 on field trips, or during transportation. A child's food allergy information must be readily
108.15 available to a staff person in the area where food is prepared and served to the child.

108.16 (e) The license holder must contact the child's parent or legal guardian as soon as possible
108.17 in any instance of exposure or allergic reaction that requires medication or medical
108.18 intervention. The license holder must call emergency medical services when epinephrine
108.19 is administered to a child in the license holder's care.

108.20 Subd. 2. **Handling and disposal of bodily fluids.** The licensed child care center must
108.21 comply with the following procedures for safely handling and disposing of bodily fluids:

108.22 (1) surfaces that come in contact with potentially infectious bodily fluids, including
108.23 blood and vomit, must be cleaned and disinfected according to Minnesota Rules, part
108.24 9503.0005, subpart 11;

108.25 (2) blood-contaminated material must be disposed of in a plastic bag with a secure tie;

108.26 (3) sharp items used for a child with special care needs must be disposed of in a "sharps
108.27 container." The sharps container must be stored out of reach of a child;

108.28 (4) the license holder must have the following bodily fluid disposal supplies in the center:
108.29 disposable gloves, disposal bags, and eye protection; and

108.30 (5) the license holder must ensure that each staff person ~~is trained on~~ follows universal
108.31 precautions to reduce the risk of spreading infectious disease. ~~A staff person's completion~~
108.32 ~~of the training must be documented in the staff person's personnel record.~~

109.1 Subd. 3. **Emergency preparedness.** (a) ~~No later than September 30, 2017,~~ A licensed
109.2 child care center must have a written emergency plan for emergencies that require evacuation,
109.3 sheltering, or other protection of a child, such as fire, natural disaster, intruder, or other
109.4 threatening situation that may pose a health or safety hazard to a child. The plan must be
109.5 written on a form developed by the commissioner and must include:

109.6 (1) procedures for an evacuation, relocation, shelter-in-place, or lockdown;

109.7 (2) a designated relocation site and evacuation route;

109.8 (3) procedures for notifying a child's parent or legal guardian of the evacuation, relocation,
109.9 shelter-in-place, or lockdown, including procedures for reunification with families;

109.10 (4) accommodations for a child with a disability or a chronic medical condition;

109.11 (5) procedures for storing a child's medically necessary medicine that facilitates easy
109.12 removal during an evacuation or relocation;

109.13 (6) procedures for continuing operations in the period during and after a crisis; ~~and~~

109.14 (7) procedures for communicating with local emergency management officials, law
109.15 enforcement officials, or other appropriate state or local authorities; and

109.16 (8) accommodations for infants and toddlers.

109.17 (b) The license holder must train staff persons on the emergency plan at orientation,
109.18 when changes are made to the plan, and at least once each calendar year. Training must be
109.19 documented in each staff person's personnel file.

109.20 (c) The license holder must conduct drills according to the requirements in Minnesota
109.21 Rules, part 9503.0110, subpart 3. The date and time of the drills must be documented.

109.22 (d) The license holder must review and update the emergency plan annually.
109.23 Documentation of the annual emergency plan review shall be maintained in the program's
109.24 administrative records.

109.25 (e) The license holder must include the emergency plan in the program's policies and
109.26 procedures as specified under section 245A.04, subdivision 14. The license holder must
109.27 provide a physical or electronic copy of the emergency plan to the child's parent or legal
109.28 guardian upon enrollment.

109.29 (f) The relocation site and evacuation route must be posted in a visible place as part of
109.30 the written procedures for emergencies and accidents in Minnesota Rules, part 9503.0140,
109.31 subpart 21.

110.1 Subd. 4. **Child passenger restraint requirements.** A license holder must comply with
 110.2 all seat belt and child passenger restraint system requirements under section 169.685.

110.3 Subd. 5. **Telephone requirement in licensed child care centers.** (a) A working telephone
 110.4 which is capable of making outgoing calls and receiving incoming calls must be located
 110.5 within the licensed child care center at all times. Staff must have access to a working
 110.6 telephone while providing care and supervision to children in care, even if the care occurs
 110.7 outside of the child care facility. A license holder may use a cellular telephone to meet the
 110.8 requirements of this subdivision.

110.9 (b) If a cellular telephone is used to satisfy the requirements of this subdivision, the
 110.10 cellular telephone must be accessible to staff, be stored in a centrally located area when not
 110.11 in use, and be sufficiently charged for use at all times.

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

110.13 Sec. 49. Minnesota Statutes 2018, section 245A.50, is amended to read:

110.14 **245A.50 FAMILY CHILD CARE TRAINING REQUIREMENTS.**

110.15 Subdivision 1. **Initial training.** (a) License holders, caregivers, ~~and~~ substitutes, and
 110.16 helpers must comply with the training requirements in this section.

110.17 ~~(b) Helpers who assist with care on a regular basis must complete six hours of training~~
 110.18 ~~within one year after the date of initial employment.~~

110.19 (b) The license holder, before initial licensure, and a caregiver, before caring for a child,
 110.20 must complete:

110.21 (1) the six-hour Supervising for Safety for Family Child Care course developed by the
 110.22 commissioner;

110.23 (2) a two-hour course in Knowledge and Competency Area I: Child Development and
 110.24 Learning, as required by subdivision 2;

110.25 (3) a two-hour course in behavior guidance that may be fulfilled by completing any
 110.26 course in Knowledge and Competency Area II-C: Promoting Social and Emotional
 110.27 Development, as required by subdivision 2;

110.28 (4) pediatric first aid, as required by subdivision 3;

110.29 (5) pediatric cardiopulmonary resuscitation, as required by subdivision 4;

110.30 (6) if applicable, training in reducing the risk of sudden unexpected infant death and
 110.31 abusive head trauma as required by subdivision 5; and

111.1 (7) if applicable, training in child passenger restraint as required by subdivision 6.

111.2 The license holder or caregiver may take one four-hour course that covers both clauses (2)
 111.3 and (3) to meet the requirements of this subdivision.

111.4 (c) Before caring for a child, each substitute must complete:

111.5 (1) the four-hour Basics of Licensed Family Child Care for Substitutes course developed
 111.6 by the commissioner;

111.7 (2) pediatric first aid, as required by subdivision 3;

111.8 (3) pediatric cardiopulmonary resuscitation, as required by subdivision 4;

111.9 (4) if applicable, training in reducing the risk of sudden unexpected infant death and
 111.10 abusive head trauma as required by subdivision 5; and

111.11 (5) if applicable, training in child passenger restraint as required by subdivision 6.

111.12 (d) Each helper must complete:

111.13 (1) if applicable, before assisting with the care of a child under school age, training in
 111.14 reducing the risk of sudden unexpected infant death and abusive head trauma, as required
 111.15 by subdivision 5;

111.16 (2) within 90 days of the start of employment, the one-hour Child Development for
 111.17 Helpers course developed by the commissioner; and

111.18 (3) if applicable, training in child passenger restraint as required by subdivision 6.

111.19 (e) Before caring for a child or assisting in the care of a child, the license holder must
 111.20 train each caregiver and substitute on:

111.21 (1) the emergency plan required under section 245A.51, subdivision 3, paragraph (b);

111.22 (2) allergy prevention and response required under section 245A.51, subdivision 1,
 111.23 paragraph (b); and

111.24 (3) the drug and alcohol policy required under section 245A.04, subdivision 1, paragraph
 111.25 (c).

111.26 ~~(e)~~ (f) Training requirements established under this section that must be completed prior
 111.27 to initial licensure must be satisfied only by a newly licensed child care provider or by a
 111.28 child care provider who has not held an active child care license in Minnesota in the previous
 111.29 12 months. A child care provider who relocates within the state or who voluntarily cancels
 111.30 a license or allows the license to lapse for a period of less than 12 months and who seeks
 111.31 reinstatement of the lapsed or canceled license within 12 months of the lapse or cancellation

112.1 must satisfy the annual, ongoing training requirements, and is not required to satisfy the
 112.2 training requirements that must be completed prior to initial licensure.

112.3 Subd. 1a. **Definitions.** (a) For the purposes of this section, the following terms have the
 112.4 meanings given them.

112.5 (b) "Basics of Family Child Care for Substitutes" means a class developed by the
 112.6 commissioner that includes the following topics: prevention and control of infectious
 112.7 diseases; administering medication; preventing and responding to allergies; ensuring building
 112.8 and physical premise safety; handling and storing biological contaminants; preventing and
 112.9 reporting abuse and child maltreatment; emergency preparedness; and child development.

112.10 (c) "Caregiver" means an adult other than the license holder who supervises children
 112.11 for a cumulative total of 300 or more hours in any calendar year.

112.12 (d) "Helper" means a minor, ages 13 through 17, who assists in the care of the children.

112.13 (e) "Substitute" means an adult who assumes the responsibility of a provider for a
 112.14 cumulative total of not more than 300 hours in any calendar year.

112.15 **Subd. 2. Child development and learning and behavior guidance training.** (a) ~~For~~
 112.16 ~~purposes of family and group family child care, The license holder and each adult caregiver~~
 112.17 ~~who provides care in the licensed setting for more than 30 days in any 12-month period~~
 112.18 ~~shall complete and document at least four hours of child growth and learning and behavior~~
 112.19 ~~guidance training prior to initial licensure, and before caring for children. For purposes of~~
 112.20 ~~this subdivision, "child development and learning training" means training in understanding~~
 112.21 ~~how children develop physically, cognitively, emotionally, and socially and learn as part~~
 112.22 ~~of the children's family, culture, and community. "Behavior guidance training" means~~
 112.23 ~~training in the understanding of the functions of child behavior and strategies for managing~~
 112.24 ~~challenging situations. At least two hours of child development and learning or behavior~~
 112.25 ~~guidance training must be repeated annually. Training curriculum shall be developed or~~
 112.26 ~~approved by the commissioner of human services.~~

112.27 (b) Notwithstanding paragraph (a), individuals are exempt from this requirement if they:

112.28 (1) have taken a three-credit course on early childhood development within the past five
 112.29 years;

112.30 (2) have received a baccalaureate or master's degree in early childhood education or
 112.31 school-age child care within the past five years;

113.1 (3) are licensed in Minnesota as a prekindergarten teacher, an early childhood educator,
 113.2 a kindergarten to grade 6 teacher with a prekindergarten specialty, an early childhood special
 113.3 education teacher, or an elementary teacher with a kindergarten endorsement; or

113.4 (4) have received a baccalaureate degree with a Montessori certificate within the past
 113.5 five years.

113.6 (c) The license holder and each caregiver must complete at least two hours of child
 113.7 development training annually that may be fulfilled by completing any course in Knowledge
 113.8 and Competency Area I: Child Development and Learning; or behavior guidance training
 113.9 that may be fulfilled by completing any course in Knowledge and Competency Area II-C:
 113.10 Promoting Social and Emotional Development. The commissioner shall develop or approve
 113.11 training curriculum.

113.12 Subd. 3. **First aid.** (a) ~~When children are present in a family child care home governed~~
 113.13 ~~by Minnesota Rules, parts 9502.0315 to 9502.0445, at least one staff person must be present~~
 113.14 ~~in the home who has been trained in first aid.~~ The license holder must complete pediatric
 113.15 first aid training before licensure and each caregiver and substitute must complete pediatric
 113.16 first aid training before caring for children. The first aid training must have been provided
 113.17 by an individual approved to provide first aid instruction. First aid training may be less than
 113.18 eight hours and persons qualified to provide first aid training include individuals approved
 113.19 as first aid instructors. ~~First aid training must be repeated every two years.~~

113.20 (b) ~~A family child care provider is exempt from the first aid training requirements under~~
 113.21 ~~this subdivision related to any substitute caregiver who provides less than 30 hours of care~~
 113.22 ~~during any 12-month period.~~ The license holder, each caregiver and each substitute must
 113.23 complete additional pediatric first aid training every two years.

113.24 (c) Video training reviewed and approved by the county licensing agency satisfies the
 113.25 training requirement of this subdivision.

113.26 Subd. 4. **Cardiopulmonary resuscitation.** (a) ~~When children are present in a family~~
 113.27 ~~child care home governed by Minnesota Rules, parts 9502.0315 to 9502.0445, at least one~~
 113.28 ~~caregiver must be present in the home who has been trained in cardiopulmonary resuscitation~~
 113.29 ~~(CPR), including CPR techniques for infants and children, and in the treatment of obstructed~~
 113.30 ~~airways. The CPR training must have been provided by an individual approved to provide~~
 113.31 ~~CPR instruction, must be repeated at least once every two years, and must be documented~~
 113.32 ~~in the caregiver's records.~~ The family child care license holder must complete pediatric
 113.33 cardiopulmonary resuscitation (CPR) training prior to licensure. Caregivers and substitutes

114.1 must complete pediatric CPR training prior to caring for children. Training that has been
 114.2 completed in the previous two years fulfills this requirement.

114.3 ~~(b) A family child care provider is exempt from the CPR training requirement in this~~
 114.4 ~~subdivision related to any substitute caregiver who provides less than 30 hours of care during~~
 114.5 ~~any 12-month period. The CPR training must be provided by an individual approved to~~
 114.6 ~~provide CPR instruction.~~

114.7 ~~(c) Persons providing CPR training must use CPR training that has been developed. The~~
 114.8 ~~Pediatric CPR training must:~~

114.9 ~~(1) by the American Heart Association or the American Red Cross and incorporates~~
 114.10 ~~psychomotor skills to support the instruction; or~~

114.11 ~~(2) using nationally recognized, evidence-based guidelines for CPR training and~~
 114.12 ~~incorporates psychomotor skills to support the instruction.~~

114.13 (1) cover CPR techniques for infants and children and the treatment of obstructed airways;

114.14 (2) include instruction, hands-on practice, and an in-person observed skills assessment
 114.15 under the direct supervision of a CPR instructor; and

114.16 (3) be developed by the American Heart Association, the American Red Cross, or another
 114.17 organization that uses nationally recognized, evidence-based guidelines for CPR.

114.18 (d) License holders, caregivers, and substitutes must complete pediatric CPR training
 114.19 at least once every two years.

114.20 **Subd. 5. Sudden unexpected infant death and abusive head trauma training. (a)**
 114.21 The license holder must complete training on reducing the risk of sudden unexpected infant
 114.22 death prior to caring for infants. License holders must document ensure that before staff
 114.23 persons, caregivers, substitutes, and helpers assist in the care of infants, they are instructed
 114.24 on the standards in section 245A.1435 and receive training on reducing the risk of sudden
 114.25 unexpected infant death.

114.26 (b) The license holder must complete training on reducing the risk of abusive head
 114.27 trauma, prior to caring for infants and children under school age. In addition, license holders
 114.28 must document ensure that before staff persons, caregivers, substitutes, and helpers assist
 114.29 in the care of infants and children under school age, they receive training on reducing the
 114.30 risk of abusive head trauma from shaking infants and young children. The training in this
 114.31 subdivision may be provided as initial training under subdivision 1 or ongoing annual
 114.32 training under subdivision 7.

115.1 ~~(b)~~ (c) Sudden unexpected infant death reduction training required under this subdivision
 115.2 must, at a minimum, address the risk factors related to sudden unexpected infant death,
 115.3 means of reducing the risk of sudden unexpected infant death in child care, and license
 115.4 holder communication with parents regarding reducing the risk of sudden unexpected infant
 115.5 death.

115.6 ~~(e)~~ (d) Abusive head trauma training required under this subdivision must, at a minimum,
 115.7 address the risk factors related to shaking infants and young children, means of reducing
 115.8 the risk of abusive head trauma in child care, and license holder communication with parents
 115.9 regarding reducing the risk of abusive head trauma.

115.10 ~~(d)~~ (e) Training for family and group family child care providers must be developed by
 115.11 the commissioner ~~in conjunction with the Minnesota Sudden Infant Death Center and~~
 115.12 approved by ~~the Minnesota Center for Professional Development~~ Achieve - The MN Center
 115.13 for Professional Development. Sudden unexpected infant death reduction training and
 115.14 abusive head trauma training may be provided in a single course of no more than two hours
 115.15 in length.

115.16 ~~(e)~~ (f) Sudden unexpected infant death reduction training and abusive head trauma
 115.17 training required under this subdivision must be completed in person or as allowed under
 115.18 subdivision 10, clause (1) or (2), at least once every two years. On the years when the license
 115.19 holder ~~is, caregiver, substitute, and helper are not receiving training in person or as allowed~~
 115.20 under subdivision 10, clause (1) or (2), the license holder, caregiver, substitute, and helper
 115.21 must receive sudden unexpected infant death reduction training and abusive head trauma
 115.22 training through a video of no more than one hour in length. The video must be developed
 115.23 or approved by the commissioner.

115.24 ~~(f)~~ (g) An individual who is related to the license holder as defined in section 245A.02,
 115.25 subdivision 13, and who is involved only in the care of the license holder's own infant or
 115.26 child under school age and who is not designated to be a caregiver, helper, or substitute, as
 115.27 defined in Minnesota Rules, part 9502.0315, for the licensed program, is exempt from the
 115.28 sudden unexpected infant death and abusive head trauma training.

115.29 **Subd. 6. Child passenger restraint systems; training requirement.** ~~(a) A license~~
 115.30 ~~holder must comply with all seat belt and child passenger restraint system requirements~~
 115.31 ~~under section 169.685.~~

115.32 ~~(b) Family and group family child care programs licensed by the Department of Human~~
 115.33 ~~Services that serve a child or children under nine years of age must document training that~~
 115.34 ~~fulfills the requirements in this subdivision.~~

116.1 ~~(a) (1) Before~~ A license holder, ~~staff person, caregiver, or helper~~ caregiver, or substitute
 116.2 transports may transport a child or children under age ~~nine~~ eight in a motor vehicle, ~~the~~
 116.3 ~~person~~ Before placing the child or children in a passenger restraint, the person must
 116.4 satisfactorily complete training on the proper use and installation of child restraint systems
 116.5 in motor vehicles. Training completed under this subdivision may be used to meet initial
 116.6 training under subdivision 1 or ongoing training under subdivision 7.

116.7 (2) Training required under this subdivision must be ~~at least one hour in length, completed~~
 116.8 ~~at initial training, and~~ repeated at least once every five years.

116.9 (3) At a minimum, the training must address the proper use of child restraint systems
 116.10 based on the child's size, weight, and age, and the proper installation of a car seat or booster
 116.11 seat in the motor vehicle used by the license holder to transport the child or children.

116.12 ~~(3)~~ (4) Training under this subdivision must be provided by individuals who are certified
 116.13 and approved by the Department of Public Safety, Office of Traffic Safety. License holders
 116.14 may obtain a list of certified and approved trainers through the Department of Public Safety
 116.15 website or by contacting the agency.

116.16 ~~(e)~~ (b) Child care providers that only transport school-age children as defined in section
 116.17 245A.02, subdivision 19, paragraph (f), in child care buses as defined in section 169.448,
 116.18 subdivision 1, paragraph (e), are exempt from this subdivision.

116.19 Subd. 7. **Ongoing training requirements for family and group family child care**
 116.20 **license holders and caregivers.** ~~For purposes of family and group family child care, (a)~~
 116.21 The license holder and each ~~primary~~ caregiver must complete 16 hours of ongoing training
 116.22 each year. ~~For purposes of this subdivision, a primary caregiver is an adult caregiver who~~
 116.23 ~~provides services in the licensed setting for more than 30 days in any 12-month period.~~
 116.24 ~~Repeat of topical training requirements in subdivisions 2 to 8 shall count toward the annual~~
 116.25 ~~16-hour training requirement.~~

116.26 (b) The license holder and caregiver must annually complete ongoing training as follows:

116.27 (1) as required by subdivision 2, a two-hour course in: child development that may be
 116.28 fulfilled by any course in Knowledge and Competency Area I: Child Development and
 116.29 Learning; or behavior guidance that may be fulfilled by any course in Knowledge and
 116.30 Competency Area II-C: Promoting Social and Emotional Development;

116.31 (2) a two-hour course in active supervision that may be fulfilled by any course in:
 116.32 Knowledge and Competency Area VII-A: Establishing Healthy Practices; or Knowledge
 116.33 and Competency Area VII-B: Ensuring Safety; and

117.1 (3) if applicable, ongoing training in reducing the risk of sudden unexpected infant death
117.2 and abusive head trauma, as required under subdivision 5.

117.3 (c) At least once every two years, the license holder and caregiver must complete ongoing
117.4 training as follows:

117.5 (1) training in pediatric first aid as required under subdivision 3;

117.6 (2) training in pediatric CPR as required under subdivision 4; and

117.7 (3) a two-hour course on accommodating children with disabilities or on cultural
117.8 dynamics that may be fulfilled by completing any course in Knowledge and Competency
117.9 Area III: Relationships with Families.

117.10 (d) At least once every five years, the license holder and caregiver must complete ongoing
117.11 training as follows:

117.12 (1) the two-hour courses Health and Safety I and Health and Safety II; and

117.13 (2) if applicable, ongoing training in child passenger restraint, as required under
117.14 subdivision 6.

117.15 (e) Additional ongoing training subjects to meet the annual 16-hour training requirement
117.16 must be selected from the following areas training in the following content areas of the
117.17 Minnesota Knowledge and Competency Framework:

117.18 (1) Content area I: child development and learning, including training under subdivision
117.19 2, paragraph (a) in understanding how children develop physically, cognitively, emotionally,
117.20 and socially; and learn as part of the children's family, culture, and community;

117.21 (2) Content area II: developmentally appropriate learning experiences, including training
117.22 in creating positive learning experiences, promoting cognitive development, promoting
117.23 social and emotional development, promoting physical development, promoting creative
117.24 development; and behavior guidance;

117.25 (3) Content area III: relationships with families, including training in building a positive,
117.26 respectful relationship with the child's family;

117.27 (4) Content area IV: assessment, evaluation, and individualization, including training
117.28 in observing, recording, and assessing development; assessing and using information to
117.29 plan; and assessing and using information to enhance and maintain program quality;

117.30 (5) Content area V: historical and contemporary development of early childhood
117.31 education, including training in past and current practices in early childhood education and
117.32 how current events and issues affect children, families, and programs;

118.1 (6) Content area VI: professionalism, including training in knowledge, skills, and abilities
 118.2 that promote ongoing professional development; and

118.3 (7) Content area VII: health, safety, and nutrition, including training in establishing
 118.4 healthy practices; ensuring safety; and providing healthy nutrition.

118.5 Subd. 8. ~~Other required training requirements~~ Ongoing training requirements for
 118.6 substitutes and helpers. (a) ~~The training required of family and group family child care~~
 118.7 ~~providers and staff must include training in the cultural dynamics of early childhood~~
 118.8 ~~development and child care. The cultural dynamics and disabilities training and skills~~
 118.9 ~~development of child care providers must be designed to achieve outcomes for providers~~
 118.10 ~~of child care that include, but are not limited to:~~

118.11 (1) ~~an understanding and support of the importance of culture and differences in ability~~
 118.12 ~~in children's identity development;~~

118.13 (2) ~~understanding the importance of awareness of cultural differences and similarities~~
 118.14 ~~in working with children and their families;~~

118.15 (3) ~~understanding and support of the needs of families and children with differences in~~
 118.16 ~~ability;~~

118.17 (4) ~~developing skills to help children develop unbiased attitudes about cultural differences~~
 118.18 ~~and differences in ability;~~

118.19 (5) ~~developing skills in culturally appropriate caregiving; and~~

118.20 (6) ~~developing skills in appropriate caregiving for children of different abilities.~~

118.21 ~~The commissioner shall approve the curriculum for cultural dynamics and disability~~
 118.22 ~~training.~~

118.23 (b) ~~The provider must meet the training requirement in section 245A.14, subdivision~~
 118.24 ~~11, paragraph (a), clause (4), to be eligible to allow a child cared for at the family child care~~
 118.25 ~~or group family child care home to use the swimming pool located at the home.~~

118.26 (a) Each substitute must complete ongoing training on the following schedule:

118.27 (1) annually, if applicable, training in reducing the risk of sudden unexpected infant
 118.28 death and abusive head trauma as required under subdivision 5;

118.29 (2) at least once every two years: (i) training in pediatric first aid as required under
 118.30 subdivision 3; (ii) training in pediatric CPR as required under subdivision 4; and (iii) the
 118.31 four-hour Basics of Licensed Family Child Care for Substitutes course; and

119.1 (3) at least once every five years, if applicable, training in child passenger restraints, as
 119.2 required under subdivision 6.

119.3 (b) Each helper must complete training on the following schedule:

119.4 (1) annually, if applicable, training in reducing the risk of sudden unexpected infant
 119.5 death and abusive head trauma as required under subdivision 5; and

119.6 (2) at least once every two years: (i) the one-hour course Basics of Child Development
 119.7 for Helpers; or (ii) any course in Knowledge and Competency Area I: Child Development
 119.8 and Learning.

119.9 ~~Subd. 9. **Supervising for safety; training requirement.** (a) Before initial licensure and~~
 119.10 ~~before caring for a child, all family child care license holders and each adult caregiver who~~
 119.11 ~~provides care in the licensed family child care home for more than 30 days in any 12-month~~
 119.12 ~~period shall complete and document the completion of the six-hour Supervising for Safety~~
 119.13 ~~for Family Child Care course developed by the commissioner.~~

119.14 ~~(b) The family child care license holder and each adult caregiver who provides care in~~
 119.15 ~~the licensed family child care home for more than 30 days in any 12-month period shall~~
 119.16 ~~complete and document:~~

119.17 ~~(1) the annual completion of a two-hour active supervision course developed by the~~
 119.18 ~~commissioner; and~~

119.19 ~~(2) the completion at least once every five years of the two-hour courses Health and~~
 119.20 ~~Safety I and Health and Safety II. A license holder's or adult caregiver's completion of either~~
 119.21 ~~training in a given year meets the annual active supervision training requirement in clause~~
 119.22 ~~(1).~~

119.23 Subd. 10. **Approved training.** County licensing staff must accept training approved by
 119.24 ~~the Minnesota Center for Professional Development~~ Achieve - the MN Center for
 119.25 Professional Development, including:

119.26 (1) face-to-face or classroom training;

119.27 (2) online training; and

119.28 (3) relationship-based professional development, such as mentoring, coaching, and
 119.29 consulting.

119.30 Subd. 11. **Provider training.** New and increased training requirements under this section
 119.31 must not be imposed on providers until the commissioner establishes statewide accessibility
 119.32 to the required provider training.

120.1 Subd. 12. **Documentation.** The license holder must document the date of a completed
120.2 training required by this section for the license holder, each caregiver, substitute, and helper.

120.3 Subd. 13. **Training exemption.** An individual who is related to the license holder, as
120.4 defined in section 245A.02, subdivision 13, who is involved only in the care of the family
120.5 child care license holder's own child and who is not a designated caregiver, helper, or
120.6 substitute for the licensed program is exempt from the training requirements in this section.

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

120.8 Sec. 50. Minnesota Statutes 2018, section 245A.51, subdivision 3, is amended to read:

120.9 Subd. 3. **Emergency preparedness plan.** (a) ~~No later than September 30, 2017,~~ A
120.10 licensed family child care provider must have a written emergency preparedness plan for
120.11 emergencies that require evacuation, sheltering, or other protection of children, such as fire,
120.12 natural disaster, intruder, or other threatening situation that may pose a health or safety
120.13 hazard to children. The plan must be written on a form developed by the commissioner and
120.14 updated at least annually. The plan must include:

120.15 (1) procedures for an evacuation, relocation, shelter-in-place, or lockdown;

120.16 (2) a designated relocation site and evacuation route;

120.17 (3) procedures for notifying a child's parent or legal guardian of the evacuation,
120.18 shelter-in-place, or lockdown, including procedures for reunification with families;

120.19 (4) accommodations for a child with a disability or a chronic medical condition;

120.20 (5) procedures for storing a child's medically necessary medicine that facilitate easy
120.21 removal during an evacuation or relocation;

120.22 (6) procedures for continuing operations in the period during and after a crisis; ~~and~~

120.23 (7) procedures for communicating with local emergency management officials, law
120.24 enforcement officials, or other appropriate state or local authorities; and

120.25 (8) accommodations for infants and toddlers.

120.26 (b) The license holder must train caregivers before the caregiver provides care and at
120.27 least annually on the emergency preparedness plan and document completion of this training.

120.28 (c) The license holder must conduct drills according to the requirements in Minnesota
120.29 Rules, part 9502.0435, subpart 8. The date and time of the drills must be documented.

121.1 (d) The license holder must have the emergency preparedness plan available for review
 121.2 and posted in a prominent location. The license holder must provide a physical or electronic
 121.3 copy of the plan to the child's parent or legal guardian upon enrollment.

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

121.5 Sec. 51. Minnesota Statutes 2018, section 245A.51, is amended by adding a subdivision
 121.6 to read:

121.7 Subd. 4. **Transporting children.** A license holder must ensure compliance with all seat
 121.8 belt and child passenger restraint system requirements under section 169.685.

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

121.10 Sec. 52. Minnesota Statutes 2018, section 245A.51, is amended by adding a subdivision
 121.11 to read:

121.12 Subd. 5. **Telephone requirement.** Notwithstanding Minnesota Rules, part 9502.0435,
 121.13 subpart 8, item B, a license holder is not required to post a list of emergency numbers. A
 121.14 license holder may use a cellular telephone to meet the requirements of Minnesota Rules,
 121.15 part 9502.0435, subpart 8, if the cellular telephone is sufficiently charged for use at all times.

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

121.17 Sec. 53. **[245A.52] FAMILY CHILD CARE PHYSICAL SPACE REQUIREMENTS.**

121.18 Subdivision 1. **Means of escape.** (a) (1) At least one emergency escape route separate
 121.19 from the main exit from the space must be available in each room used for sleeping by
 121.20 anyone receiving licensed care, and (2) a basement used for child care. One means of escape
 121.21 must be a stairway or door leading to the floor of exit discharge. The other must be a door
 121.22 or window leading directly outside. A window used as an emergency escape route must be
 121.23 openable without special knowledge.

121.24 (b) In homes with construction that began before May 2, 2016, the interior of the window
 121.25 leading directly outside must have a net clear opening area of not less than 4.5 square feet
 121.26 or 648 square inches and have minimum clear opening dimensions of 20 inches wide and
 121.27 20 inches high. The opening must be no higher than 48 inches from the floor. The height
 121.28 to the window may be measured from a platform if a platform is located below the window.

121.29 (c) In homes with construction that began on or after May 2, 2016, the interior of the
 121.30 window leading directly outside must have minimum clear opening dimensions of 20 inches

122.1 wide and 24 inches high. The net clear opening dimensions shall be the result of normal
122.2 operation of the opening. The opening must be no higher than 44 inches from the floor.

122.3 (d) Additional requirements are dependent on the distance of the openings from the
122.4 ground outside the window: (1) windows or other openings with a sill height not more than
122.5 44 inches above or below the finished ground level adjacent to the opening (grade-floor
122.6 emergency escape and rescue openings) must have a minimum opening of five square feet;
122.7 and (2) non-grade floor emergency escape and rescue openings must have a minimum
122.8 opening of 5.7 square feet.

122.9 Subd. 2. **Door to attached garage.** Notwithstanding Minnesota Rules, part 9502.0425,
122.10 subpart 5, day care residences with an attached garage are not required to have a self-closing
122.11 door to the residence. The door to the residence may be a steel insulated door if the door is
122.12 at least 1-3/8 inches thick.

122.13 Subd. 3. **Heating and venting systems.** Notwithstanding Minnesota Rules, part
122.14 9502.0425, subpart 7, items that can be ignited and support combustion, including but not
122.15 limited to plastic, fabric, and wood products must not be located within 18 inches of a gas
122.16 or fuel-oil heater or furnace. If a license holder produces manufacturer instructions listing
122.17 a smaller distance, then the manufacturer instructions control the distance combustible items
122.18 must be from gas, fuel-oil, or solid-fuel burning heaters or furnaces.

122.19 Subd. 4. **Fire extinguisher.** A portable, operational, multipurpose, dry chemical fire
122.20 extinguisher with a minimum 2 A 10 BC rating must be located in or near the kitchen and
122.21 cooking areas of the residence at all times. The fire extinguisher must be serviced annually
122.22 by a qualified inspector. All caregivers must know how to properly use the fire extinguisher.

122.23 Subd. 5. **Carbon monoxide and smoke alarms.** (a) All homes must have an approved
122.24 and operational carbon monoxide alarm installed within ten feet of each room used for
122.25 sleeping children in care.

122.26 (b) Smoke alarms that have been listed by the Underwriter Laboratory must be properly
122.27 installed and maintained on all levels including basements, but not including crawl spaces
122.28 and uninhabitable attics, and in hallways outside rooms used for sleeping children in care.

122.29 (c) In homes with construction that began on or after May 2, 2016, smoke alarms must
122.30 be installed and maintained in each room used for sleeping children in care.

122.31 Subd. 6. **Updates.** After readoption of the Minnesota State Fire Code, the fire marshal
122.32 must notify the commissioner of any changes that conflict with this section and Minnesota
122.33 Rules, chapter 9502. The state fire marshal must identify necessary statutory changes to

123.1 align statutes with the revised code. The commissioner must recommend updates to sections
123.2 of chapter 245A that are derived from the Minnesota State Fire Code in the legislative
123.3 session following readoption of the code.

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

123.5 Sec. 54. **[245A.53] SUBSTITUTE CAREGIVERS AND REPLACEMENTS IN**
123.6 **FAMILY CHILD CARE.**

123.7 Subdivision 1. **Total hours allowed.** Notwithstanding Minnesota Rules, part 9502.0365,
123.8 subpart 5, the use of a substitute caregiver in a licensed family child care program must be
123.9 limited to a cumulative total of not more than 400 hours in a calendar year. The license
123.10 holder must document the name, dates, and number of hours of the substitute who provided
123.11 care.

123.12 Subd. 2. **Emergency replacement supervision.** (a) A license holder may allow an adult
123.13 who has not completed the training requirements under this chapter or the background study
123.14 requirements under chapter 245C to supervise children in a family child care program in
123.15 an emergency. For purposes of this subdivision, an emergency is a situation in which:

123.16 (1) the license holder has begun operating the family child care program for the day and
123.17 for reasons beyond the license holder's control, including, but not limited to a serious illness
123.18 or injury, accident, or situation requiring the license holder's immediate attention, the license
123.19 holder needs to leave the licensed space and close the program for the day; and

123.20 (2) the parents or guardians of the children attending the program are contacted to pick
123.21 up their children as soon as is practicable.

123.22 (b) The license holder must make reasonable efforts to minimize the time the emergency
123.23 replacement has unsupervised contact with the children in care, not to exceed 24 hours per
123.24 emergency incident.

123.25 (c) The license holder shall not knowingly use a person as an emergency replacement
123.26 who has committed an action or has been convicted of a crime that would cause the person
123.27 to be disqualified from providing care to children, if a background study was conducted
123.28 under chapter 245C.

123.29 (d) To the extent practicable, the license holder must attempt to arrange for emergency
123.30 care by a substitute caregiver before using an emergency replacement.

123.31 (e) To the extent practicable, the license holder must notify the county licensing agency
123.32 within seven days that an emergency replacement was used, and specify the circumstances

124.1 that led to the use of the emergency replacement. The county licensing agency must notify
 124.2 the commissioner within three business days after receiving the license holder's notice that
 124.3 an emergency replacement was used, and specify the circumstances that led to the use of
 124.4 the emergency replacement.

124.5 (f) Notwithstanding the requirements in Minnesota Rules, part 9502.0405, a license
 124.6 holder is not required to provide the names of persons who may be used as substitutes or
 124.7 replacements in emergencies to parents or the county licensing agency.

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

124.9 Sec. 55. Minnesota Statutes 2018, section 245A.66, subdivision 2, is amended to read:

124.10 Subd. 2. **Child care centers; risk reduction plan.** (a) Child care centers licensed under
 124.11 this chapter and Minnesota Rules, chapter 9503, must develop a risk reduction plan that
 124.12 identifies the general risks to children served by the child care center. The license holder
 124.13 must establish procedures to minimize identified risks, train staff on the procedures, and
 124.14 annually review the procedures.

124.15 (b) The risk reduction plan must include an assessment of risk to children the center
 124.16 serves or intends to serve and identify specific risks based on the outcome of the assessment.
 124.17 The assessment of risk must be based on the following:

124.18 (1) an assessment of the risks presented by the physical plant where the licensed services
 124.19 are provided, including an evaluation of the following factors: the condition and design of
 124.20 the facility and its outdoor space, bathrooms, storage areas, and accessibility of medications
 124.21 and cleaning products that are harmful to children when children are not supervised and the
 124.22 existence of areas that are difficult to supervise; and

124.23 (2) an assessment of the risks presented by the environment for each facility and for
 124.24 each site, including an evaluation of the following factors: the type of grounds and terrain
 124.25 surrounding the building and the proximity to hazards, busy roads, and publicly accessed
 124.26 businesses.

124.27 (c) The risk reduction plan must include a statement of measures that will be taken to
 124.28 minimize the risk of harm presented to children for each risk identified in the assessment
 124.29 required under paragraph (b) related to the physical plant and environment. At a minimum,
 124.30 the stated measures must include the development and implementation of specific policies
 124.31 and procedures or reference to existing policies and procedures that minimize the risks
 124.32 identified.

125.1 (d) In addition to any program-specific risks identified in paragraph (b), the plan must
125.2 include development and implementation of specific policies and procedures or refer to
125.3 existing policies and procedures that minimize the risk of harm or injury to children,
125.4 including:

125.5 (1) closing children's fingers in doors, including cabinet doors;

125.6 (2) leaving children in the community without supervision;

125.7 (3) children leaving the facility without supervision;

125.8 (4) caregiver dislocation of children's elbows;

125.9 (5) burns from hot food or beverages, whether served to children or being consumed by
125.10 caregivers, and the devices used to warm food and beverages;

125.11 (6) injuries from equipment, such as scissors and glue guns;

125.12 (7) sunburn;

125.13 (8) feeding children foods to which they are allergic;

125.14 (9) children falling from changing tables; and

125.15 (10) children accessing dangerous items or chemicals or coming into contact with residue
125.16 from harmful cleaning products.

125.17 (e) The plan shall prohibit the accessibility of hazardous items to children.

125.18 (f) The plan must include specific policies and procedures to ensure adequate supervision
125.19 of children at all times as defined under section 245A.02, subdivision 18, with particular
125.20 emphasis on:

125.21 (1) times when children are transitioned from one area within the facility to another;

125.22 (2) nap-time supervision, including infant crib rooms as specified under section 245A.02,
125.23 subdivision 18, which requires that when an infant is placed in a crib to sleep, supervision
125.24 occurs when a staff person is within sight or hearing of the infant. When supervision of a
125.25 crib room is provided by sight or hearing, the center must have a plan to address the other
125.26 supervision components;

125.27 (3) child drop-off and pick-up times;

125.28 (4) supervision during outdoor play and on community activities, including but not
125.29 limited to field trips and neighborhood walks; ~~and~~

125.30 (5) supervision of children in hallways; and

126.1 (6) supervision of school-age children when using the restroom and visiting the child's
 126.2 personal storage space.

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

126.4 Sec. 56. Minnesota Statutes 2018, section 245A.66, subdivision 3, is amended to read:

126.5 Subd. 3. ~~Orientation to~~ Yearly review of risk reduction plan and annual review of
 126.6 plan. (a) ~~The license holder shall ensure that all mandated reporters, as defined in section~~
 126.7 ~~626.556, subdivision 3, who are under the control of the license holder, receive an orientation~~
 126.8 ~~to the risk reduction plan prior to first providing unsupervised direct contact services, as~~
 126.9 ~~defined in section 245C.02, subdivision 11, to children, not to exceed 14 days from the first~~
 126.10 ~~supervised direct contact, and annually thereafter. The license holder must document the~~
 126.11 ~~orientation to the risk reduction plan in the mandated reporter's personnel records.~~

126.12 ~~(b)~~ The license holder must review the risk reduction plan annually each calendar year
 126.13 and document the ~~annual~~ review. When conducting the review, the license holder must
 126.14 consider incidents that have occurred in the center since the last review, including:

126.15 (1) the assessment factors in the plan;

126.16 (2) the internal reviews conducted under this section, if any;

126.17 (3) substantiated maltreatment findings, if any; and

126.18 (4) incidents that caused injury or harm to a child, if any, that occurred since the last
 126.19 review.

126.20 Following any change to the risk reduction plan, the license holder must inform ~~mandated~~
 126.21 ~~reporters~~ staff persons, under the control of the license holder, of the changes in the risk
 126.22 reduction plan, and document that the ~~mandated reporters~~ staff were informed of the changes.

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

126.24 Sec. 57. Minnesota Statutes 2018, section 245C.02, is amended by adding a subdivision
 126.25 to read:

126.26 Subd. 5a. License-exempt child care center certification holder. "License-exempt
 126.27 child care center certification holder" has the meaning given for "certification holder" in
 126.28 section 245H.01, subdivision 4.

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

127.1 Sec. 58. Minnesota Statutes 2018, section 245C.02, subdivision 6a, is amended to read:

127.2 Subd. 6a. **Child care background study subject.** (a) "Child care background study
 127.3 subject" means an individual who is affiliated with a licensed child care center, certified
 127.4 license exempt child care center, licensed family child care program, or legal nonlicensed
 127.5 child care provider authorized under chapter 119B, and who is:

127.6 (1) ~~who is~~ employed by a child care provider for compensation;

127.7 (2) ~~whose activities involve assisting in the supervision care~~ of a child for a child care
 127.8 provider; ~~or~~

127.9 (3) ~~who is required to have a background study under section 245C.03, subdivision 1.~~

127.10 (3) a person applying for licensure, certification, or enrollment;

127.11 (4) a controlling individual as defined in section 245A.02, subdivision 5a;

127.12 (5) an individual 13 years of age or older who lives in the household where the licensed
 127.13 program will be provided and who is not receiving licensed services from the program;

127.14 (6) an individual ten to 12 years of age who lives in the household where the licensed
 127.15 services will be provided when the commissioner has reasonable cause as defined in section
 127.16 245C.02, subdivision 15;

127.17 (7) an individual who, without providing direct contact services at a licensed program,
 127.18 certified program, or program authorized under chapter 119B, may have unsupervised access
 127.19 to a child receiving services from a program when the commissioner has reasonable cause
 127.20 as defined in section 245C.02, subdivision 15; or

127.21 (8) a volunteer, contractor, prospective employee, or other individual who has
 127.22 unsupervised physical access to a child served by a program and who is not under direct,
 127.23 continuous supervision by an individual listed in clause (1) or (5), regardless of whether
 127.24 the individual provides program services.

127.25 (b) Notwithstanding paragraph (a), an individual who is providing services that are not
 127.26 part of the child care program is not required to have a background study if:

127.27 (1) the child receiving services is signed out of the child care program for the duration
 127.28 that the services are provided;

127.29 (2) the licensed child care center, certified license exempt child care center, licensed
 127.30 family child care program, or legal nonlicensed child care provider authorized under chapter
 127.31 119B has obtained advanced written permission from the parent authorizing the child to
 127.32 receive the services, which is maintained in the child's record;

128.1 (3) the licensed child care center, certified license exempt child care center, licensed
 128.2 family child care program, or legal nonlicensed child care provider authorized under chapter
 128.3 119B maintains documentation on-site that identifies the individual service provider and
 128.4 the services being provided; and

128.5 (4) the licensed child care center, certified license exempt child care center, licensed
 128.6 family child care program, or legal nonlicensed child care provider authorized under chapter
 128.7 119B ensures that the service provider does not have unsupervised access to a child not
 128.8 receiving the provider's services.

128.9 Sec. 59. Minnesota Statutes 2018, section 245C.02, is amended by adding a subdivision
 128.10 to read:

128.11 Subd. 6b. **Children's residential facility.** "Children's residential facility" means a
 128.12 children's residential facility licensed by the commissioner of corrections or the commissioner
 128.13 of human services under Minnesota Rules, chapter 2960.

128.14 **EFFECTIVE DATE.** This section is effective July 1, 2019, for background studies
 128.15 initiated on or after that date.

128.16 Sec. 60. Minnesota Statutes 2018, section 245C.02, is amended by adding a subdivision
 128.17 to read:

128.18 Subd. 12a. **Licensed family child foster care.** "Licensed family child foster care"
 128.19 includes providers who have submitted an application for family child foster care licensure
 128.20 under section 245A.04, subdivision 1. Licensed family child foster care does not include
 128.21 foster residence settings that meet the licensing requirements of Minnesota Rules, parts
 128.22 2960.3200 to 2960.3230.

128.23 **EFFECTIVE DATE.** This section is effective March 1, 2020.

128.24 Sec. 61. Minnesota Statutes 2018, section 245C.02, is amended by adding a subdivision
 128.25 to read:

128.26 Subd. 20. **Substance use disorder treatment field.** "Substance use disorder treatment
 128.27 field" means a program exclusively serving individuals 18 years of age and older and that
 128.28 is required to be:

128.29 (1) licensed under chapter 245G; or

128.30 (2) registered under section 157.17 as a board and lodge establishment that predominantly
 128.31 serves individuals being treated for or recovering from a substance use disorder.

129.1 Sec. 62. Minnesota Statutes 2018, section 245C.03, subdivision 1, is amended to read:

129.2 Subdivision 1. **Licensed programs.** (a) The commissioner shall conduct a background
129.3 study on:

129.4 (1) the person or persons applying for a license;

129.5 (2) an individual age 13 and over living in the household where the licensed program
129.6 will be provided who is not receiving licensed services from the program;

129.7 (3) current or prospective employees or contractors of the applicant who will have direct
129.8 contact with persons served by the facility, agency, or program;

129.9 (4) volunteers or student volunteers who will have direct contact with persons served
129.10 by the program to provide program services if the contact is not under the continuous, direct
129.11 supervision by an individual listed in clause (1) or (3);

129.12 (5) an individual age ten to 12 living in the household where the licensed services will
129.13 be provided when the commissioner has reasonable cause as defined in section 245C.02,
129.14 subdivision 15;

129.15 (6) an individual who, without providing direct contact services at a licensed program,
129.16 may have unsupervised access to children or vulnerable adults receiving services from a
129.17 program, when the commissioner has reasonable cause as defined in section 245C.02,
129.18 subdivision 15;

129.19 (7) all controlling individuals as defined in section 245A.02, subdivision 5a; and

129.20 (8) notwithstanding the other requirements in this subdivision, child care background
129.21 study subjects as defined in section 245C.02, subdivision 6a.

129.22 ~~(b) Paragraph (a), clauses (2), (5), and (6), apply to legal nonlicensed child care and~~
129.23 ~~certified license-exempt child care programs.~~

129.24 ~~(e)~~ (b) For child foster care when the license holder resides in the home where foster
129.25 care services are provided, a short-term substitute caregiver providing direct contact services
129.26 for a child for less than 72 hours of continuous care is not required to receive a background
129.27 study under this chapter.

129.28 Sec. 63. Minnesota Statutes 2018, section 245C.05, subdivision 2c, is amended to read:

129.29 Subd. 2c. **Privacy notice to background study subject.** (a) Prior to initiating each
129.30 background study, the entity initiating the study must provide the commissioner's privacy
129.31 notice to the background study subject required under section 13.04, subdivision 2. The

130.1 notice must be available through the commissioner's electronic NETStudy and NETStudy
130.2 2.0 systems and shall include the information in paragraphs (b) and (c).

130.3 (b) The background study subject shall be informed that any previous background studies
130.4 that received a set-aside will be reviewed, and without further contact with the background
130.5 study subject, the commissioner may notify the agency that initiated the subsequent
130.6 background study:

130.7 (1) that the individual has a disqualification that has been set aside for the program or
130.8 agency that initiated the study;

130.9 (2) the reason for the disqualification; and

130.10 (3) that information about the decision to set aside the disqualification will be available
130.11 to the license holder upon request without the consent of the background study subject.

130.12 (c) The background study subject must also be informed that:

130.13 (1) the subject's fingerprints collected for purposes of completing the background study
130.14 under this chapter must not be retained by the Department of Public Safety, Bureau of
130.15 Criminal Apprehension, or by the commissioner. The Federal Bureau of Investigation will
130.16 ~~only retain fingerprints of subjects with a criminal history~~ not retain background study
130.17 subjects' fingerprints;

130.18 (2) effective upon implementation of NETStudy 2.0, the subject's photographic image
130.19 will be retained by the commissioner, and if the subject has provided the subject's Social
130.20 Security number for purposes of the background study, the photographic image will be
130.21 available to prospective employers and agencies initiating background studies under this
130.22 chapter to verify the identity of the subject of the background study;

130.23 (3) the commissioner's authorized fingerprint collection vendor shall, for purposes of
130.24 verifying the identity of the background study subject, be able to view the identifying
130.25 information entered into NETStudy 2.0 by the entity that initiated the background study,
130.26 but shall not retain the subject's fingerprints, photograph, or information from NETStudy
130.27 2.0. The authorized fingerprint collection vendor shall retain no more than the subject's
130.28 name and the date and time the subject's fingerprints were recorded and sent, only as
130.29 necessary for auditing and billing activities;

130.30 (4) the commissioner shall provide the subject notice, as required in section 245C.17,
130.31 subdivision 1, paragraph (a), when an entity initiates a background study on the individual;

131.1 (5) the subject may request in writing a report listing the entities that initiated a
 131.2 background study on the individual as provided in section 245C.17, subdivision 1, paragraph
 131.3 (b);

131.4 (6) the subject may request in writing that information used to complete the individual's
 131.5 background study in NETStudy 2.0 be destroyed if the requirements of section 245C.051,
 131.6 paragraph (a), are met; and

131.7 (7) notwithstanding clause (6), the commissioner shall destroy:

131.8 (i) the subject's photograph after a period of two years when the requirements of section
 131.9 245C.051, paragraph (c), are met; and

131.10 (ii) any data collected on a subject under this chapter after a period of two years following
 131.11 the individual's death as provided in section 245C.051, paragraph (d).

131.12 Sec. 64. Minnesota Statutes 2018, section 245C.05, subdivision 2d, is amended to read:

131.13 Subd. 2d. **Fingerprint data notification.** The commissioner of human services shall
 131.14 notify all background study subjects under this chapter that the Department of Human
 131.15 Services, Department of Public Safety, and the Bureau of Criminal Apprehension do not
 131.16 retain fingerprint data after a background study is completed, and that the Federal Bureau
 131.17 of Investigation ~~only retains the fingerprints of subjects who have a criminal history of~~
 131.18 Investigation will not retain background study subjects' fingerprints.

131.19 Sec. 65. Minnesota Statutes 2018, section 245C.05, subdivision 4, is amended to read:

131.20 Subd. 4. **Electronic transmission.** (a) For background studies conducted by the
 131.21 Department of Human Services, the commissioner shall implement a secure system for the
 131.22 electronic transmission of:

131.23 (1) background study information to the commissioner;

131.24 (2) background study results to the license holder;

131.25 (3) background study results and relevant underlying investigative information to county
 131.26 and private agencies for background studies conducted by the commissioner for child foster
 131.27 care, including a summary of nondisqualifying results, except as prohibited by law; and

131.28 (4) background study results to county agencies for background studies conducted by
 131.29 the commissioner for adult foster care and family adult day services and, upon
 131.30 implementation of NETStudy 2.0, family child care and legal nonlicensed child care
 131.31 authorized under chapter 119B.

132.1 (b) Unless the commissioner has granted a hardship variance under paragraph (c), a
132.2 license holder or an applicant must use the electronic transmission system known as
132.3 NETStudy or NETStudy 2.0 to submit all requests for background studies to the
132.4 commissioner as required by this chapter.

132.5 (c) A license holder or applicant whose program is located in an area in which high-speed
132.6 Internet is inaccessible may request the commissioner to grant a variance to the electronic
132.7 transmission requirement.

132.8 (d) Section 245C.08, subdivision 3, paragraph (c), applies to results transmitted under
132.9 this subdivision.

132.10 **EFFECTIVE DATE.** This section is effective March 1, 2020.

132.11 Sec. 66. Minnesota Statutes 2018, section 245C.05, subdivision 5, is amended to read:

132.12 Subd. 5. **Fingerprints and photograph.** (a) Notwithstanding paragraph (b), for
132.13 background studies conducted by the commissioner for child foster care, children's residential
132.14 facilities, adoptions, or a transfer of permanent legal and physical custody of a child, the
132.15 subject of the background study, who is 18 years of age or older, shall provide the
132.16 commissioner with a set of classifiable fingerprints obtained from an authorized agency for
132.17 a national criminal history record check.

132.18 (b) For background studies initiated on or after the implementation of NETStudy 2.0,
132.19 except as provided under subdivision 5a, every subject of a background study must provide
132.20 the commissioner with a set of the background study subject's classifiable fingerprints and
132.21 photograph. The photograph and fingerprints must be recorded at the same time by the
132.22 commissioner's authorized fingerprint collection vendor and sent to the commissioner
132.23 through the commissioner's secure data system described in section 245C.32, subdivision
132.24 1a, paragraph (b).

132.25 (c) The fingerprints shall be submitted by the commissioner to the Bureau of Criminal
132.26 Apprehension and, when specifically required by law, submitted to the Federal Bureau of
132.27 Investigation for a national criminal history record check.

132.28 (d) The fingerprints must not be retained by the Department of Public Safety, Bureau
132.29 of Criminal Apprehension, or the commissioner. The Federal Bureau of Investigation will
132.30 ~~only retain fingerprints of subjects with a criminal history~~ not retain background study
132.31 subjects' fingerprints.

132.32 (e) The commissioner's authorized fingerprint collection vendor shall, for purposes of
132.33 verifying the identity of the background study subject, be able to view the identifying

133.1 information entered into NETStudy 2.0 by the entity that initiated the background study,
 133.2 but shall not retain the subject's fingerprints, photograph, or information from NETStudy
 133.3 2.0. The authorized fingerprint collection vendor shall retain no more than the name and
 133.4 date and time the subject's fingerprints were recorded and sent, only as necessary for auditing
 133.5 and billing activities.

133.6 (f) For any background study conducted under this chapter, the subject shall provide the
 133.7 commissioner with a set of classifiable fingerprints when the commissioner has reasonable
 133.8 cause to require a national criminal history record check as defined in section 245C.02,
 133.9 subdivision 15a.

133.10 EFFECTIVE DATE. Paragraph (a) is effective July 1, 2019, for background studies
 133.11 initiated on or after that date.

133.12 Sec. 67. Minnesota Statutes 2018, section 245C.05, subdivision 5a, is amended to read:

133.13 Subd. 5a. **Background study requirements for minors.** (a) A background study
 133.14 completed under this chapter on a subject who is required to be studied under section
 133.15 245C.03, subdivision 1, and is 17 years of age or younger shall be completed by the
 133.16 commissioner for:

133.17 (1) a legal nonlicensed child care provider authorized under chapter 119B;

133.18 (2) a licensed family child care program; or

133.19 (3) a licensed foster care home.

133.20 (b) The subject shall submit to the commissioner only the information under subdivision
 133.21 1, paragraph (a).

133.22 (c) A subject who is 17 years of age or younger is required to submit fingerprints and a
 133.23 photograph, and the commissioner shall conduct a national criminal history record check,
 133.24 if:

133.25 (1) the commissioner has reasonable cause to require a national criminal history record
 133.26 check defined in section 245C.02, subdivision 15a; or

133.27 (2) under paragraph (a), clauses (1) and (2), the subject is employed by the provider or
 133.28 supervises children served by the program.

133.29 (d) A subject who is 17 years of age or younger is required to submit
 133.30 non-fingerprint-based data according to section 245C.08, subdivision 1, paragraph (a),
 133.31 clause (6), item (iii), and the commissioner shall conduct the check if:

- 134.1 (1) the commissioner has reasonable cause to require a national criminal history record
 134.2 check defined in section 245C.02, subdivision 15a; or
 134.3 (2) the subject is employed by the provider or supervises children served by the program
 134.4 under paragraph (a), clauses (1) and (2).

134.5 Sec. 68. Minnesota Statutes 2018, section 245C.08, subdivision 1, is amended to read:

134.6 Subdivision 1. **Background studies conducted by Department of Human Services.** (a)

134.7 For a background study conducted by the Department of Human Services, the commissioner
 134.8 shall review:

134.9 (1) information related to names of substantiated perpetrators of maltreatment of
 134.10 vulnerable adults that has been received by the commissioner as required under section
 134.11 626.557, subdivision 9c, paragraph (j);

134.12 (2) the commissioner's records relating to the maltreatment of minors in licensed
 134.13 programs, and from findings of maltreatment of minors as indicated through the social
 134.14 service information system;

134.15 (3) information from juvenile courts as required in subdivision 4 for individuals listed
 134.16 in section 245C.03, subdivision 1, paragraph (a), when there is reasonable cause;

134.17 (4) information from the Bureau of Criminal Apprehension, including information
 134.18 regarding a background study subject's registration in Minnesota as a predatory offender
 134.19 under section 243.166;

134.20 (5) except as provided in clause (6), information received as a result of submission of
 134.21 fingerprints for a national criminal history record check, as defined in section 245C.02,
 134.22 subdivision 13c, when the commissioner has reasonable cause for a national criminal history
 134.23 record check as defined under section 245C.02, subdivision 15a, or as required under section
 134.24 144.057, subdivision 1, clause (2);

134.25 (6) for a background study related to a child foster care application for licensure, children's
 134.26 residential facilities, a transfer of permanent legal and physical custody of a child under
 134.27 sections 260C.503 to 260C.515, or adoptions, and for a background study required for
 134.28 family child care, certified license-exempt child care, child care centers, and legal nonlicensed
 134.29 child care authorized under chapter 119B, the commissioner shall also review:

134.30 (i) information from the child abuse and neglect registry for any state in which the
 134.31 background study subject has resided for the past five years; ~~and~~

135.1 (ii) when the background study subject is 18 years of age or older, or a minor under
135.2 section 245C.05, subdivision 5a, paragraph (c), information received following submission
135.3 of fingerprints for a national criminal history record check; and

135.4 (iii) when the background study subject is 18 years of age or older or a minor under
135.5 section 245C.05, subdivision 5a, paragraph (d), for licensed family child care, certified
135.6 license-exempt child care, licensed child care centers, and legal nonlicensed child care
135.7 authorized under chapter 119B, information obtained using non-fingerprint-based data
135.8 including information from the criminal and sex offender registries for any state in which
135.9 the background study subject resided for the past five years and information from the national
135.10 crime information database and the national sex offender registry; and

135.11 (7) for a background study required for family child care, certified license-exempt child
135.12 care centers, licensed child care centers, and legal nonlicensed child care authorized under
135.13 chapter 119B, the background study shall also include, to the extent practicable, a name
135.14 and date-of-birth search of the National Sex Offender Public website.

135.15 (b) Notwithstanding expungement by a court, the commissioner may consider information
135.16 obtained under paragraph (a), clauses (3) and (4), unless the commissioner received notice
135.17 of the petition for expungement and the court order for expungement is directed specifically
135.18 to the commissioner.

135.19 (c) The commissioner shall also review criminal case information received according
135.20 to section 245C.04, subdivision 4a, from the Minnesota court information system that relates
135.21 to individuals who have already been studied under this chapter and who remain affiliated
135.22 with the agency that initiated the background study.

135.23 (d) When the commissioner has reasonable cause to believe that the identity of a
135.24 background study subject is uncertain, the commissioner may require the subject to provide
135.25 a set of classifiable fingerprints for purposes of completing a fingerprint-based record check
135.26 with the Bureau of Criminal Apprehension. Fingerprints collected under this paragraph
135.27 shall not be saved by the commissioner after they have been used to verify the identity of
135.28 the background study subject against the particular criminal record in question.

135.29 (e) The commissioner may inform the entity that initiated a background study under
135.30 NETStudy 2.0 of the status of processing of the subject's fingerprints.

135.31 **EFFECTIVE DATE.** Paragraph (a) is effective July 1, 2019, for background studies
135.32 initiated on or after that date.

136.1 Sec. 69. Minnesota Statutes 2018, section 245C.08, subdivision 3, is amended to read:

136.2 Subd. 3. **Arrest and investigative information.** (a) For any background study completed
136.3 under this section, if the commissioner has reasonable cause to believe the information is
136.4 pertinent to the disqualification of an individual, the commissioner also may review arrest
136.5 and investigative information from:

136.6 (1) the Bureau of Criminal Apprehension;

136.7 (2) the ~~commissioner~~ commissioners of health and human services;

136.8 (3) a county attorney;

136.9 (4) a county sheriff;

136.10 (5) a county agency;

136.11 (6) a local chief of police;

136.12 (7) other states;

136.13 (8) the courts;

136.14 (9) the Federal Bureau of Investigation;

136.15 (10) the National Criminal Records Repository; and

136.16 (11) criminal records from other states.

136.17 (b) Except when specifically required by law, the commissioner is not required to conduct
136.18 more than one review of a subject's records from the Federal Bureau of Investigation if a
136.19 review of the subject's criminal history with the Federal Bureau of Investigation has already
136.20 been completed by the commissioner and there has been no break in the subject's affiliation
136.21 with the ~~license holder who~~ entity that initiated the background study.

136.22 (c) If the commissioner conducts a national criminal history record check when required
136.23 by law and uses the information from the national criminal history record check to make a
136.24 disqualification determination, the data obtained is private data and cannot be shared with
136.25 county agencies, private agencies, or prospective employers of the background study subject.

136.26 (d) If the commissioner conducts a national criminal history record check when required
136.27 by law and uses the information from the national criminal history record check to make a
136.28 disqualification determination, the license holder or entity that submitted the study is not
136.29 required to obtain a copy of the background study subject's disqualification letter under
136.30 section 245C.17, subdivision 3.

137.1 **EFFECTIVE DATE.** This section is effective for background studies requested on or
137.2 after October 1, 2019.

137.3 Sec. 70. Minnesota Statutes 2018, section 245C.10, is amended by adding a subdivision
137.4 to read:

137.5 **Subd. 14. Children's residential facilities.** The commissioner shall recover the cost of
137.6 background studies initiated by a licensed children's residential facility through a fee of no
137.7 more than \$51 per study. Fees collected under this subdivision are appropriated to the
137.8 commissioner for purposes of conducting background studies.

137.9 **EFFECTIVE DATE.** This section is effective July 1, 2019, for background studies
137.10 initiated on or after that date.

137.11 Sec. 71. Minnesota Statutes 2018, section 245C.13, subdivision 2, is amended to read:

137.12 **Subd. 2. Direct contact pending completion of background study.** The subject of a
137.13 background study may not perform any activity requiring a background study under
137.14 paragraph (b) until the commissioner has issued one of the notices under paragraph (a).

137.15 (a) Notices from the commissioner required prior to activity under paragraph (b) include:

137.16 (1) a notice of the study results under section 245C.17 stating that:

137.17 (i) the individual is not disqualified; or

137.18 (ii) more time is needed to complete the study but the individual is not required to be
137.19 removed from direct contact or access to people receiving services prior to completion of
137.20 the study as provided under section 245C.17, subdivision 1, paragraph (b) or (c). The notice
137.21 that more time is needed to complete the study must also indicate whether the individual is
137.22 required to be under continuous direct supervision prior to completion of the background
137.23 study;

137.24 (2) a notice that a disqualification has been set aside under section 245C.23; or

137.25 (3) a notice that a variance has been granted related to the individual under section
137.26 245C.30.

137.27 (b) For a background study affiliated with a licensed child care center or certified license
137.28 exempt child care center, the notice sent under paragraph (a), clause (1), item (ii), must
137.29 require the individual to be under continuous direct supervision prior to completion of the
137.30 background study except as permitted in subdivision 3.

137.31 (c) Activities prohibited prior to receipt of notice under paragraph (a) include:

- 138.1 (1) being issued a license;
- 138.2 (2) living in the household where the licensed program will be provided;
- 138.3 (3) providing direct contact services to persons served by a program unless the subject
- 138.4 is under continuous direct supervision; ~~or~~
- 138.5 (4) having access to persons receiving services if the background study was completed
- 138.6 under section 144.057, subdivision 1, or 245C.03, subdivision 1, paragraph (a), clause (2),
- 138.7 (5), or (6), unless the subject is under continuous direct supervision; or
- 138.8 (5) for licensed child care center and certified license exempt child care centers, providing
- 138.9 direct contact services to persons served by the program.

138.10 Sec. 72. Minnesota Statutes 2018, section 245C.13, is amended by adding a subdivision

138.11 to read:

138.12 Subd. 3. **Other state information.** If the commissioner has not received criminal, sex

138.13 offender, or maltreatment information from another state that is required to be reviewed

138.14 under this chapter within ten days of requesting the information, and the lack of the

138.15 information is the only reason that a notice is issued under subdivision 2, paragraph (a),

138.16 clause (1), item (ii), the commissioner may issue a notice under subdivision 2, paragraph

138.17 (a), clause (1), item (i). The commissioner may take action on information received from

138.18 other states after issuing a notice under subdivision 2, paragraph (a), clause (1), item (ii).

138.19 Sec. 73. Minnesota Statutes 2018, section 245C.14, subdivision 1, is amended to read:

138.20 Subdivision 1. **Disqualification from direct contact.** (a) The commissioner shall

138.21 disqualify an individual who is the subject of a background study from any position allowing

138.22 direct contact with persons receiving services from the license holder or entity identified in

138.23 section 245C.03, upon receipt of information showing, or when a background study

138.24 completed under this chapter shows any of the following:

- 138.25 (1) a conviction of, admission to, or Alford plea to one or more crimes listed in section
- 138.26 245C.15, regardless of whether the conviction or admission is a felony, gross misdemeanor,
- 138.27 or misdemeanor level crime;
- 138.28 (2) a preponderance of the evidence indicates the individual has committed an act or
- 138.29 acts that meet the definition of any of the crimes listed in section 245C.15, regardless of
- 138.30 whether the preponderance of the evidence is for a felony, gross misdemeanor, or
- 138.31 misdemeanor level crime; or

139.1 (3) an investigation results in an administrative determination listed under section
139.2 245C.15, subdivision 4, paragraph (b).

139.3 (b) No individual who is disqualified following a background study under section
139.4 245C.03, subdivisions 1 and 2, may be retained in a position involving direct contact with
139.5 persons served by a program or entity identified in section 245C.03, unless the commissioner
139.6 has provided written notice under section 245C.17 stating that:

139.7 (1) the individual may remain in direct contact during the period in which the individual
139.8 may request reconsideration as provided in section 245C.21, subdivision 2;

139.9 (2) the commissioner has set aside the individual's disqualification for that program or
139.10 entity identified in section 245C.03, as provided in section 245C.22, subdivision 4; or

139.11 (3) the license holder has been granted a variance for the disqualified individual under
139.12 section 245C.30.

139.13 (c) Notwithstanding paragraph (a), for the purposes of a background study affiliated
139.14 with a licensed family child foster care provider, the commissioner shall disqualify an
139.15 individual who is the subject of a background study from any position allowing direct contact
139.16 with persons receiving services from the license holder or entity identified in section 245C.03,
139.17 upon receipt of information showing, or when a background study completed under this
139.18 chapter is disqualifying under section 245C.15, subdivision 6.

139.19 **EFFECTIVE DATE.** This section is effective March 1, 2020.

139.20 Sec. 74. Minnesota Statutes 2018, section 245C.15, is amended by adding a subdivision
139.21 to read:

139.22 **Subd. 6. Licensed family child foster care disqualifications.** (a) Notwithstanding
139.23 subdivisions 1 to 5, for a background study affiliated with a licensed family child foster
139.24 care, an individual is disqualified under section 245C.14, regardless of how much time has
139.25 passed, if the individual committed an act that resulted in a felony-level conviction for:
139.26 609.185 (murder in the first degree); 609.19 (murder in the second degree); 609.195 (murder
139.27 in the third degree); 609.20 (manslaughter in the first degree); 609.205 (manslaughter in
139.28 the second degree); 609.2112 (criminal vehicular homicide); 609.223, subdivision 2 (assault
139.29 in the third degree, past pattern of child abuse); 609.223, subdivision 3 (assault in the third
139.30 degree, victim under four); a felony offense under sections 609.2242 and 609.2243 (domestic
139.31 assault), spousal abuse, child abuse or neglect, or a crime against children; 609.2247
139.32 (domestic assault by strangulation); 609.25 (kidnapping); 609.255 (false imprisonment);
139.33 609.265 (abduction); 609.2661 (murder of an unborn child in the first degree); 609.2662

140.1 (murder of an unborn child in the second degree); 609.2663 (murder of an unborn child in
 140.2 the third degree); 609.2664 (manslaughter of an unborn child in the first degree); 609.2665
 140.3 (manslaughter of an unborn child in the second degree); 609.267 (assault of an unborn child
 140.4 in the first degree); 609.2671 (assault of an unborn child in the second degree); 609.268
 140.5 (injury or death of an unborn child in the commission of a crime); 609.324, subdivision 1
 140.6 (other prohibited acts; engaging in, hiring, or agreeing to hire minor to engage in prostitution);
 140.7 609.342 (criminal sexual conduct in the first degree); 609.343 (criminal sexual conduct in
 140.8 the second degree); 609.344 (criminal sexual conduct in the third degree); 609.345 (criminal
 140.9 sexual conduct in the fourth degree); 609.3451 (criminal sexual conduct in the fifth degree);
 140.10 609.3453 (criminal sexual predatory conduct); 609.352 (solicitation of children to engage
 140.11 in sexual conduct); 609.377 (malicious punishment of a child); 609.378 (neglect or
 140.12 endangerment of a child); 617.246 (use of minors in sexual performance prohibited); or
 140.13 617.247 (possession of pictorial representations of minors).

140.14 (b) Notwithstanding subdivisions 1 to 5, for the purposes of a background study affiliated
 140.15 with a licensed family foster care license, an individual is disqualified under section 245C.14,
 140.16 regardless of how much time has passed, if the individual:

140.17 (1) committed an action under paragraph (d) that resulted in death or involved sexual
 140.18 abuse;

140.19 (2) committed an act that resulted in a felony-level conviction for section 609.746
 140.20 (interference with privacy);

140.21 (3) committed an act that resulted in a gross misdemeanor-level conviction for section
 140.22 609.3451 (criminal sexual conduct in the fifth degree); or

140.23 (4) committed an act against or involving a minor that resulted in a felony-level conviction
 140.24 for: section 609.221 (assault in the first degree); 609.222 (assault in the second degree);
 140.25 609.223, subdivision 1 (assault in the third degree); 609.2231 (assault in the fourth degree);
 140.26 or 609.224, subdivision 4 (assault in the fifth degree).

140.27 (c) Notwithstanding subdivisions 1 to 5, for a background study affiliated with a licensed
 140.28 family child foster care license, an individual is disqualified under section 245C.14 if:

140.29 (1) less than five years have passed since the termination of parental rights under section
 140.30 260C.301, subdivision 1, paragraph (b);

140.31 (2) less than five years have passed since a felony-level conviction for: 152.021
 140.32 (controlled substance crime in the first degree); 152.022 (controlled substance crime in the
 140.33 second degree); 152.023 (controlled substance crime in the third degree); 152.024 (controlled

141.1 substance crime in the fourth degree); 152.025 (controlled substance crime in the fifth
 141.2 degree); 152.0261 (importing controlled substances across state borders); 152.0262,
 141.3 subdivision 1, paragraph (b) (possession of substance with intent to manufacture
 141.4 methamphetamine); 152.027, subdivision 6, paragraph (c) (sale or possession of synthetic
 141.5 cannabinoids); 152.096 (conspiracies prohibited); 152.097 (simulated controlled substances);
 141.6 152.136 (anhydrous ammonia; prohibited conduct; criminal penalties; civil liabilities);
 141.7 152.137 (methamphetamine-related crimes involving children or vulnerable adults); 169A.24
 141.8 (felony first-degree driving while impaired); 609.2113 (criminal vehicular operation; bodily
 141.9 harm); 609.2114 (criminal vehicular operation; unborn child); 609.228 (great bodily harm
 141.10 caused by distribution of drugs); 609.2325 (criminal abuse of a vulnerable adult); 609.235
 141.11 (use of drugs to injure or facilitate a crime); 609.66, subdivision 1e (felony drive-by
 141.12 shooting); 609.687 (adulteration); or 609.855, subdivision 5 (shooting at or in a public
 141.13 transit vehicle or facility); or

141.14 (3) less than five years have passed since a felony-level conviction for an act not against
 141.15 or involving a minor under: section 609.221 (assault in the first degree); 609.222 (assault
 141.16 in the second degree); 609.223, subdivision 1 (assault in the third degree); 609.2231 (assault
 141.17 in the fourth degree); or 609.224, subdivision 4 (assault in the fifth degree).

141.18 (d) Notwithstanding subdivisions 1 to 5, except as provided in paragraph (a), for a
 141.19 background study affiliated with a licensed family child foster care license, an individual
 141.20 is disqualified under section 245C.14 if less than five years have passed since:

141.21 (1) a determination or disposition of the individual's failure to make required reports
 141.22 under section 626.556, subdivision 3, or 626.557, subdivision 3, for incidents in which the
 141.23 final disposition under section 626.556 or 626.557 was substantiated maltreatment and the
 141.24 maltreatment was recurring or serious;

141.25 (2) a determination or disposition of the individual's substantiated serious or recurring
 141.26 maltreatment of a minor under section 626.556, a vulnerable adult under section 626.557,
 141.27 or serious or recurring maltreatment in any other state, the elements of which are substantially
 141.28 similar to the elements of maltreatment under section 626.556 or 626.557 and meet the
 141.29 definition of serious maltreatment or recurring maltreatment;

141.30 (3) the termination of the individual's parental rights under section 260C.301, subdivision
 141.31 1, paragraph (a); or

141.32 (4) a gross misdemeanor-level conviction for: section 609.746 (interference with privacy);
 141.33 609.2242 and 609.2243 (domestic assault); 609.377 (malicious punishment of a child); or
 141.34 609.378 (neglect or endangerment of a child).

142.1 (e) An individual is disqualified under this subdivision if the individual is convicted of
142.2 an offense in any other state or country and the elements of the offense are substantially
142.3 similar to any of the offenses listed in this subdivision.

142.4 **EFFECTIVE DATE.** This section is effective March 1, 2020.

142.5 Sec. 75. Minnesota Statutes 2018, section 245C.22, subdivision 4, is amended to read:

142.6 Subd. 4. **Risk of harm; set aside.** (a) The commissioner may set aside the disqualification
142.7 if the commissioner finds that the individual has submitted sufficient information to
142.8 demonstrate that the individual does not pose a risk of harm to any person served by the
142.9 applicant, license holder, or other entities as provided in this chapter.

142.10 (b) In determining whether the individual has met the burden of proof by demonstrating
142.11 the individual does not pose a risk of harm, the commissioner shall consider:

142.12 (1) the nature, severity, and consequences of the event or events that led to the
142.13 disqualification;

142.14 (2) whether there is more than one disqualifying event;

142.15 (3) the age and vulnerability of the victim at the time of the event;

142.16 (4) the harm suffered by the victim;

142.17 (5) vulnerability of persons served by the program;

142.18 (6) the similarity between the victim and persons served by the program;

142.19 (7) the time elapsed without a repeat of the same or similar event;

142.20 (8) documentation of successful completion by the individual studied of training or
142.21 rehabilitation pertinent to the event; and

142.22 (9) any other information relevant to reconsideration.

142.23 (c) If the individual requested reconsideration on the basis that the information relied
142.24 upon to disqualify the individual was incorrect or inaccurate and the commissioner determines
142.25 that the information relied upon to disqualify the individual is correct, the commissioner
142.26 must also determine if the individual poses a risk of harm to persons receiving services in
142.27 accordance with paragraph (b).

142.28 (d) For an individual seeking employment in the substance use disorder treatment field,
142.29 the commissioner shall set aside the disqualification if the following criteria are met:

143.1 (1) the individual is not disqualified for a crime of violence as listed under section
 143.2 624.712, subdivision 5, except for the following crimes: crimes listed under section 152.021,
 143.3 subdivision 2 or 2a; 152.022, subdivision 2; 152.023, subdivision 2; 152.024; or 152.025;

143.4 (2) the individual is not disqualified under section 245C.15, subdivision 1;

143.5 (3) the individual is not disqualified under section 245C.15, subdivision 4, paragraph
 143.6 (b);

143.7 (4) the individual provided documentation of successful completion of treatment, at least
 143.8 one year prior to the date of the request for reconsideration, at a program licensed under
 143.9 chapter 245G, and has had no disqualifying crimes or conduct under section 245C.15 after
 143.10 the successful completion of treatment;

143.11 (5) the individual provided documentation demonstrating abstinence from controlled
 143.12 substances, as defined in section 152.01, subdivision 4, for the period of one year prior to
 143.13 the date of the request for reconsideration; and

143.14 (6) the individual is seeking employment in the substance use disorder treatment field.

143.15 Sec. 76. Minnesota Statutes 2018, section 245C.22, subdivision 5, is amended to read:

143.16 **Subd. 5. Scope of set-aside.** (a) If the commissioner sets aside a disqualification under
 143.17 this section, the disqualified individual remains disqualified, but may hold a license and
 143.18 have direct contact with or access to persons receiving services. Except as provided in
 143.19 paragraph (b), the commissioner's set-aside of a disqualification is limited solely to the
 143.20 licensed program, applicant, or agency specified in the set aside notice under section 245C.23.
 143.21 For personal care provider organizations, the commissioner's set-aside may further be limited
 143.22 to a specific individual who is receiving services. For new background studies required
 143.23 under section 245C.04, subdivision 1, paragraph (h), if an individual's disqualification was
 143.24 previously set aside for the license holder's program and the new background study results
 143.25 in no new information that indicates the individual may pose a risk of harm to persons
 143.26 receiving services from the license holder, the previous set-aside shall remain in effect.

143.27 (b) If the commissioner has previously set aside an individual's disqualification for one
 143.28 or more programs or agencies, and the individual is the subject of a subsequent background
 143.29 study for a different program or agency, the commissioner shall determine whether the
 143.30 disqualification is set aside for the program or agency that initiated the subsequent
 143.31 background study. A notice of a set-aside under paragraph (c) shall be issued within 15
 143.32 working days if all of the following criteria are met:

144.1 (1) the subsequent background study was initiated in connection with a program licensed
144.2 or regulated under the same provisions of law and rule for at least one program for which
144.3 the individual's disqualification was previously set aside by the commissioner;

144.4 (2) the individual is not disqualified for an offense specified in section 245C.15,
144.5 subdivision 1 or 2;

144.6 (3) the commissioner has received no new information to indicate that the individual
144.7 may pose a risk of harm to any person served by the program; and

144.8 (4) the previous set-aside was not limited to a specific person receiving services.

144.9 (c) Notwithstanding paragraph (b), clause (2), for an individual who is employed in the
144.10 substance use disorder field, if the commissioner has previously set aside an individual's
144.11 disqualification for one or more programs or agencies in the substance use disorder treatment
144.12 field, and the individual is the subject of a subsequent background study for a different
144.13 program or agency in the substance use disorder treatment field, the commissioner shall set
144.14 aside the disqualification for the program or agency in the substance use disorder treatment
144.15 field that initiated the subsequent background study when the criteria under paragraph (b),
144.16 clauses (1), (3), and (4), are met and the individual is not disqualified for an offense specified
144.17 in section 254C.15, subdivision 1. A notice of a set-aside under paragraph (d) shall be issued
144.18 within 15 working days.

144.19 ~~(e)~~ (d) When a disqualification is set aside under paragraph (b), the notice of background
144.20 study results issued under section 245C.17, in addition to the requirements under section
144.21 245C.17, shall state that the disqualification is set aside for the program or agency that
144.22 initiated the subsequent background study. The notice must inform the individual that the
144.23 individual may request reconsideration of the disqualification under section 245C.21 on the
144.24 basis that the information used to disqualify the individual is incorrect.

144.25 Sec. 77. Minnesota Statutes 2018, section 245C.24, is amended to read:

144.26 **245C.24 DISQUALIFICATION; BAR TO SET ASIDE A DISQUALIFICATION;**
144.27 **REQUEST FOR VARIANCE.**

144.28 Subdivision 1. **Minimum disqualification periods.** The disqualification periods under
144.29 subdivisions 3 ~~and 4~~ to 6 are the minimum applicable disqualification periods. The
144.30 commissioner may determine that an individual should continue to be disqualified from
144.31 licensure because the individual continues to pose a risk of harm to persons served by that
144.32 individual, even after the minimum disqualification period has passed.

145.1 Subd. 2. **Permanent bar to set aside a disqualification.** (a) Except as provided in
145.2 ~~paragraph paragraphs~~ (b); to (d), the commissioner may not set aside the disqualification
145.3 of any individual disqualified pursuant to this chapter, regardless of how much time has
145.4 passed, if the individual was disqualified for a crime or conduct listed in section 245C.15,
145.5 subdivision 1.

145.6 (b) For an individual ~~in the chemical dependency or corrections field~~ who was disqualified
145.7 for a crime or conduct listed under section 245C.15, subdivision 1, and ~~whose disqualification~~
145.8 ~~was set aside prior to July 1, 2005~~ more than 20 years have passed since the discharge of
145.9 the sentence imposed or, if the disqualification is not based on a conviction, more than 20
145.10 years have passed since the individual committed the act upon which the disqualification
145.11 was based, the commissioner must consider granting a set aside or variance pursuant to
145.12 section 245C.22 or 245C.30 for the license holder for a program dealing primarily with
145.13 adults. ~~A request for reconsideration evaluated under this paragraph must include a letter~~
145.14 ~~of recommendation from the license holder that was subject to the prior set-aside decision~~
145.15 ~~addressing the individual's quality of care to children or vulnerable adults and the~~
145.16 ~~circumstances of the individual's departure from that service~~ This paragraph does not apply
145.17 to a person disqualified based on a violation of sections 609.342 to 609.3453; 617.23,
145.18 subdivision 2, clause (1), or subdivision 3, clause (1); 617.246; or 617.247.

145.19 (c) When a licensed foster care provider adopts an individual who had received foster
145.20 care services from the provider for over six months, and the adopted individual is required
145.21 to receive a background study under section 245C.03, subdivision 1, paragraph (a), clause
145.22 (2) or (6), the commissioner may grant a variance to the license holder under section 245C.30
145.23 to permit the adopted individual with a permanent disqualification to remain affiliated with
145.24 the license holder under the conditions of the variance when the variance is recommended
145.25 by the county of responsibility for each of the remaining individuals in placement in the
145.26 home and the licensing agency for the home.

145.27 (d) For an individual 18 years of age or older affiliated with a licensed family child foster
145.28 care program, the commissioner must not set aside the disqualification of any individual
145.29 disqualified pursuant to this chapter, regardless of how much time has passed, if the individual
145.30 was disqualified for a crime or conduct listed in section 245C.15, subdivision 6, paragraph
145.31 (a). This paragraph does not apply to an individual younger than 18 years of age at the time
145.32 the background study is submitted.

145.33 Subd. 3. **Ten-year bar to set aside disqualification.** (a) The commissioner may not set
145.34 aside the disqualification of an individual in connection with a license to provide family
145.35 child care for children, ~~foster care for children in the provider's home~~, or foster care or day

146.1 care services for adults in the provider's home if: (1) less than ten years has passed since
146.2 the discharge of the sentence imposed, if any, for the offense; or (2) when disqualified based
146.3 on a preponderance of the evidence determination under section 245C.14, subdivision 1,
146.4 paragraph (a), clause (2), or an admission under section 245C.14, subdivision 1, paragraph
146.5 (a), clause (1), and less than ten years has passed since the individual committed the act or
146.6 admitted to committing the act, whichever is later; and (3) the individual has committed a
146.7 violation of any of the following offenses: sections 609.165 (felon ineligible to possess
146.8 firearm); criminal vehicular homicide or criminal vehicular operation causing death under
146.9 609.2112, 609.2113, or 609.2114 (criminal vehicular homicide or injury); 609.215 (aiding
146.10 suicide or aiding attempted suicide); felony violations under 609.223 or 609.2231 (assault
146.11 in the third or fourth degree); 609.229 (crimes committed for benefit of a gang); 609.713
146.12 (terroristic threats); 609.235 (use of drugs to injure or to facilitate crime); 609.24 (simple
146.13 robbery); 609.255 (false imprisonment); 609.562 (arson in the second degree); 609.71 (riot);
146.14 609.498, subdivision 1 or 1b (aggravated first-degree or first-degree tampering with a
146.15 witness); burglary in the first or second degree under 609.582 (burglary); 609.66 (dangerous
146.16 weapon); 609.665 (spring guns); 609.67 (machine guns and short-barreled shotguns);
146.17 609.749, subdivision 2 (gross misdemeanor stalking); 152.021 or 152.022 (controlled
146.18 substance crime in the first or second degree); 152.023, subdivision 1, clause (3) or (4) or
146.19 subdivision 2, clause (4) (controlled substance crime in the third degree); 152.024,
146.20 subdivision 1, clause (2), (3), or (4) (controlled substance crime in the fourth degree);
146.21 609.224, subdivision 2, paragraph (c) (fifth-degree assault by a caregiver against a vulnerable
146.22 adult); 609.23 (mistreatment of persons confined); 609.231 (mistreatment of residents or
146.23 patients); 609.2325 (criminal abuse of a vulnerable adult); 609.233 (criminal neglect of a
146.24 vulnerable adult); 609.2335 (financial exploitation of a vulnerable adult); 609.234 (failure
146.25 to report); 609.265 (abduction); 609.2664 to 609.2665 (manslaughter of an unborn child in
146.26 the first or second degree); 609.267 to 609.2672 (assault of an unborn child in the first,
146.27 second, or third degree); 609.268 (injury or death of an unborn child in the commission of
146.28 a crime); repeat offenses under 617.23 (indecent exposure); 617.293 (disseminating or
146.29 displaying harmful material to minors); a felony-level conviction involving alcohol or drug
146.30 use, a gross misdemeanor offense under 609.324, subdivision 1 (other prohibited acts); a
146.31 gross misdemeanor offense under 609.378 (neglect or endangerment of a child); a gross
146.32 misdemeanor offense under 609.377 (malicious punishment of a child); 609.72, subdivision
146.33 3 (disorderly conduct against a vulnerable adult); or 624.713 (certain persons not to possess
146.34 firearms); or Minnesota Statutes 2012, section 609.21.

146.35 (b) The commissioner may not set aside the disqualification of an individual if less than
146.36 ten years have passed since the individual's aiding and abetting, attempt, or conspiracy to

147.1 commit any of the offenses listed in paragraph (a) as each of these offenses is defined in
147.2 Minnesota Statutes.

147.3 (c) The commissioner may not set aside the disqualification of an individual if less than
147.4 ten years have passed since the discharge of the sentence imposed for an offense in any
147.5 other state or country, the elements of which are substantially similar to the elements of any
147.6 of the offenses listed in paragraph (a).

147.7 Subd. 4. **Seven-year bar to set aside disqualification.** The commissioner may not set
147.8 aside the disqualification of an individual in connection with a license to provide family
147.9 child care for children, ~~foster care for children in the provider's home,~~ or foster care or day
147.10 care services for adults in the provider's home if within seven years preceding the study:

147.11 (1) the individual committed an act that constitutes maltreatment of a child under section
147.12 626.556, subdivision 10e, and the maltreatment resulted in substantial bodily harm as defined
147.13 in section 609.02, subdivision 7a, or substantial mental or emotional harm as supported by
147.14 competent psychological or psychiatric evidence; or

147.15 (2) the individual was determined under section 626.557 to be the perpetrator of a
147.16 substantiated incident of maltreatment of a vulnerable adult that resulted in substantial
147.17 bodily harm as defined in section 609.02, subdivision 7a, or substantial mental or emotional
147.18 harm as supported by competent psychological or psychiatric evidence.

147.19 Subd. 5. **Five-year bar to set aside disqualification.** The commissioner must not set
147.20 aside the disqualification of an individual 18 years of age or older in connection with a
147.21 family child foster care license if the individual is disqualified under section 245C.15,
147.22 subdivision 6, paragraph (c). This paragraph does not apply to an individual younger than
147.23 18 years of age at the time the background study is submitted.

147.24 Subd. 6. **Five-year bar to set aside disqualification; children's residential**
147.25 **facilities.** The commissioner shall not set aside the disqualification of an individual in
147.26 connection with a license for a children's residential facility who was convicted of a felony
147.27 within the past five years for: (1) physical assault or battery; or (2) a drug-related offense.

147.28 **EFFECTIVE DATE.** This section is effective March 1, 2020, except subdivision 6 is
147.29 effective for background studies initiated on or after July 1, 2019.

147.30 Sec. 78. Minnesota Statutes 2018, section 245C.30, subdivision 1, is amended to read:

147.31 Subdivision 1. **License holder and license-exempt child care center certification**
147.32 **holder variance.** (a) Except for any disqualification under section 245C.15, subdivision 1,
147.33 when the commissioner has not set aside a background study subject's disqualification, and

148.1 there are conditions under which the disqualified individual may provide direct contact
148.2 services or have access to people receiving services that minimize the risk of harm to people
148.3 receiving services, the commissioner may grant a time-limited variance to a license holder
148.4 or license-exempt child care center certification holder.

148.5 (b) The variance shall state the reason for the disqualification, the services that may be
148.6 provided by the disqualified individual, and the conditions with which the license holder,
148.7 license-exempt child care center certification holder, or applicant must comply for the
148.8 variance to remain in effect.

148.9 (c) Except for programs licensed to provide family child care, foster care for children
148.10 in the provider's own home, or foster care or day care services for adults in the provider's
148.11 own home, the variance must be requested by the license holder or license-exempt child
148.12 care center certification holder.

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

148.14 Sec. 79. Minnesota Statutes 2018, section 245C.30, subdivision 2, is amended to read:

148.15 Subd. 2. **Disclosure of reason for disqualification.** (a) The commissioner may not grant
148.16 a variance for a disqualified individual unless the applicant, license-exempt child care center
148.17 certification holder, or license holder requests the variance and the disqualified individual
148.18 provides written consent for the commissioner to disclose to the applicant, license-exempt
148.19 child care center certification holder, or license holder the reason for the disqualification.

148.20 (b) This subdivision does not apply to programs licensed to provide family child care
148.21 for children, foster care for children in the provider's own home, or foster care or day care
148.22 services for adults in the provider's own home. When the commissioner grants a variance
148.23 for a disqualified individual in connection with a license to provide the services specified
148.24 in this paragraph, the disqualified individual's consent is not required to disclose the reason
148.25 for the disqualification to the license holder in the variance issued under subdivision 1,
148.26 provided that the commissioner may not disclose the reason for the disqualification if the
148.27 disqualification is based on a felony-level conviction for a drug-related offense within the
148.28 past five years.

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

148.30 Sec. 80. Minnesota Statutes 2018, section 245C.30, subdivision 3, is amended to read:

148.31 Subd. 3. **Consequences for failing to comply with conditions of variance.** When a
148.32 license holder or license-exempt child care center certification holder permits a disqualified

149.1 individual to provide any services for which the subject is disqualified without complying
149.2 with the conditions of the variance, the commissioner may terminate the variance effective
149.3 immediately and subject the license holder to a licensing action under sections 245A.06
149.4 and 245A.07 or a license-exempt child care center certification holder to an action under
149.5 sections 245H.06 and 245H.07.

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

149.7 Sec. 81. Minnesota Statutes 2018, section 245E.01, subdivision 8, is amended to read:

149.8 Subd. 8. **Financial misconduct or misconduct.** "Financial misconduct" or "misconduct"
149.9 means an entity's or individual's acts or omissions that result in fraud and abuse or error
149.10 against the Department of Human Services. Financial misconduct includes: (1) acting as a
149.11 recruiter offering conditional employment on behalf of a provider that has received funds
149.12 from the child care assistance program; and (2) committing an act or acts that meet the
149.13 definition of offenses listed in section 609.817.

149.14 Sec. 82. Minnesota Statutes 2018, section 245E.02, is amended by adding a subdivision
149.15 to read:

149.16 Subd. 1a. **Provider definitions.** For the purposes of this section, "provider" includes:

149.17 (1) individuals or entities meeting the definition of provider in section 245E.01,
149.18 subdivision 12; and

149.19 (2) owners and controlling individuals of entities identified in clause (1).

149.20 Sec. 83. Minnesota Statutes 2018, section 245E.02, is amended by adding a subdivision
149.21 to read:

149.22 Subd. 5. **Administrative disqualifications.** (a) The department shall pursue an
149.23 administrative disqualification in subdivision 4, paragraph (c), clause (1), if the provider
149.24 committed an intentional program violation. Intentional program violations include
149.25 intentionally making false or misleading statements; intentionally misrepresenting,
149.26 concealing, or withholding facts; and intentionally violating child care assistance program
149.27 regulations under this chapter and section 256.983. Intent may be proven by demonstrating
149.28 a pattern or conduct that violates regulations under this chapter and section 256.983.

149.29 (b) To initiate an administrative disqualification, the department must issue a notice to
149.30 the provider under section 245E.06, subdivision 2.

150.1 (c) The provider may appeal the department's administrative disqualification according
150.2 to section 256.045. The appeal must be made in writing and must be received by the
150.3 department no later than 30 days after the issuance of the notice to the provider. On appeal
150.4 the department bears the burden of proof to demonstrate by a preponderance of the evidence
150.5 that the provider committed an intentional program violation.

150.6 (d) The human services judge may combine a fair hearing and administrative
150.7 disqualification hearing into a single hearing if the factual issues arise out of the same or
150.8 related circumstances and the provider receives prior notice that the hearings will be
150.9 combined.

150.10 (e) A provider found to have committed an intentional program violation and is
150.11 administratively disqualified shall be disqualified, for a period of three years for the first
150.12 offense and permanently for any subsequent offense, from receiving any payments from
150.13 any child care program under chapter 119B. Unless a timely and proper appeal made under
150.14 this section is received by the department, the administrative determination of the department
150.15 is final and binding.

150.16 Sec. 84. Minnesota Statutes 2018, section 245H.01, is amended by adding a subdivision
150.17 to read:

150.18 Subd. 7. **Substitute.** "Substitute" means an adult who is temporarily filling a position
150.19 as a staff person for less than 240 hours total in a calendar year due to the absence of a
150.20 regularly employed staff person who provides direct contact services to a child.

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

150.22 Sec. 85. Minnesota Statutes 2018, section 245H.01, is amended by adding a subdivision
150.23 to read:

150.24 Subd. 8. **Staff person.** "Staff person" means an employee of a certified center who
150.25 provides direct contact services to children.

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

150.27 Sec. 86. Minnesota Statutes 2018, section 245H.01, is amended by adding a subdivision
150.28 to read:

150.29 Subd. 9. **Unsupervised volunteer.** "Unsupervised volunteer" means an individual who:
150.30 (1) assists in the care of a child in care; (2) is not under the continuous direct supervision
150.31 of a staff person; and (3) is not employed by the certified center.

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

151.2 Sec. 87. Minnesota Statutes 2018, section 245H.03, is amended by adding a subdivision
151.3 to read:

151.4 **Subd. 4. Reconsideration of certification denial.** (a) The applicant may request
151.5 reconsideration of the denial by notifying the commissioner by certified mail or personal
151.6 service. The request must be made in writing. If sent by certified mail, the request must be
151.7 postmarked and sent to the commissioner within ten calendar days after the applicant received
151.8 the order. If a request is made by personal service, it must be received by the commissioner
151.9 within ten calendar days after the applicant received the order. The applicant may submit
151.10 with the request for reconsideration a written argument or evidence in support of the request
151.11 for reconsideration.

151.12 (b) The commissioner's disposition of a request for reconsideration is final and not
151.13 subject to appeal under chapter 14.

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

151.15 Sec. 88. Minnesota Statutes 2018, section 245H.07, is amended to read:

151.16 **245H.07 DECERTIFICATION.**

151.17 **Subdivision 1. Generally.** (a) The commissioner may decertify a center if a certification
151.18 holder:

151.19 (1) failed to comply with an applicable law or rule; ~~or~~

151.20 (2) knowingly withheld relevant information from or gave false or misleading information
151.21 to the commissioner in connection with an application for certification, in connection with
151.22 the background study status of an individual, during an investigation, or regarding compliance
151.23 with applicable laws or rules; or

151.24 (3) has authorization to receive child care assistance payments revoked pursuant to
151.25 chapter 119B.

151.26 (b) When considering decertification, the commissioner shall consider the nature,
151.27 chronicity, or severity of the violation of law or rule.

151.28 (c) When a center is decertified, the center is ineligible to receive a child care assistance
151.29 payment under chapter 119B.

151.30 **Subd. 2. Reconsideration of decertification.** (a) The certification holder may request
151.31 reconsideration of the decertification by notifying the commissioner by certified mail or

152.1 personal service. The request must be made in writing. If sent by certified mail, the request
 152.2 must be postmarked and sent to the commissioner within ten calendar days after the
 152.3 certification holder received the order. If a request is made by personal service, it must be
 152.4 received by the commissioner within ten calendar days after the certification holder received
 152.5 the order. With the request for reconsideration, the certification holder may submit a written
 152.6 argument or evidence in support of the request for reconsideration.

152.7 (b) The commissioner's disposition of a request for reconsideration is final and not
 152.8 subject to appeal under chapter 14.

152.9 Subd. 3. **Decertification due to maltreatment.** If the commissioner decertifies a center
 152.10 pursuant to subdivision 1, paragraph (a), clause (1), based on a determination that the center
 152.11 was responsible for maltreatment, and if the center requests reconsideration of the
 152.12 decertification according to subdivision 2, paragraph (a), and appeals the maltreatment
 152.13 determination under section 626.556, subdivision 10i, the final decertification determination
 152.14 is stayed until the commissioner issues a final decision regarding the maltreatment appeal.

152.15 Subd. 4. **Decertification due to revocation of child care assistance.** If the commissioner
 152.16 decertifies a center that had payments revoked pursuant to chapter 119B, and if the center
 152.17 appeals the revocation of the center's authorization to receive child care assistance payments,
 152.18 the final decertification determination is stayed until the appeal of the center's authorization
 152.19 under chapter 119B is resolved. If the center also requests reconsideration of the
 152.20 decertification, the center must do so according to subdivision 2, paragraph (a). The final
 152.21 decision on reconsideration is stayed until the appeal of the center's authorization under
 152.22 chapter 119B is resolved.

152.23 **EFFECTIVE DATE.** Subdivisions 1 to 3 are effective September 30, 2019. Subdivision
 152.24 4 is effective February 26, 2021.

152.25 Sec. 89. Minnesota Statutes 2018, section 245H.10, subdivision 1, is amended to read:

152.26 Subdivision 1. ~~Documentation~~ **Individuals to be studied.** (a) The applicant or
 152.27 certification holder must submit ~~and maintain documentation of a completed background~~
 152.28 ~~study for:~~ each child care background study subject as defined in section 245C.02, subdivision
 152.29 6a.

152.30 ~~(1) each person applying for the certification;~~

152.31 ~~(2) each person identified as a center operator or program operator as defined in section~~
 152.32 ~~245H.01, subdivision 3;~~

153.1 ~~(3) each current or prospective staff person or contractor of the certified center who will~~
 153.2 ~~have direct contact with a child served by the center;~~

153.3 ~~(4) each volunteer who has direct contact with a child served by the center if the contact~~
 153.4 ~~is not under the continuous, direct supervision by an individual listed in clause (1), (2), or~~
 153.5 ~~(3); and~~

153.6 ~~(5) each managerial staff person of the certification holder with oversight and supervision~~
 153.7 ~~of the certified center.~~

153.8 (b) To be accepted for certification, a background study on every individual in paragraph
 153.9 ~~(a), clause (1),~~ applying for certification must be completed under chapter 245C and result
 153.10 in a not disqualified determination under section 245C.14 or a disqualification that was set
 153.11 aside under section 245C.22.

153.12 Sec. 90. Minnesota Statutes 2018, section 245H.11, is amended to read:

153.13 **245H.11 REPORTING.**

153.14 (a) The certification holder must comply and must have written policies for staff to
 153.15 comply with the reporting requirements for abuse and neglect specified in section 626.556.
 153.16 A person mandated to report physical or sexual child abuse or neglect occurring within a
 153.17 certified center shall report the information to the commissioner.

153.18 (b) The certification holder must inform the commissioner within 24 hours of:

153.19 (1) the death of a child in the program; and

153.20 (2) any injury to a child in the program that required treatment by a physician.

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

153.22 Sec. 91. Minnesota Statutes 2018, section 245H.12, is amended to read:

153.23 **245H.12 FEES.**

153.24 ~~The commissioner shall consult with stakeholders to develop an administrative fee to~~
 153.25 ~~implement this chapter. By February 15, 2019, the commissioner shall provide~~
 153.26 ~~recommendations on the amount of an administrative fee to the legislative committees with~~
 153.27 ~~jurisdiction over health and human services policy and finance. A certified center must pay~~
 153.28 an initial application fee of \$200. For calendar year 2020 and thereafter, a certified center
 153.29 shall pay an annual nonrefundable certification fee of \$100.

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

154.1 Sec. 92. Minnesota Statutes 2018, section 245H.13, subdivision 5, is amended to read:

154.2 Subd. 5. **Building and physical premises; free of hazards.** (a) ~~The certified center~~
154.3 ~~must document compliance with the State Fire Code by providing~~ To be accepted for
154.4 certification, the applicant must demonstrate compliance with the State Fire Code, section
154.5 299F.011, by either:

154.6 (1) providing documentation of a fire marshal inspection completed within the previous
154.7 three years by a state fire marshal or a local fire code inspector trained by the state fire
154.8 marshal; or

154.9 (2) complying with the fire marshal inspection requirements according to section
154.10 245A.151.

154.11 (b) The certified center must designate a primary indoor and outdoor space used for
154.12 child care on a facility site floor plan.

154.13 (c) The certified center must ensure the areas used by a child are clean and in good repair,
154.14 with structurally sound and functional furniture and equipment that is appropriate to the
154.15 age and size of a child who uses the area.

154.16 (d) The certified center must ensure hazardous items including but not limited to sharp
154.17 objects, medicines, cleaning supplies, poisonous plants, and chemicals are out of reach of
154.18 a child.

154.19 (e) The certified center must safely handle and dispose of bodily fluids and other
154.20 potentially infectious fluids by using gloves, disinfecting surfaces that come in contact with
154.21 potentially infectious bodily fluids, and disposing of bodily fluid in a securely sealed plastic
154.22 bag.

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

154.24 Sec. 93. Minnesota Statutes 2018, section 245H.13, is amended by adding a subdivision
154.25 to read:

154.26 Subd. 7. **Risk reduction plan.** (a) The certified center must develop a risk reduction
154.27 plan that identifies risks to children served by the child care center. The assessment of risk
154.28 must include risks presented by (1) the physical plant where the certified services are
154.29 provided, including electrical hazards; and (2) the environment, including the proximity to
154.30 busy roads and bodies of water.

155.1 (b) The certification holder must establish policies and procedures to minimize identified
155.2 risks. After any change to the risk reduction plan, the certification holder must inform staff
155.3 of the change in the risk reduction plan and document that staff were informed of the change.

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

155.5 Sec. 94. Minnesota Statutes 2018, section 245H.13, is amended by adding a subdivision
155.6 to read:

155.7 Subd. 8. **Required policies.** A certified center must have written policies for health and
155.8 safety items in subdivisions 1 to 6.

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

155.10 Sec. 95. Minnesota Statutes 2018, section 245H.13, is amended by adding a subdivision
155.11 to read:

155.12 Subd. 9. **Behavior guidance.** The certified center must ensure that staff and volunteers
155.13 use positive behavior guidance and do not subject children to:

155.14 (1) corporal punishment, including but not limited to rough handling, shoving, hair
155.15 pulling, ear pulling, shaking, slapping, kicking, biting, pinching, hitting, and spanking;

155.16 (2) humiliation;

155.17 (3) abusive language;

155.18 (4) the use of mechanical restraints, including tying;

155.19 (5) the use of physical restraints other than to physically hold a child when containment
155.20 is necessary to protect a child or others from harm; or

155.21 (6) the withholding or forcing of food and other basic needs.

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

155.23 Sec. 96. Minnesota Statutes 2018, section 245H.13, is amended by adding a subdivision
155.24 to read:

155.25 Subd. 10. **Supervision.** Staff must supervise each child at all times. Staff are responsible
155.26 for the ongoing activity of each child, appropriate visual or auditory awareness, physical
155.27 proximity, and knowledge of activity requirements and each child's needs. Staff must
155.28 intervene when necessary to ensure a child's safety. In determining the appropriate level of
155.29 supervision of a child, staff must consider: (1) the age of a child; (2) individual differences

156.1 and abilities; (3) indoor and outdoor layout of the child care program; and (4) environmental
 156.2 circumstances, hazards, and risks.

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

156.4 Sec. 97. Minnesota Statutes 2018, section 245H.14, subdivision 1, is amended to read:

156.5 Subdivision 1. **First aid and cardiopulmonary resuscitation.** ~~At least one designated~~
 156.6 ~~staff person who completed pediatric first aid training and pediatric cardiopulmonary~~
 156.7 ~~resuscitation (CPR) training must be present at all times at the program, during field trips,~~
 156.8 ~~and when transporting a child. The designated staff person must repeat pediatric first aid~~
 156.9 ~~training and pediatric CPR training at least once every two years.~~

156.10 (a) Before having unsupervised direct contact with a child, but within the first 90 days
 156.11 of employment for the director and all staff persons, and within 90 days after the first date
 156.12 of direct contact with a child for substitutes and unsupervised volunteers, each person must
 156.13 successfully complete pediatric first aid and pediatric cardiopulmonary resuscitation (CPR)
 156.14 training, unless the training has been completed within the previous two calendar years.
 156.15 Staff must complete the pediatric first aid and pediatric CPR training at least every other
 156.16 calendar year and the center must document the training in the staff person's personnel
 156.17 record.

156.18 (b) Training completed under this subdivision may be used to meet the in-service training
 156.19 requirements under subdivision 6.

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

156.21 Sec. 98. Minnesota Statutes 2018, section 245H.14, subdivision 3, is amended to read:

156.22 Subd. 3. **Abusive head trauma.** A certified center that cares for a child ~~through four~~
 156.23 ~~years of age~~ under school age must ensure that the director and all staff persons and
 156.24 ~~volunteers, including substitutes and unsupervised volunteers,~~ receive training on abusive
 156.25 head trauma ~~from shaking infants and young children~~ before assisting in the care of a child
 156.26 ~~through four years of age~~ under school age.

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

156.28 Sec. 99. Minnesota Statutes 2018, section 245H.14, subdivision 4, is amended to read:

156.29 Subd. 4. **Child development.** The certified center must ensure ~~each staff person completes~~
 156.30 ~~at least two hours of~~ that the director and all staff persons complete child development and
 156.31 learning training within ~~14~~ 90 days of employment and ~~annually~~ every second calendar year

157.1 thereafter. Substitutes and unsupervised volunteers must complete child development and
 157.2 learning training within 90 days after the first date of direct contact with a child and every
 157.3 second calendar year thereafter. The director and staff persons not including substitutes
 157.4 must complete at least two hours of training on child development. The training for substitutes
 157.5 and unsupervised volunteers is not required to be of a minimum length. For purposes of
 157.6 this subdivision, "child development and learning training" means how a child develops
 157.7 physically, cognitively, emotionally, and socially and learns as part of the child's family,
 157.8 culture, and community.

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

157.10 Sec. 100. Minnesota Statutes 2018, section 245H.14, subdivision 5, is amended to read:

157.11 Subd. 5. **Orientation.** The certified center must ensure ~~each staff person is~~ the director
 157.12 and all staff persons, substitutes, and unsupervised volunteers are trained at orientation on
 157.13 health and safety requirements in sections 245H.11, 245H.13, 245H.14, and 245H.15. The
 157.14 certified center must provide staff with an orientation within 14 days of employment after
 157.15 the first date of direct contact with a child. Before the completion of orientation, ~~a staff~~
 157.16 ~~person~~ these individuals must be supervised while providing direct care to a child.

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

157.18 Sec. 101. Minnesota Statutes 2018, section 245H.14, subdivision 6, is amended to read:

157.19 Subd. 6. **In service.** (a) The certified center must ensure ~~each~~ that the director and all
 157.20 staff person is persons, including substitutes and unsupervised volunteers, are trained at
 157.21 least annually once each calendar year on health and safety requirements in sections 245H.11,
 157.22 245H.13, 245H.14, and 245H.15.

157.23 (b) The director and each staff person, not including substitutes, must ~~annually~~ complete
 157.24 at least six hours of training each calendar year. Training required under paragraph (a) may
 157.25 be used toward the hourly training requirements of this subdivision.

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

157.27 Sec. 102. Minnesota Statutes 2018, section 245H.15, subdivision 1, is amended to read:

157.28 Subdivision 1. **Written emergency plan.** (a) A certified center must have a written
 157.29 emergency plan for emergencies that require evacuation, sheltering, or other protection of
 157.30 children, such as fire, natural disaster, intruder, or other threatening situation that may pose
 157.31 a health or safety hazard to children. The plan must be written on a form developed by the

158.1 commissioner and reviewed and updated at least once each calendar year. The annual review
 158.2 of the emergency plan must be documented.

158.3 (b) The plan must include:

158.4 (1) procedures for an evacuation, relocation, shelter-in-place, or lockdown;

158.5 (2) a designated relocation site and evacuation route;

158.6 (3) procedures for notifying a child's parent or legal guardian of the relocation and
 158.7 reunification with families;

158.8 (4) accommodations for a child with a disability or a chronic medical condition;

158.9 (5) procedures for storing a child's medically necessary medicine that facilitates easy
 158.10 removal during an evacuation or relocation;

158.11 (6) procedures for continuing operations in the period during and after a crisis; ~~and~~

158.12 (7) procedures for communicating with local emergency management officials, law
 158.13 enforcement officials, or other appropriate state or local authorities; and

158.14 (8) accommodations for infants and toddlers.

158.15 (c) The certification holder must have an emergency plan available for review upon
 158.16 request by the child's parent or legal guardian.

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

158.18 Sec. 103. Minnesota Statutes 2018, section 256.046, subdivision 1, is amended to read:

158.19 Subdivision 1. **Hearing authority.** A local agency must initiate an administrative fraud
 158.20 disqualification hearing for individuals, ~~including child care providers caring for children~~
 158.21 ~~receiving child care assistance~~, accused of wrongfully obtaining assistance or intentional
 158.22 program violations, in lieu of a criminal action when it has not been pursued, in the Minnesota
 158.23 family investment program and any affiliated program to include the diversionary work
 158.24 program and the work participation cash benefit program, child care assistance programs,
 158.25 general assistance, family general assistance program formerly codified in section 256D.05,
 158.26 subdivision 1, clause (15), Minnesota supplemental aid, food stamp programs, MinnesotaCare
 158.27 for adults without children, and upon federal approval, all categories of medical assistance
 158.28 and remaining categories of MinnesotaCare except for children through age 18. The
 158.29 Department of Human Services, in lieu of a local agency, may initiate an administrative
 158.30 fraud disqualification hearing when the state agency is directly responsible for administration
 158.31 or investigation of the program for which benefits were wrongfully obtained. The hearing

159.1 is subject to the requirements of ~~section~~ sections 256.045 and 256.0451 and the requirements
159.2 in Code of Federal Regulations, title 7, section 273.16.

159.3 Sec. 104. Minnesota Statutes 2018, section 256B.02, subdivision 7, is amended to read:

159.4 Subd. 7. **Vendor of medical care.** (a) "Vendor of medical care" means any person or
159.5 persons furnishing, within the scope of the vendor's respective license, any or all of the
159.6 following goods or services: medical, surgical, hospital, ambulatory surgical center services,
159.7 optical, visual, dental and nursing services; drugs and medical supplies; appliances;
159.8 laboratory, diagnostic, and therapeutic services; nursing home and convalescent care;
159.9 screening and health assessment services provided by public health nurses as defined in
159.10 section 145A.02, subdivision 18; health care services provided at the residence of the patient
159.11 if the services are performed by a public health nurse and the nurse indicates in a statement
159.12 submitted under oath that the services were actually provided; and such other ~~medical~~
159.13 services or supplies provided or prescribed by persons authorized by state law to give such
159.14 services and supplies. The term includes, but is not limited to, directors and officers of
159.15 corporations or members of partnerships who, either individually or jointly with another or
159.16 others, have the legal control, supervision, or responsibility of submitting claims for
159.17 reimbursement to the medical assistance program. The term only includes directors and
159.18 officers of corporations who personally receive a portion of the distributed assets upon
159.19 liquidation or dissolution, and their liability is limited to the portion of the claim that bears
159.20 the same proportion to the total claim as their share of the distributed assets bears to the
159.21 total distributed assets.

159.22 (b) "Vendor of medical care" also includes any person who is credentialed as a health
159.23 professional under standards set by the governing body of a federally recognized Indian
159.24 tribe authorized under an agreement with the federal government according to United States
159.25 Code, title 25, section 450f, to provide health services to its members, and who through a
159.26 tribal facility provides covered services to American Indian people within a contract health
159.27 service delivery area of a Minnesota reservation, as defined under Code of Federal
159.28 Regulations, title 42, section 36.22.

159.29 (c) A federally recognized Indian tribe that intends to implement standards for
159.30 credentialing health professionals must submit the standards to the commissioner of human
159.31 services, along with evidence of meeting, exceeding, or being exempt from corresponding
159.32 state standards. The commissioner shall maintain a copy of the standards and supporting
159.33 evidence, and shall use those standards to enroll tribal-approved health professionals as

160.1 medical assistance providers. For purposes of this section, "Indian" and "Indian tribe" mean
160.2 persons or entities that meet the definition in United States Code, title 25, section 450b.

160.3 Sec. 105. Minnesota Statutes 2018, section 256B.064, subdivision 1a, is amended to read:

160.4 Subd. 1a. **Grounds for sanctions against vendors.** The commissioner may impose
160.5 sanctions against a vendor of medical care for any of the following: (1) fraud, theft, or abuse
160.6 in connection with the provision of medical care to recipients of public assistance; (2) a
160.7 pattern of presentment of false or duplicate claims or claims for services not medically
160.8 necessary; (3) a pattern of making false statements of material facts for the purpose of
160.9 obtaining greater compensation than that to which the vendor is legally entitled; (4)
160.10 suspension or termination as a Medicare vendor; (5) refusal to grant the state agency access
160.11 during regular business hours to examine all records necessary to disclose the extent of
160.12 services provided to program recipients and appropriateness of claims for payment; (6)
160.13 failure to repay an overpayment or a fine finally established under this section; (7) failure
160.14 to correct errors in the maintenance of health service or financial records for which a fine
160.15 was imposed or after issuance of a warning by the commissioner; ~~and~~ (8) any reason for
160.16 which a vendor could be excluded from participation in the Medicare program under section
160.17 1128, 1128A, or 1866(b)(2) of the Social Security Act; and (9) there is a preponderance of
160.18 the evidence that the vendor committed an act or acts that meet the definition of offenses
160.19 listed in section 609.817.

160.20 Sec. 106. Minnesota Statutes 2018, section 256B.064, subdivision 1b, is amended to read:

160.21 Subd. 1b. **Sanctions available.** The commissioner may impose the following sanctions
160.22 for the conduct described in subdivision 1a: suspension or withholding of payments to a
160.23 vendor and suspending or terminating participation in the program, or imposition of a fine
160.24 under subdivision 2, paragraph (f). When imposing sanctions under this section, the
160.25 commissioner shall consider the nature, chronicity, or severity of the conduct and the effect
160.26 of the conduct on the health and safety of persons served by the vendor. The commissioner
160.27 shall suspend a vendor's participation in the program for a minimum of five years if, for an
160.28 offense related to a provision of a health service under medical assistance or health care
160.29 fraud, the vendor is convicted of a crime, received a stay of adjudication, or entered a
160.30 court-ordered diversion program. Regardless of imposition of sanctions, the commissioner
160.31 may make a referral to the appropriate state licensing board.

161.1 Sec. 107. Minnesota Statutes 2018, section 256B.064, subdivision 2, is amended to read:

161.2 Subd. 2. **Imposition of monetary recovery and sanctions.** (a) The commissioner shall
161.3 determine any monetary amounts to be recovered and sanctions to be imposed upon a vendor
161.4 of medical care under this section. Except as provided in paragraphs (b) and (d), neither a
161.5 monetary recovery nor a sanction will be imposed by the commissioner without prior notice
161.6 and an opportunity for a hearing, according to chapter 14, on the commissioner's proposed
161.7 action, provided that the commissioner may suspend or reduce payment to a vendor of
161.8 medical care, except a nursing home or convalescent care facility, after notice and prior to
161.9 the hearing if in the commissioner's opinion that action is necessary to protect the public
161.10 welfare and the interests of the program.

161.11 (b) Except when the commissioner finds good cause not to suspend payments under
161.12 Code of Federal Regulations, title 42, section 455.23 (e) or (f), the commissioner shall
161.13 withhold or reduce payments to a vendor of medical care without providing advance notice
161.14 of such withholding or reduction if either of the following occurs:

161.15 (1) the vendor is convicted of a crime involving the conduct described in subdivision
161.16 1a; or

161.17 (2) the commissioner determines there is a credible allegation of fraud for which an
161.18 investigation is pending under the program. A credible allegation of fraud is an allegation
161.19 which has been verified by the state, from any source, including but not limited to:

161.20 (i) fraud hotline complaints;

161.21 (ii) claims data mining; and

161.22 (iii) patterns identified through provider audits, civil false claims cases, and law
161.23 enforcement investigations.

161.24 Allegations are considered to be credible when they have an indicia of reliability and
161.25 the state agency has reviewed all allegations, facts, and evidence carefully and acts
161.26 judiciously on a case-by-case basis.

161.27 (c) The commissioner must send notice of the withholding or reduction of payments
161.28 under paragraph (b) within five days of taking such action unless requested in writing by a
161.29 law enforcement agency to temporarily withhold the notice. The notice must:

161.30 (1) state that payments are being withheld according to paragraph (b);

161.31 (2) set forth the general allegations as to the nature of the withholding action, but need
161.32 not disclose any specific information concerning an ongoing investigation;

162.1 (3) except in the case of a conviction for conduct described in subdivision 1a, state that
162.2 the withholding is for a temporary period and cite the circumstances under which withholding
162.3 will be terminated;

162.4 (4) identify the types of claims to which the withholding applies; and

162.5 (5) inform the vendor of the right to submit written evidence for consideration by the
162.6 commissioner.

162.7 The withholding or reduction of payments will not continue after the commissioner
162.8 determines there is insufficient evidence of fraud by the vendor, or after legal proceedings
162.9 relating to the alleged fraud are completed, unless the commissioner has sent notice of
162.10 intention to impose monetary recovery or sanctions under paragraph (a). Upon conviction
162.11 for a crime related to the provision, management, or administration of a health service under
162.12 medical assistance, a payment held pursuant to this section by the commissioner or a managed
162.13 care organization that contracts with the commissioner under section 256B.035 is forfeited
162.14 by the commissioner or managed care organization, regardless of the amount charged in
162.15 the criminal complaint or the amount of criminal restitution ordered.

162.16 (d) The commissioner shall suspend or terminate a vendor's participation in the program
162.17 without providing advance notice and an opportunity for a hearing when the suspension or
162.18 termination is required because of the vendor's exclusion from participation in Medicare.
162.19 Within five days of taking such action, the commissioner must send notice of the suspension
162.20 or termination. The notice must:

162.21 (1) state that suspension or termination is the result of the vendor's exclusion from
162.22 Medicare;

162.23 (2) identify the effective date of the suspension or termination; and

162.24 (3) inform the vendor of the need to be reinstated to Medicare before reapplying for
162.25 participation in the program.

162.26 (e) Upon receipt of a notice under paragraph (a) that a monetary recovery or sanction is
162.27 to be imposed, a vendor may request a contested case, as defined in section 14.02, subdivision
162.28 3, by filing with the commissioner a written request of appeal. The appeal request must be
162.29 received by the commissioner no later than 30 days after the date the notification of monetary
162.30 recovery or sanction was mailed to the vendor. The appeal request must specify:

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

162.33 (2) the computation that the vendor believes is correct;

163.1 (3) the authority in statute or rule upon which the vendor relies for each disputed item;
 163.2 (4) the name and address of the person or entity with whom contacts may be made
 163.3 regarding the appeal; and

163.4 (5) other information required by the commissioner.

163.5 (f) The commissioner may order a vendor to forfeit a fine for failure to fully document
 163.6 services according to standards in this chapter and Minnesota Rules, chapter 9505. The
 163.7 commissioner may assess fines if specific required components of documentation are
 163.8 missing. The fine for incomplete documentation shall equal 20 percent of the amount paid
 163.9 on the claims for reimbursement submitted by the vendor, or up to \$5,000, whichever is
 163.10 less. If the commissioner determines that a vendor repeatedly violated this chapter or
 163.11 Minnesota Rules, chapter 9505, related to the provision of services to program recipients
 163.12 and the submission of claims for payment, the commissioner may order a vendor to forfeit
 163.13 a fine based on the nature, severity, and chronicity of the violations in an amount of up to
 163.14 \$5,000 or 20 percent of the value of the claims, whichever is greater.

163.15 (g) The vendor shall pay the fine assessed on or before the payment date specified. If
 163.16 the vendor fails to pay the fine, the commissioner may withhold or reduce payments and
 163.17 recover the amount of the fine. A timely appeal shall stay payment of the fine until the
 163.18 commissioner issues a final order.

163.19 Sec. 108. Minnesota Statutes 2018, section 256B.064, is amended by adding a subdivision
 163.20 to read:

163.21 Subd. 3. **Vendor mandates on prohibited hiring.** (a) The commissioner shall maintain
 163.22 and publish a list of each excluded individual and entity that was convicted of a crime related
 163.23 to the provision, management, or administration of a medical assistance health service, or
 163.24 suspended or terminated under subdivision 2. A vendor that receives funding from medical
 163.25 assistance shall not: (1) employ an individual or entity who is on the exclusion list; or (2)
 163.26 enter into or maintain a business relationship with an individual or entity that is on the
 163.27 exclusion list.

163.28 (b) Before hiring or entering into a business transaction, a vendor must check the
 163.29 exclusion list. The vendor must check the exclusion list on a monthly basis and document
 163.30 the date and time with a.m. and p.m. designations that the exclusion list was checked and
 163.31 the name and title of the person who checked the exclusion list. The vendor must: (1)
 163.32 immediately terminate a current employee on the exclusion list; and (2) immediately
 163.33 terminate a business relationship with an individual or entity on the exclusion list.

164.1 (c) A vendor's requirement to check the exclusion list and to terminate an employee on
164.2 the exclusion list applies to each employee, even if the named employee is not responsible
164.3 for direct patient care or direct submission of a claim to medical assistance. A vendor's
164.4 requirement to check the exclusion list and terminate a business relationship with an
164.5 individual or entity on the exclusion list applies to each business relationship, even if the
164.6 named individual or entity is not responsible for direct patient care or direct submission of
164.7 a claim to medical assistance.

164.8 (d) A vendor that employs or enters into or maintains a business relationship with an
164.9 individual or entity on the exclusion list must refund any payment related to a service
164.10 rendered by an individual or entity on the exclusion list from the date the individual is
164.11 employed or the date the individual is placed on the exclusion list, whichever is later, and
164.12 a vendor may be subject to:

164.13 (1) sanctions under subdivision 2;

164.14 (2) a civil monetary penalty of up to \$25,000 for each determination by the department
164.15 that the vendor employed or contracted with an individual or entity on the exclusion list;
164.16 and

164.17 (3) other fines or penalties allowed by law.

164.18 Sec. 109. Minnesota Statutes 2018, section 256B.064, is amended by adding a subdivision
164.19 to read:

164.20 Subd. 4. **Notice.** (a) The notice required under subdivision 2 shall be served by first class
164.21 mail at the address submitted to the department by the vendor. Service is complete upon
164.22 mailing. The commissioner shall place an affidavit of the first class mailing in the vendor's
164.23 file as an indication of the address and the date of mailing.

164.24 (b) The department shall give notice in writing to a recipient placed in the Minnesota
164.25 restricted recipient program under section 256B.0646 and Minnesota Rules, part 9505.2200.
164.26 The notice shall be sent by first class mail to the recipient's current address on file with the
164.27 department. A recipient placed in the Minnesota restricted recipient program may contest
164.28 the placement by submitting a written request for a hearing to the department within 90
164.29 days of the notice being mailed.

165.1 Sec. 110. Minnesota Statutes 2018, section 256B.064, is amended by adding a subdivision
165.2 to read:

165.3 Subd. 5. **Immunity; good faith reporters.** (a) A person who makes a good faith report
165.4 is immune from any civil or criminal liability that might otherwise arise from reporting or
165.5 participating in the investigation. Nothing in this subdivision affects a vendor's responsibility
165.6 for an overpayment established under this subdivision.

165.7 (b) A person employed by a lead investigative agency who is conducting or supervising
165.8 an investigation or enforcing the law according to the applicable law or rule is immune from
165.9 any civil or criminal liability that might otherwise arise from the person's actions, if the
165.10 person is acting in good faith and exercising due care.

165.11 (c) For purposes of this subdivision, "person" includes a natural person or any form of
165.12 a business or legal entity.

165.13 (d) After an investigation is complete, the reporter's name must be kept confidential.
165.14 The subject of the report may compel disclosure of the reporter's name only with the consent
165.15 of the reporter or upon a written finding by a district court that the report was false and there
165.16 is evidence that the report was made in bad faith. This subdivision does not alter disclosure
165.17 responsibilities or obligations under the Rules of Criminal Procedure, except that when the
165.18 identity of the reporter is relevant to a criminal prosecution the district court shall conduct
165.19 an in-camera review before determining whether to order disclosure of the reporter's identity.

165.20 Sec. 111. **[256B.0646] MINNESOTA RESTRICTED RECIPIENT PROGRAM;**
165.21 **PERSONAL CARE ASSISTANCE SERVICES.**

165.22 (a) When a recipient's use of personal care assistance services or community first services
165.23 and supports under section 256B.85 results in abusive or fraudulent billing, the commissioner
165.24 may place a recipient in the Minnesota restricted recipient program under Minnesota Rules,
165.25 part 9505.2165. A recipient placed in the Minnesota restricted recipient program under this
165.26 section must: (1) use a designated traditional personal care assistance provider agency; and
165.27 (2) obtain a new assessment under section 256B.0911, including consultation with a registered
165.28 or public health nurse on the long-term care consultation team pursuant to section 256B.0911,
165.29 subdivision 3, paragraph (b), clause (2).

165.30 (b) A recipient must comply with additional conditions for the use of personal care
165.31 assistance services or community first services and supports if the commissioner determines
165.32 it is necessary to prevent future misuse of personal care assistance services or abusive or
165.33 fraudulent billing. Additional conditions may include but are not limited to restricting service

166.1 authorizations for a duration of no more than one month and requiring a qualified professional
166.2 to monitor and report services on a monthly basis.

166.3 (c) A recipient placed in the Minnesota restricted recipient program under this section
166.4 may appeal the placement according to section 256.045.

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

166.6 Sec. 112. Minnesota Statutes 2018, section 256B.0651, subdivision 17, is amended to
166.7 read:

166.8 Subd. 17. **Recipient protection.** (a) Providers of home care services must provide each
166.9 recipient with a copy of the home care bill of rights under section 144A.44 at least 30 days
166.10 prior to terminating services to a recipient, if the termination results from provider sanctions
166.11 under section 256B.064, such as a payment withhold, a suspension of participation, or a
166.12 termination of participation. If a home care provider determines it is unable to continue
166.13 providing services to a recipient, the provider must notify the recipient, the recipient's
166.14 responsible party, and the commissioner 30 days prior to terminating services to the recipient
166.15 because of an action under section 256B.064, and must assist the commissioner and lead
166.16 agency in supporting the recipient in transitioning to another home care provider of the
166.17 recipient's choice.

166.18 (b) In the event of a payment withhold from a home care provider, a suspension of
166.19 participation, or a termination of participation of a home care provider under section
166.20 256B.064, the commissioner may inform the Office of Ombudsman for Long-Term Care
166.21 and the lead agencies for all recipients with active service agreements with the provider. At
166.22 the commissioner's request, the lead agencies must contact recipients to ensure that the
166.23 recipients are continuing to receive needed care, and that the recipients have been given
166.24 free choice of provider if they transfer to another home care provider. In addition, the
166.25 commissioner or the commissioner's delegate may directly notify recipients who receive
166.26 care from the provider that payments have been or may be withheld or that the provider's
166.27 participation in medical assistance has been or may be suspended or terminated, if the
166.28 commissioner determines that notification is necessary to protect the welfare of the recipients.
166.29 For purposes of this subdivision, "lead agencies" means counties, tribes, and managed care
166.30 organizations.

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

167.1 Sec. 113. Minnesota Statutes 2018, section 256B.0659, subdivision 12, is amended to
167.2 read:

167.3 Subd. 12. **Documentation of personal care assistance services provided.** (a) Personal
167.4 care assistance services for a recipient must be documented daily by each personal care
167.5 assistant, on a time sheet form approved by the commissioner. All documentation may be
167.6 web-based, electronic, or paper documentation. The completed form must be submitted on
167.7 a monthly basis to the provider and kept in the recipient's health record.

167.8 (b) The activity documentation must correspond to the personal care assistance care plan
167.9 and be reviewed by the qualified professional.

167.10 (c) The personal care assistant time sheet must be on a form approved by the
167.11 commissioner documenting time the personal care assistant provides services in the home.
167.12 The following criteria must be included in the time sheet:

167.13 (1) full name of personal care assistant and individual provider number;

167.14 (2) provider name and telephone numbers;

167.15 (3) full name of recipient and either the recipient's medical assistance identification
167.16 number or date of birth;

167.17 (4) consecutive dates, including month, day, and year, and arrival and departure times
167.18 with a.m. or p.m. notations;

167.19 (5) signatures of recipient or the responsible party;

167.20 (6) personal signature of the personal care assistant;

167.21 (7) any shared care provided, if applicable;

167.22 (8) a statement that it is a federal crime to provide false information on personal care
167.23 service billings for medical assistance payments; and

167.24 (9) dates and location of recipient stays in a hospital, care facility, or incarceration.

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

167.26 Sec. 114. Minnesota Statutes 2018, section 256B.27, subdivision 3, is amended to read:

167.27 Subd. 3. **Access to medical records.** The commissioner of human services, with the
167.28 written consent of the recipient, on file with the local welfare agency, shall be allowed
167.29 access to all personal medical records of medical assistance recipients solely for the purposes
167.30 of investigating whether or not: (a) a vendor of medical care has submitted a claim for
167.31 reimbursement, a cost report or a rate application which is duplicative, erroneous, or false

168.1 in whole or in part, or which results in the vendor obtaining greater compensation than the
168.2 vendor is legally entitled to; or (b) the medical care was medically necessary. ~~The vendor~~
168.3 ~~of medical care shall receive notification from the commissioner at least 24 hours before~~
168.4 ~~the commissioner gains access to such records.~~ When the commissioner is investigating a
168.5 possible overpayment of Medicaid funds, the commissioner must be given immediate access
168.6 without prior notice to the vendor's office during regular business hours and to documentation
168.7 and records related to services provided and submission of claims for services provided.
168.8 Denying the commissioner access to records is cause for the vendor's immediate suspension
168.9 of payment or termination according to section 256B.064. The determination of provision
168.10 of services not medically necessary shall be made by the commissioner. Notwithstanding
168.11 any other law to the contrary, a vendor of medical care shall not be subject to any civil or
168.12 criminal liability for providing access to medical records to the commissioner of human
168.13 services pursuant to this section.

168.14 Sec. 115. Minnesota Statutes 2018, section 256B.4912, is amended by adding a subdivision
168.15 to read:

168.16 Subd. 11. **Home and community-based service billing requirements.** (a) A home and
168.17 community-based service is eligible for reimbursement if:

168.18 (1) the service is provided according to a federally approved waiver plan as authorized
168.19 under sections 256B.0913, 256B.0915, 256B.092, and 256B.49;

168.20 (2) if applicable, the service is provided on days and times during the days and hours of
168.21 operation specified on any license required under chapter 245A or 245D; and

168.22 (3) the provider complies with subdivisions 12 to 15, if applicable.

168.23 (b) The provider must maintain documentation that, upon employment and annually
168.24 thereafter, staff providing a service have attested to reviewing and understanding the
168.25 following statement: "It is a federal crime to provide materially false information on service
168.26 billings for medical assistance or services provided under a federally approved waiver plan
168.27 as authorized under Minnesota Statutes, sections 256B.0913, 256B.0915, 256B.092, and
168.28 256B.49."

168.29 (c) The department may recover payment according to section 256B.064 and Minnesota
168.30 Rules, parts 9505.2160 to 9505.2245, for a service that does not satisfy this subdivision.

169.1 Sec. 116. Minnesota Statutes 2018, section 256B.4912, is amended by adding a subdivision
169.2 to read:

169.3 Subd. 12. **Home and community-based service documentation requirements.** (a)
169.4 Documentation may be collected and maintained electronically or in paper form by providers
169.5 and must be produced upon request by the commissioner.

169.6 (b) Documentation of a delivered service must be in English and must be legible according
169.7 to the standard of a reasonable person.

169.8 (c) If the service is reimbursed at an hourly or specified minute-based rate, each
169.9 documentation of the provision of a service, unless otherwise specified, must include:

169.10 (1) the date the documentation occurred;

169.11 (2) the day, month, and year when the service was provided;

169.12 (3) the start and stop times with a.m. and p.m. designations, except for case management
169.13 services as defined under sections 256B.0913, subdivision 7; 256B.0915, subdivision 1a;
169.14 256B.092, subdivision 1a; and 256B.49, subdivision 13;

169.15 (4) the service name or description of the service provided; and

169.16 (5) the name, signature, and title, if any, of the provider of service. If the service is
169.17 provided by multiple staff members, the provider may designate a staff member responsible
169.18 for verifying services and completing the documentation required by this paragraph.

169.19 (d) If the service is reimbursed at a daily rate or does not meet the requirements in
169.20 paragraph (c), each documentation of the provision of a service, unless otherwise specified,
169.21 must include:

169.22 (1) the date the documentation occurred;

169.23 (2) the day, month, and year when the service was provided;

169.24 (3) the service name or description of the service provided; and

169.25 (4) the name, signature, and title, if any, of the person providing the service. If the service
169.26 is provided by multiple staff, the provider may designate a staff member responsible for
169.27 verifying services and completing the documentation required by this paragraph.

169.28 Sec. 117. Minnesota Statutes 2018, section 256B.4912, is amended by adding a subdivision
169.29 to read:

169.30 Subd. 13. **Waiver transportation documentation and billing requirements.** (a) A
169.31 waiver transportation service must be a waiver transportation service that: (1) is not covered

170.1 by medical transportation under the Medicaid state plan; and (2) is not included as a
170.2 component of another waiver service.

170.3 (b) In addition to the documentation requirements in subdivision 12, a waiver
170.4 transportation service provider must maintain:

170.5 (1) odometer and other records pursuant to section 256B.0625, subdivision 17b, paragraph
170.6 (b), clause (3), sufficient to distinguish an individual trip with a specific vehicle and driver
170.7 for a waiver transportation service that is billed directly by the mile. A common carrier as
170.8 defined by Minnesota Rules, part 9505.0315, subpart 1, item B, or a publicly operated transit
170.9 system provider are exempt from this clause; and

170.10 (2) documentation demonstrating that a vehicle and a driver meet the standards determined
170.11 by the Department of Human Services on vehicle and driver qualifications in section
170.12 256B.0625, subdivision 17, paragraph (c).

170.13 Sec. 118. Minnesota Statutes 2018, section 256B.4912, is amended by adding a subdivision
170.14 to read:

170.15 Subd. 14. **Equipment and supply documentation requirements.** (a) In addition to the
170.16 requirements in subdivision 12, an equipment and supply services provider must for each
170.17 documentation of the provision of a service include:

170.18 (1) the recipient's assessed need for the equipment or supply;

170.19 (2) the reason the equipment or supply is not covered by the Medicaid state plan;

170.20 (3) the type and brand name of the equipment or supply delivered to or purchased by
170.21 the recipient, including whether the equipment or supply was rented or purchased;

170.22 (4) the quantity of the equipment or supply delivered or purchased; and

170.23 (5) the cost of the equipment or supply if the amount paid for the service depends on
170.24 the cost.

170.25 (b) A provider must maintain a copy of the shipping invoice or a delivery service tracking
170.26 log or other documentation showing the date of delivery that proves the equipment or supply
170.27 was delivered to the recipient or a receipt if the equipment or supply was purchased by the
170.28 recipient.

171.1 Sec. 119. Minnesota Statutes 2018, section 256B.4912, is amended by adding a subdivision
171.2 to read:

171.3 Subd. 15. **Adult day service documentation and billing requirements.** (a) In addition
171.4 to the requirements in subdivision 12, a provider of adult day services as defined in section
171.5 245A.02, subdivision 2a, and licensed under Minnesota Rules, parts 9555.9600 to 9555.9730,
171.6 must maintain documentation of:

171.7 (1) a needs assessment and current plan of care according to section 245A.143,
171.8 subdivisions 4 to 7, or Minnesota Rules, part 9555.9700, for each recipient, if applicable;

171.9 (2) attendance records as specified under section 245A.14, subdivision 14, paragraph
171.10 (c), including the date of attendance with the day, month, and year; and the pickup and
171.11 drop-off time in hours and minutes with a.m. and p.m. designations;

171.12 (3) the monthly and quarterly program requirements in Minnesota Rules, part 9555.9710,
171.13 subparts 1, items E and H; 3; 4; and 6, if applicable;

171.14 (4) the name and qualification of each registered physical therapist, registered nurse,
171.15 and registered dietitian who provides services to the adult day services or nonresidential
171.16 program; and

171.17 (5) the location where the service was provided. If the location is an alternate location
171.18 from the usual place of service, the documentation must include the address, or a description
171.19 if the address is not available, of both the origin site and destination site; the length of time
171.20 at the alternate location with a.m. and p.m. designations; and a list of participants who went
171.21 to the alternate location.

171.22 (b) A provider must not exceed the provider's licensed capacity. If a provider exceeds
171.23 the provider's licensed capacity, the department must recover all Minnesota health care
171.24 programs payments from the date the provider exceeded licensed capacity.

171.25 **EFFECTIVE DATE.** This section is effective August 1, 2019.

171.26 Sec. 120. **[609.817] CRIMINAL PENALTIES FOR ACTS INVOLVING HUMAN**
171.27 **SERVICES PROGRAMS.**

171.28 Subdivision 1. **Payments made relating to human services programs.** A person who
171.29 intentionally offers or pays any remuneration, including any kickback, bribe, or rebate,
171.30 directly or indirectly, overtly or covertly, in cash or in kind, to a person is guilty of a crime
171.31 and may be sentenced as provided in subdivision 3 if the offer or payment is made to induce
171.32 the person:

172.1 (1) to apply for, receive, or induce another person to apply for or receive a human services
 172.2 benefit, service, or grant related to a program funded in whole or in part by the Department
 172.3 of Human Services or administered by the commissioner of human services, including but
 172.4 not limited to a human services benefit, service, or grant funded in whole or in part by a
 172.5 local social services agency, the Department of Human Services, or the United States
 172.6 Department of Health and Human Services; or

172.7 (2) to apply for or to use a particular vendor providing a service administered or funded
 172.8 in whole or in part by the Department of Human Services, a local social services agency,
 172.9 or the United States Department of Health and Human Services.

172.10 **Subd. 2. Payments received relating to human services programs.** A person who
 172.11 intentionally solicits or receives any remuneration, including any kickback, bribe, or rebate,
 172.12 directly or indirectly, overtly or covertly, in cash or in kind, is guilty of a crime and may
 172.13 be sentenced as provided in subdivision 3 if the remuneration is solicited or received:

172.14 (1) in return for applying for or receiving a human services benefit, service, or grant
 172.15 administered or funded in whole or in part by the Department of Human Services or
 172.16 administered by the commissioner of human services, including but not limited to a human
 172.17 services benefit, service, or grant funded in whole or in part by a local social services agency,
 172.18 the Department of Human Services, or the United States Department of Health and Human
 172.19 Services;

172.20 (2) in return for applying for or using a particular vendor providing a service administered
 172.21 or funded in whole or in part by the Department of Human Services, a local social services
 172.22 agency, or the United States Department of Health and Human Services; or

172.23 (3) in return for receiving or agreeing to receive payments in excess of fair and reasonable
 172.24 market value for services or supplies provided to a company or person who is being paid
 172.25 in whole or in part by the Department of Human Services, a local social services agency,
 172.26 or the United States Department of Health and Human Services to provide a human services
 172.27 benefit to a person.

172.28 **Subd. 3. Sentence.** Whoever violates subdivision 1 or 2 may be sentenced to
 172.29 imprisonment for not more than five years or to payment of a fine of not more than \$10,000,
 172.30 or both.

172.31 **Subd. 4. Defense.** It is not a defense under this section for the person or company
 172.32 receiving or making the payments in excess of fair and reasonable market value to claim
 172.33 the person did not have knowledge of the source of the payments.

173.1 Subd. 5. **Persons exempt.** This section does not apply if:

173.2 (1) the employee receiving the remuneration is a bona fide employee of the company
 173.3 receiving payment for providing care or services;

173.4 (2) the remuneration received by the employee is for work performed by the employee
 173.5 and is paid via a standard payroll check or a direct deposit from the company payroll account
 173.6 to the bank designated by the employee; and

173.7 (3) the company making the payment complies with all state and federal laws relating
 173.8 to tax withholding, Social Security and Medicare withholding, and wage reporting to the
 173.9 Department of Employment and Economic Development.

173.10 Subd. 6. **Additional sanctions.** (a) Claims or payments for any service rendered or
 173.11 claimed to have been rendered by a provider or individual who violated this section in regard
 173.12 to the person for whom the services were rendered or claimed to have been rendered are
 173.13 noncompensable, unenforceable as a matter of law, and constitute the value of any restitution
 173.14 owed to the Department of Human Services, a county, or the United States Department of
 173.15 Health and Human Services.

173.16 (b) For purposes of this section, service includes any benefit, service, or grant
 173.17 administered or funded in whole or in part by the Department of Human Services, a county,
 173.18 or the United States Department of Health and Human Services.

173.19 (c) A person convicted under this section is subject to prohibitions described under
 173.20 section 245.095.

173.21 Sec. 121. **REPEALER.**

173.22 (a) Minnesota Rules, parts 9502.0425, subparts 4, 16, and 17; and 9503.0155, subpart
 173.23 8, are repealed.

173.24 (b) Minnesota Statutes 2018, section 245H.10, subdivision 2, is repealed.

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

173.26

ARTICLE 3

173.27

DIRECT CARE AND TREATMENT

173.28 Section 1. Minnesota Statutes 2018, section 246.54, is amended by adding a subdivision
 173.29 to read:

173.30 Subd. 3. **Administrative review of county liability for cost of care.** (a) The county of
 173.31 financial responsibility may submit a written request for administrative review by the

174.1 commissioner of the county's payment of the cost of care when a delay in discharge of a
 174.2 client from a regional treatment center, state-operated community-based behavioral health
 174.3 hospital, or other state-operated facility results from the following actions by the facility:

174.4 (1) the facility did not provide notice to the county that the facility has determined that
 174.5 it is clinically appropriate for a client to be discharged;

174.6 (2) the notice to the county that the facility has determined that it is clinically appropriate
 174.7 for a client to be discharged was communicated on a holiday or weekend;

174.8 (3) the required documentation or procedures for discharge were not completed in order
 174.9 for the discharge to occur in a timely manner; or

174.10 (4) the facility disagrees with the county's discharge plan.

174.11 (b) The county of financial responsibility may not appeal the determination that it is
 174.12 clinically appropriate for a client to be discharged from a regional treatment center,
 174.13 state-operated community-based behavioral health hospital, or other state-operated facility.

174.14 (c) The commissioner must evaluate the request for administrative review and determine
 174.15 if the facility's actions listed in paragraph (a) caused undue delay in discharging the client.
 174.16 If the commissioner determines that the facility's actions listed in paragraph (a) caused
 174.17 undue delay in discharging the client, the county's liability must be reduced to the level of
 174.18 the cost of care for a client whose stay in a facility is determined to be clinically appropriate,
 174.19 effective on the date of the facility's action or failure to act that caused the delay. The
 174.20 commissioner's determination under this subdivision is final and not subject to appeal.

174.21 (d) If a county's liability is reduced pursuant to paragraph (c), a county's liability must
 174.22 return to the level of the cost of care for a client whose stay in a facility is determined to no
 174.23 longer be appropriate effective on the date the facility rectifies the action or failure to act
 174.24 that caused the delay under paragraph (a).

174.25 (e) Any difference in the county cost of care liability resulting from administrative review
 174.26 under this subdivision must not be billed to the client or applied to future reimbursement
 174.27 from the client's estate or relatives.

174.28 Sec. 2. Minnesota Statutes 2018, section 246B.10, is amended to read:

174.29 **246B.10 LIABILITY OF COUNTY; REIMBURSEMENT.**

174.30 (a) The civilly committed sex offender's county shall pay to the state a portion of the
 174.31 cost of care provided in the Minnesota sex offender program to a civilly committed sex
 174.32 offender who has legally settled in that county.

175.1 (b) A county's payment must be made from the county's own sources of revenue and
175.2 payments must:

175.3 (1) equal ten percent of the cost of care, as determined by the commissioner, for each
175.4 day or portion of a day that the civilly committed sex offender spends at the facility for
175.5 individuals admitted to the Minnesota sex offender program before August 1, 2011; or

175.6 (2) equal 25 percent of the cost of care, as determined by the commissioner, for each
175.7 day or portion of a day; that the civilly committed sex offender:

175.8 (i) spends at the facility; for individuals admitted to the Minnesota sex offender program
175.9 on or after August 1, 2011; or

175.10 (ii) receives services within a program operated by the Minnesota sex offender program
175.11 while on provisional discharge.

175.12 (c) The county is responsible for paying the state the remaining amount if payments
175.13 received by the state under this chapter exceed:

175.14 (1) 90 percent of the cost of care for individuals admitted to the Minnesota sex offender
175.15 program before August 1, 2011; or

175.16 (2) 75 percent of the cost of care, ~~the county is responsible for paying the state the~~
175.17 ~~remaining amount~~ for individuals:

175.18 (i) admitted to the Minnesota sex offender program on or after August 1, 2011; or

175.19 (ii) receiving services within a program operated by the Minnesota sex offender program
175.20 while on provisional discharge.

175.21 (d) The county is not entitled to reimbursement from the civilly committed sex offender,
175.22 the civilly committed sex offender's estate, or from the civilly committed sex offender's
175.23 relatives, except as provided in section 246B.07.

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

175.25 Sec. 3. **DIRECTION TO COMMISSIONER; REPORT REQUIRED.**

175.26 No later than January 1, 2023, the commissioner of human services must submit a report
175.27 to the chairs and ranking minority members of the legislative committees with jurisdiction
175.28 over human services that provides an update on county and state efforts to reduce the number
175.29 of days clients spend in state-operated facilities after discharge from the facility has been
175.30 determined to be clinically appropriate. The report must also include information on the
175.31 fiscal impact of clinically inappropriate stays in these facilities.

176.1 Sec. 4. **REPEALER.**

176.2 (a) Minnesota Statutes 2018, section 246.18, subdivisions 8 and 9, are repealed.

176.3 (b) Laws 2010, First Special Session chapter 1, article 25, section 3, subdivision 10, is
 176.4 repealed.

176.5 ARTICLE 4

176.6 CONTINUING CARE FOR OLDER ADULTS

176.7 Section 1. Minnesota Statutes 2018, section 144.0724, subdivision 4, is amended to read:

176.8 Subd. 4. **Resident assessment schedule.** (a) A facility must conduct and electronically
 176.9 submit to the commissioner of health MDS assessments that conform with the assessment
 176.10 schedule defined by Code of Federal Regulations, title 42, section 483.20, and published
 176.11 by the United States Department of Health and Human Services, Centers for Medicare and
 176.12 Medicaid Services, in the Long Term Care Assessment Instrument User's Manual, version
 176.13 3.0, and subsequent updates when issued by the Centers for Medicare and Medicaid Services.
 176.14 The commissioner of health may substitute successor manuals or question and answer
 176.15 documents published by the United States Department of Health and Human Services,
 176.16 Centers for Medicare and Medicaid Services, to replace or supplement the current version
 176.17 of the manual or document.

176.18 (b) The assessments used to determine a case mix classification for reimbursement
 176.19 include the following:

176.20 (1) a new admission assessment;

176.21 (2) an annual assessment which must have an assessment reference date (ARD) within
 176.22 92 days of the previous assessment and the previous comprehensive assessment;

176.23 (3) a significant change in status assessment must be completed within 14 days of the
 176.24 identification of a significant change, whether improvement or decline, and regardless of
 176.25 the amount of time since the last significant change in status assessment; Effective for
 176.26 rehabilitation therapy completed on or after January 1, 2020, a facility must complete a
 176.27 significant change in status assessment if for any reason all speech, occupational, and
 176.28 physical therapies have ended. The ARD of the significant change in status assessment must
 176.29 be the eighth day after all speech, occupational, and physical therapies have ended. The last
 176.30 day on which rehabilitation therapy was furnished is considered day zero when determining
 176.31 the ARD for the significant change in status assessment;

177.1 (4) all quarterly assessments must have an assessment reference date (ARD) within 92
177.2 days of the ARD of the previous assessment;

177.3 (5) any significant correction to a prior comprehensive assessment, if the assessment
177.4 being corrected is the current one being used for RUG classification; ~~and~~

177.5 (6) any significant correction to a prior quarterly assessment, if the assessment being
177.6 corrected is the current one being used for RUG classification; and

177.7 (7) modifications to the most recent assessment in clauses (1) to (6).

177.8 (c) In addition to the assessments listed in paragraph (b), the assessments used to
177.9 determine nursing facility level of care include the following:

177.10 (1) preadmission screening completed under section 256.975, subdivisions 7a to 7c, by
177.11 the Senior LinkAge Line or other organization under contract with the Minnesota Board on
177.12 Aging; and

177.13 (2) a nursing facility level of care determination as provided for under section 256B.0911,
177.14 subdivision 4e, as part of a face-to-face long-term care consultation assessment completed
177.15 under section 256B.0911, by a county, tribe, or managed care organization under contract
177.16 with the Department of Human Services.

177.17 Sec. 2. Minnesota Statutes 2018, section 144.0724, subdivision 5, is amended to read:

177.18 Subd. 5. **Short stays.** (a) A facility must submit to the commissioner of health an
177.19 admission assessment for all residents who stay in the facility 14 days or less.

177.20 (b) Notwithstanding the admission assessment requirements of paragraph (a), a facility
177.21 may elect to accept a short stay rate with a case mix index of 1.0 for all facility residents
177.22 who stay 14 days or less in lieu of submitting an admission assessment. Facilities shall make
177.23 this election annually.

177.24 (c) Nursing facilities must elect one of the options described in paragraphs (a) and (b)
177.25 by reporting to the commissioner of health, as prescribed by the commissioner. The election
177.26 is effective on July 1 each year.

177.27 (d) An admission assessment is not required regardless of the facility's election status
177.28 when a resident is admitted to and discharged from the facility on the same day.

177.29 **EFFECTIVE DATE.** This section is effective for admissions on or after July 1, 2019.

178.1 Sec. 3. Minnesota Statutes 2018, section 144.0724, subdivision 8, is amended to read:

178.2 Subd. 8. **Request for reconsideration of resident classifications.** (a) The resident, or
178.3 resident's representative, or the nursing facility or boarding care home may request that the
178.4 commissioner of health reconsider the assigned reimbursement classification including any
178.5 items changed during the audit process. The request for reconsideration must be submitted
178.6 in writing to the commissioner within 30 days of the day the resident or the resident's
178.7 representative receives the resident classification notice. The request for reconsideration
178.8 must include the name of the resident, the name and address of the facility in which the
178.9 resident resides, the reasons for the reconsideration, and documentation supporting the
178.10 request. The documentation accompanying the reconsideration request is limited to ~~a copy~~
178.11 ~~of the MDS that determined the classification and other~~ documents that would support or
178.12 change the MDS findings.

178.13 (b) Upon request, the nursing facility must give the resident or the resident's representative
178.14 a copy of the assessment form and the other documentation that was given to the
178.15 commissioner of health to support the assessment findings. The nursing facility shall also
178.16 provide access to and a copy of other information from the resident's record that has been
178.17 requested by or on behalf of the resident to support a resident's reconsideration request. A
178.18 copy of any requested material must be provided within three working days of receipt of a
178.19 written request for the information. Notwithstanding any law to the contrary, the facility
178.20 may not charge a fee for providing copies of the requested documentation. If a facility fails
178.21 to provide the material within this time, it is subject to the issuance of a correction order
178.22 and penalty assessment under sections 144.653 and 144A.10. Notwithstanding those sections,
178.23 any correction order issued under this subdivision must require that the nursing facility
178.24 immediately comply with the request for information and that as of the date of the issuance
178.25 of the correction order, the facility shall forfeit to the state a \$100 fine for the first day of
178.26 noncompliance, and an increase in the \$100 fine by \$50 increments for each day the
178.27 noncompliance continues.

178.28 (c) In addition to the information required under paragraphs (a) and (b), a reconsideration
178.29 request from a nursing facility must contain the following information: (i) the date the
178.30 reimbursement classification notices were received by the facility; (ii) the date the
178.31 classification notices were distributed to the resident or the resident's representative; and
178.32 (iii) a copy of a notice sent to the resident or to the resident's representative. This notice
178.33 must inform the resident or the resident's representative that a reconsideration of the resident's
178.34 classification is being requested, the reason for the request, that the resident's rate will change
178.35 if the request is approved by the commissioner, the extent of the change, that copies of the

179.1 facility's request and supporting documentation are available for review, and that the resident
179.2 also has the right to request a reconsideration. If the facility fails to provide the required
179.3 information listed in item (iii) with the reconsideration request, the commissioner may
179.4 request that the facility provide the information within 14 calendar days. The reconsideration
179.5 request must be denied if the information is then not provided, and the facility may not
179.6 make further reconsideration requests on that specific reimbursement classification.

179.7 (d) Reconsideration by the commissioner must be made by individuals not involved in
179.8 reviewing the assessment, audit, or reconsideration that established the disputed classification.
179.9 The reconsideration must be based upon the assessment that determined the classification
179.10 and upon the information provided to the commissioner under paragraphs (a) and (b). If
179.11 necessary for evaluating the reconsideration request, the commissioner may conduct on-site
179.12 reviews. Within 15 working days of receiving the request for reconsideration, the
179.13 commissioner shall affirm or modify the original resident classification. The original
179.14 classification must be modified if the commissioner determines that the assessment resulting
179.15 in the classification did not accurately reflect characteristics of the resident at the time of
179.16 the assessment. The resident and the nursing facility or boarding care home shall be notified
179.17 within five working days after the decision is made. A decision by the commissioner under
179.18 this subdivision is the final administrative decision of the agency for the party requesting
179.19 reconsideration.

179.20 (e) The resident classification established by the commissioner shall be the classification
179.21 that applies to the resident while the request for reconsideration is pending. If a request for
179.22 reconsideration applies to an assessment used to determine nursing facility level of care
179.23 under subdivision 4, paragraph (c), the resident shall continue to be eligible for nursing
179.24 facility level of care while the request for reconsideration is pending.

179.25 (f) The commissioner may request additional documentation regarding a reconsideration
179.26 necessary to make an accurate reconsideration determination.

179.27 Sec. 4. Minnesota Statutes 2018, section 144A.071, subdivision 1a, is amended to read:

179.28 Subd. 1a. **Definitions.** For purposes of sections 144A.071 to 144A.073, the following
179.29 terms have the meanings given them:

179.30 (a) "Attached fixtures" has the meaning given in Minnesota Rules, part 9549.0020,
179.31 subpart 6.

179.32 (b) "~~Buildings~~" "Building" has the meaning given in ~~Minnesota Rules, part 9549.0020,~~
179.33 ~~subpart 7~~ section 256R.261, subdivision 4.

180.1 (c) "Capital assets" has the meaning given in section ~~256B.421, subdivision 16~~ 256R.02,
180.2 subdivision 8.

180.3 (d) "Commenced construction" means that all of the following conditions were met: the
180.4 final working drawings and specifications were approved by the commissioner of health;
180.5 the construction contracts were let; a timely construction schedule was developed, stipulating
180.6 dates for beginning, achieving various stages, and completing construction; and all zoning
180.7 and building permits were applied for.

180.8 (e) "Completion date" means the date on which clearance for the construction project
180.9 is issued, or if a clearance for the construction project is not required, the date on which the
180.10 construction project assets are available for facility use.

180.11 (f) "Construction" means any erection, building, alteration, reconstruction, modernization,
180.12 or improvement necessary to comply with the nursing home licensure rules.

180.13 (g) "Construction project" means:

180.14 (1) a capital asset addition to, or replacement of a nursing home or certified boarding
180.15 care home that results in new space or the remodeling of or renovations to existing facility
180.16 space; and

180.17 (2) the remodeling or renovation of existing facility space the use of which is modified
180.18 as a result of the project described in clause (1). This existing space and the project described
180.19 in clause (1) must be used for the functions as designated on the construction plans on
180.20 completion of the project described in clause (1) for a period of not less than 24 months.

180.21 (h) "Depreciation guidelines" ~~means the most recent publication of "The Estimated~~
180.22 ~~Useful Lives of Depreciable Hospital Assets," issued by the American Hospital Association,~~
180.23 ~~840 North Lake Shore Drive, Chicago, Illinois, 60611~~ has the meaning given in section
180.24 256R.261, subdivision 9.

180.25 (i) "New licensed" or "new certified beds" means:

180.26 (1) newly constructed beds in a facility or the construction of a new facility that would
180.27 increase the total number of licensed nursing home beds or certified boarding care or nursing
180.28 home beds in the state; or

180.29 (2) newly licensed nursing home beds or newly certified boarding care or nursing home
180.30 beds that result from remodeling of the facility that involves relocation of beds but does not
180.31 result in an increase in the total number of beds, except when the project involves the upgrade
180.32 of boarding care beds to nursing home beds, as defined in section 144A.073, subdivision

181.1 1. "Remodeling" includes any of the type of conversion, renovation, replacement, or
 181.2 upgrading projects as defined in section 144A.073, subdivision 1.

181.3 ~~(j) "Project construction costs" means the cost of the following items that have a~~
 181.4 ~~completion date within 12 months before or after the completion date of the project described~~
 181.5 ~~in item (g), clause (1):~~

181.6 ~~(1) facility capital asset additions;~~

181.7 ~~(2) replacements;~~

181.8 ~~(3) renovations;~~

181.9 ~~(4) remodeling projects;~~

181.10 ~~(5) construction site preparation costs;~~

181.11 ~~(6) related soft costs; and~~

181.12 ~~(7) the cost of new technology implemented as part of the construction project and~~
 181.13 ~~depreciable equipment directly identified to the project, if the construction costs for clauses~~
 181.14 ~~(1) to (6) exceed the threshold for additions and replacements stated in section 256B.431,~~
 181.15 ~~subdivision 16. Technology and depreciable equipment shall be included in the project~~
 181.16 ~~construction costs unless a written election is made by the facility, to not include it in the~~
 181.17 ~~facility's appraised value for purposes of Minnesota Rules, part 9549.0020, subpart 5. Debt~~
 181.18 ~~incurred for purchase of technology and depreciable equipment shall be included as allowable~~
 181.19 ~~debt for purposes of Minnesota Rules, part 9549.0060, subpart 5, items A and C, unless the~~
 181.20 ~~written election is to not include it. Any new technology and depreciable equipment included~~
 181.21 ~~in the project construction costs that the facility elects not to include in its appraised value~~
 181.22 ~~and allowable debt shall be treated as provided in section 256B.431, subdivision 17,~~
 181.23 ~~paragraph (b). Written election under this paragraph must be included in the facility's request~~
 181.24 ~~for the rate change related to the project, and this election may not be changed.~~

181.25 ~~(k) "Technology" means information systems or devices that make documentation,~~
 181.26 ~~charting, and staff time more efficient or encourage and allow for care through alternative~~
 181.27 ~~settings including, but not limited to, touch screens, monitors, hand-helds, swipe cards,~~
 181.28 ~~motion detectors, pagers, telemedicine, medication dispensers, and equipment to monitor~~
 181.29 ~~vital signs and self-injections, and to observe skin and other conditions.~~

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

182.1 Sec. 5. Minnesota Statutes 2018, section 144A.071, subdivision 2, is amended to read:

182.2 Subd. 2. **Moratorium.** The commissioner of health, in coordination with the
182.3 commissioner of human services, shall deny each request for new licensed or certified
182.4 nursing home or certified boarding care beds except as provided in subdivision 3 or 4a, or
182.5 section 144A.073. "Certified bed" means a nursing home bed or a boarding care bed certified
182.6 by the commissioner of health for the purposes of the medical assistance program, under
182.7 United States Code, title 42, sections 1396 et seq. Certified beds in facilities which do not
182.8 allow medical assistance intake shall be deemed to be decertified for purposes of this section
182.9 only.

182.10 The commissioner of human services, in coordination with the commissioner of health,
182.11 shall deny any request to issue a license under section 252.28 and chapter 245A to a nursing
182.12 home or boarding care home, if that license would result in an increase in the medical
182.13 assistance reimbursement amount.

182.14 In addition, the commissioner of health must not approve any construction project whose
182.15 cost exceeds ~~\$1,000,000~~ \$1,500,000, unless:

182.16 (a) any construction costs exceeding ~~\$1,000,000~~ \$1,500,000 are not added to the facility's
182.17 appraised value and are not included in the facility's payment rate for reimbursement under
182.18 the medical assistance program; or

182.19 (b) the project:

182.20 (1) has been approved through the process described in section 144A.073;

182.21 (2) meets an exception in subdivision 3 or 4a;

182.22 (3) is necessary to correct violations of state or federal law issued by the commissioner
182.23 of health;

182.24 (4) is necessary to repair or replace a portion of the facility that was damaged by fire,
182.25 lightning, ground shifts, or other such hazards, including environmental hazards, provided
182.26 that the provisions of subdivision 4a, clause (a), are met;

182.27 (5) as of May 1, 1992, the facility has submitted to the commissioner of health written
182.28 documentation evidencing that the facility meets the "commenced construction" definition
182.29 as specified in subdivision 1a, paragraph (d), or that substantial steps have been taken prior
182.30 to April 1, 1992, relating to the construction project. "Substantial steps" require that the
182.31 facility has made arrangements with outside parties relating to the construction project and
182.32 include the hiring of an architect or construction firm, submission of preliminary plans to

183.1 the Department of Health or documentation from a financial institution that financing
183.2 arrangements for the construction project have been made; or

183.3 (6) is being proposed by a licensed nursing facility that is not certified to participate in
183.4 the medical assistance program and will not result in new licensed or certified beds.

183.5 Prior to the final plan approval of any construction project, the ~~commissioner~~
183.6 commissioners of health and human services shall be provided with an itemized cost estimate
183.7 for the project construction costs. If a construction project is anticipated to be completed in
183.8 phases, the total estimated cost of all phases of the project shall be submitted to the
183.9 ~~commissioner~~ commissioners and shall be considered as one construction project. Once the
183.10 construction project is completed and prior to the final clearance by the ~~commissioner~~
183.11 commissioners, the total project construction costs for the construction project shall be
183.12 submitted to the ~~commissioner~~ commissioners. If the final project construction cost exceeds
183.13 the dollar threshold in this subdivision, the commissioner of human services shall not
183.14 recognize any of the project construction costs or the related financing costs in excess of
183.15 this threshold in establishing the facility's property-related payment rate.

183.16 The dollar thresholds for construction projects are as follows: for construction projects
183.17 other than those authorized in clauses (1) to (6), the dollar threshold is \$1,000,000. For
183.18 projects authorized after July 1, 1993, under clause (1), the dollar threshold is the cost
183.19 estimate submitted with a proposal for an exception under section 144A.073, plus inflation
183.20 as calculated according to section 256B.431, subdivision 3f, paragraph (a). For projects
183.21 authorized under clauses (2) to (4), the dollar threshold is the itemized estimate project
183.22 construction costs submitted to the commissioner of health at the time of final plan approval,
183.23 plus inflation as calculated according to section 256B.431, subdivision 3f, paragraph (a).

183.24 The commissioner of health shall adopt rules to implement this section or to amend the
183.25 emergency rules for granting exceptions to the moratorium on nursing homes under section
183.26 144A.073.

183.27 Sec. 6. Minnesota Statutes 2018, section 144A.071, subdivision 3, is amended to read:

183.28 **Subd. 3. Exceptions authorizing increase in beds; hardship areas.** (a) The
183.29 commissioner of health, in coordination with the commissioner of human services, may
183.30 approve the addition of new licensed and Medicare and Medicaid certified nursing home
183.31 beds, using the criteria and process set forth in this subdivision.

184.1 (b) The commissioner, in cooperation with the commissioner of human services, shall
184.2 consider the following criteria when determining that an area of the state is a hardship area
184.3 with regard to access to nursing facility services:

184.4 (1) a low number of beds per thousand in a specified area using as a standard the beds
184.5 per thousand people age 65 and older, in five year age groups, using data from the most
184.6 recent census and population projections, weighted by each group's most recent nursing
184.7 home utilization, of the county at the 20th percentile, as determined by the commissioner
184.8 of human services;

184.9 (2) a high level of out-migration for nursing facility services associated with a described
184.10 area from the county or counties of residence to other Minnesota counties, as determined
184.11 by the commissioner of human services, using as a standard an amount greater than the
184.12 out-migration of the county ranked at the 50th percentile;

184.13 (3) an adequate level of availability of noninstitutional long-term care services measured
184.14 as public spending for home and community-based long-term care services per individual
184.15 age 65 and older, in five year age groups, using data from the most recent census and
184.16 population projections, weighted by each group's most recent nursing home utilization, as
184.17 determined by the commissioner of human services using as a standard an amount greater
184.18 than the 50th percentile of counties;

184.19 (4) there must be a declaration of hardship resulting from insufficient access to nursing
184.20 home beds by local county agencies and area agencies on aging; and

184.21 (5) other factors that may demonstrate the need to add new nursing facility beds.

184.22 (c) On August 15 of odd-numbered years, the commissioner, in cooperation with the
184.23 commissioner of human services, may publish in the State Register a request for information
184.24 in which interested parties, using the data provided under section 144A.351, along with any
184.25 other relevant data, demonstrate that a specified area is a hardship area with regard to access
184.26 to nursing facility services. For a response to be considered, the commissioner must receive
184.27 it by November 15. The commissioner shall make responses to the request for information
184.28 available to the public and shall allow 30 days for comment. The commissioner shall review
184.29 responses and comments and determine if any areas of the state are to be declared hardship
184.30 areas.

184.31 (d) For each designated hardship area determined in paragraph (c), the commissioner
184.32 shall publish a request for proposals in accordance with section 144A.073 and Minnesota
184.33 Rules, parts 4655.1070 to 4655.1098. The request for proposals must be published in the
184.34 State Register by March 15 following receipt of responses to the request for information.

185.1 The request for proposals must specify the number of new beds which may be added in the
 185.2 designated hardship area, which must not exceed the number which, if added to the existing
 185.3 number of beds in the area, including beds in layaway status, would have prevented it from
 185.4 being determined to be a hardship area under paragraph (b), clause (1). Beginning July 1,
 185.5 2011, the number of new beds approved must not exceed 200 beds statewide per biennium.
 185.6 After June 30, 2019, the number of new beds that may be approved in a biennium must not
 185.7 exceed 300 statewide. For a proposal to be considered, the commissioner must receive it
 185.8 within six months of the publication of the request for proposals. The commissioner shall
 185.9 review responses to the request for proposals and shall approve or disapprove each proposal
 185.10 by the following July 15, in accordance with section 144A.073 and Minnesota Rules, parts
 185.11 4655.1070 to 4655.1098. The commissioner shall base approvals or disapprovals on a
 185.12 comparison and ranking of proposals using only the criteria in subdivision 4a. Approval of
 185.13 a proposal expires after 18 months unless the facility has added the new beds using existing
 185.14 space, subject to approval by the commissioner, or has commenced construction as defined
 185.15 in subdivision 1a, paragraph (d). If, after the approved beds have been added, fewer than
 185.16 50 percent of the beds in a facility are newly licensed, the operating payment rates previously
 185.17 in effect shall remain. If, after the approved beds have been added, 50 percent or more of
 185.18 the beds in a facility are newly licensed, operating and external fixed payment rates shall
 185.19 be determined according to ~~Minnesota Rules, part 9549.0057, using the limits under sections~~
 185.20 ~~256R.23, subdivision 5, and 256R.24, subdivision 3. External fixed costs payment rates~~
 185.21 ~~must be determined according to section 256R.25~~ section 256R.21, subdivision 5. Property
 185.22 payment rates for facilities with beds added under this subdivision must be determined ~~in~~
 185.23 ~~the same manner as rate determinations resulting from projects approved and completed~~
 185.24 ~~under section 144A.073~~ under section 256R.26.

185.25 (e) The commissioner may:

185.26 (1) certify or license new beds in a new facility that is to be operated by the commissioner
 185.27 of veterans affairs or when the costs of constructing and operating the new beds are to be
 185.28 reimbursed by the commissioner of veterans affairs or the United States Veterans
 185.29 Administration; and

185.30 (2) license or certify beds in a facility that has been involuntarily delicensed or decertified
 185.31 for participation in the medical assistance program, provided that an application for
 185.32 relicensure or recertification is submitted to the commissioner by an organization that is
 185.33 not a related organization as defined in section 256R.02, subdivision 43, to the prior licensee
 185.34 within 120 days after delicensure or decertification.

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

186.1 Sec. 7. Minnesota Statutes 2018, section 144A.071, subdivision 4a, is amended to read:

186.2 Subd. 4a. **Exceptions for replacement beds.** It is in the best interest of the state to
186.3 ensure that nursing homes and boarding care homes continue to meet the physical plant
186.4 licensing and certification requirements by permitting certain construction projects. Facilities
186.5 should be maintained in condition to satisfy the physical and emotional needs of residents
186.6 while allowing the state to maintain control over nursing home expenditure growth.

186.7 The commissioner of health in coordination with the commissioner of human services,
186.8 may approve the renovation, replacement, upgrading, or relocation of a nursing home or
186.9 boarding care home, under the following conditions:

186.10 (a) to license or certify beds in a new facility constructed to replace a facility or to make
186.11 repairs in an existing facility that was destroyed or damaged after June 30, 1987, by fire,
186.12 lightning, or other hazard provided:

186.13 (i) destruction was not caused by the intentional act of or at the direction of a controlling
186.14 person of the facility;

186.15 (ii) at the time the facility was destroyed or damaged the controlling persons of the
186.16 facility maintained insurance coverage for the type of hazard that occurred in an amount
186.17 that a reasonable person would conclude was adequate;

186.18 (iii) the net proceeds from an insurance settlement for the damages caused by the hazard
186.19 are applied to the cost of the new facility or repairs;

186.20 (iv) the number of licensed and certified beds in the new facility does not exceed the
186.21 number of licensed and certified beds in the destroyed facility; and

186.22 (v) the commissioner determines that the replacement beds are needed to prevent an
186.23 inadequate supply of beds.

186.24 Project construction costs incurred for repairs authorized under this clause shall not be
186.25 considered in the dollar threshold amount defined in subdivision 2;

186.26 (b) to license or certify beds that are moved from one location to another within a nursing
186.27 home facility, provided the total costs of remodeling performed in conjunction with the
186.28 relocation of beds does not exceed \$1,000,000;

186.29 (c) to license or certify beds in a project recommended for approval under section
186.30 144A.073;

187.1 (d) to license or certify beds that are moved from an existing state nursing home to a
187.2 different state facility, provided there is no net increase in the number of state nursing home
187.3 beds;

187.4 (e) to certify and license as nursing home beds boarding care beds in a certified boarding
187.5 care facility if the beds meet the standards for nursing home licensure, or in a facility that
187.6 was granted an exception to the moratorium under section 144A.073, and if the cost of any
187.7 remodeling of the facility does not exceed \$1,000,000. If boarding care beds are licensed
187.8 as nursing home beds, the number of boarding care beds in the facility must not increase
187.9 beyond the number remaining at the time of the upgrade in licensure. The provisions
187.10 contained in section 144A.073 regarding the upgrading of the facilities do not apply to
187.11 facilities that satisfy these requirements;

187.12 (f) to license and certify up to 40 beds transferred from an existing facility owned and
187.13 operated by the Amherst H. Wilder Foundation in the city of St. Paul to a new unit at the
187.14 same location as the existing facility that will serve persons with Alzheimer's disease and
187.15 other related disorders. The transfer of beds may occur gradually or in stages, provided the
187.16 total number of beds transferred does not exceed 40. At the time of licensure and certification
187.17 of a bed or beds in the new unit, the commissioner of health shall delicense and decertify
187.18 the same number of beds in the existing facility. As a condition of receiving a license or
187.19 certification under this clause, the facility must make a written commitment to the
187.20 commissioner of human services that it will not seek to receive an increase in its
187.21 property-related payment rate as a result of the transfers allowed under this paragraph;

187.22 (g) to license and certify nursing home beds to replace currently licensed and certified
187.23 boarding care beds which may be located either in a remodeled or renovated boarding care
187.24 or nursing home facility or in a remodeled, renovated, newly constructed, or replacement
187.25 nursing home facility within the identifiable complex of health care facilities in which the
187.26 currently licensed boarding care beds are presently located, provided that the number of
187.27 boarding care beds in the facility or complex are decreased by the number to be licensed as
187.28 nursing home beds and further provided that, if the total costs of new construction,
187.29 replacement, remodeling, or renovation exceed ten percent of the appraised value of the
187.30 facility or \$200,000, whichever is less, the facility makes a written commitment to the
187.31 commissioner of human services that it will not seek to receive an increase in its
187.32 property-related payment rate by reason of the new construction, replacement, remodeling,
187.33 or renovation. The provisions contained in section 144A.073 regarding the upgrading of
187.34 facilities do not apply to facilities that satisfy these requirements;

188.1 (h) to license as a nursing home and certify as a nursing facility a facility that is licensed
188.2 as a boarding care facility but not certified under the medical assistance program, but only
188.3 if the commissioner of human services certifies to the commissioner of health that licensing
188.4 the facility as a nursing home and certifying the facility as a nursing facility will result in
188.5 a net annual savings to the state general fund of \$200,000 or more;

188.6 (i) to certify, after September 30, 1992, and prior to July 1, 1993, existing nursing home
188.7 beds in a facility that was licensed and in operation prior to January 1, 1992;

188.8 (j) to license and certify new nursing home beds to replace beds in a facility acquired
188.9 by the Minneapolis Community Development Agency as part of redevelopment activities
188.10 in a city of the first class, provided the new facility is located within three miles of the site
188.11 of the old facility. Operating and property costs for the new facility must be determined and
188.12 allowed under section 256B.431 or 256B.434 or chapter 256R;

188.13 (k) to license and certify up to 20 new nursing home beds in a community-operated
188.14 hospital and attached convalescent and nursing care facility with 40 beds on April 21, 1991,
188.15 that suspended operation of the hospital in April 1986. The commissioner of human services
188.16 shall provide the facility with the same per diem property-related payment rate for each
188.17 additional licensed and certified bed as it will receive for its existing 40 beds;

188.18 (l) to license or certify beds in renovation, replacement, or upgrading projects as defined
188.19 in section 144A.073, subdivision 1, so long as the cumulative total costs of the facility's
188.20 remodeling projects do not exceed \$1,000,000;

188.21 (m) to license and certify beds that are moved from one location to another for the
188.22 purposes of converting up to five four-bed wards to single or double occupancy rooms in
188.23 a nursing home that, as of January 1, 1993, was county-owned and had a licensed capacity
188.24 of 115 beds;

188.25 (n) to allow a facility that on April 16, 1993, was a 106-bed licensed and certified nursing
188.26 facility located in Minneapolis to layaway all of its licensed and certified nursing home
188.27 beds. These beds may be relicensed and recertified in a newly constructed teaching nursing
188.28 home facility affiliated with a teaching hospital upon approval by the legislature. The
188.29 proposal must be developed in consultation with the interagency committee on long-term
188.30 care planning. The beds on layaway status shall have the same status as voluntarily delicensed
188.31 and decertified beds, except that beds on layaway status remain subject to the surcharge in
188.32 section 256.9657. This layaway provision expires July 1, 1998;

188.33 (o) to allow a project which will be completed in conjunction with an approved
188.34 moratorium exception project for a nursing home in southern Cass County and which is

189.1 directly related to that portion of the facility that must be repaired, renovated, or replaced,
189.2 to correct an emergency plumbing problem for which a state correction order has been
189.3 issued and which must be corrected by August 31, 1993;

189.4 (p) to allow a facility that on April 16, 1993, was a 368-bed licensed and certified nursing
189.5 facility located in Minneapolis to layaway, upon 30 days prior written notice to the
189.6 commissioner, up to 30 of the facility's licensed and certified beds by converting three-bed
189.7 wards to single or double occupancy. Beds on layaway status shall have the same status as
189.8 voluntarily delicensed and decertified beds except that beds on layaway status remain subject
189.9 to the surcharge in section 256.9657, remain subject to the license application and renewal
189.10 fees under section 144A.07 and shall be subject to a \$100 per bed reactivation fee. In
189.11 addition, at any time within three years of the effective date of the layaway, the beds on
189.12 layaway status may be:

189.13 (1) relicensed and recertified upon relocation and reactivation of some or all of the beds
189.14 to an existing licensed and certified facility or facilities located in Pine River, Brainerd, or
189.15 International Falls; provided that the total project construction costs related to the relocation
189.16 of beds from layaway status for any facility receiving relocated beds may not exceed the
189.17 dollar threshold provided in subdivision 2 unless the construction project has been approved
189.18 through the moratorium exception process under section 144A.073;

189.19 (2) relicensed and recertified, upon reactivation of some or all of the beds within the
189.20 facility which placed the beds in layaway status, if the commissioner has determined a need
189.21 for the reactivation of the beds on layaway status.

189.22 The property-related payment rate of a facility placing beds on layaway status must be
189.23 adjusted by the incremental change in its rental per diem after recalculating the rental per
189.24 diem as provided in section 256B.431, subdivision 3a, paragraph (c). The property-related
189.25 payment rate for a facility relicensing and recertifying beds from layaway status must be
189.26 adjusted by the incremental change in its rental per diem after recalculating its rental per
189.27 diem using the number of beds after the relicensing to establish the facility's capacity day
189.28 divisor, which shall be effective the first day of the month following the month in which
189.29 the relicensing and recertification became effective. Any beds remaining on layaway status
189.30 more than three years after the date the layaway status became effective must be removed
189.31 from layaway status and immediately delicensed and decertified;

189.32 (q) to license and certify beds in a renovation and remodeling project to convert 12
189.33 four-bed wards into 24 two-bed rooms, expand space, and add improvements in a nursing
189.34 home that, as of January 1, 1994, met the following conditions: the nursing home was located

190.1 in Ramsey County; had a licensed capacity of 154 beds; and had been ranked among the
190.2 top 15 applicants by the 1993 moratorium exceptions advisory review panel. The total
190.3 project construction cost estimate for this project must not exceed the cost estimate submitted
190.4 in connection with the 1993 moratorium exception process;

190.5 (r) to license and certify up to 117 beds that are relocated from a licensed and certified
190.6 138-bed nursing facility located in St. Paul to a hospital with 130 licensed hospital beds
190.7 located in South St. Paul, provided that the nursing facility and hospital are owned by the
190.8 same or a related organization and that prior to the date the relocation is completed the
190.9 hospital ceases operation of its inpatient hospital services at that hospital. After relocation,
190.10 the nursing facility's status shall be the same as it was prior to relocation. The nursing
190.11 facility's property-related payment rate resulting from the project authorized in this paragraph
190.12 shall become effective no earlier than April 1, 1996. For purposes of calculating the
190.13 incremental change in the facility's rental per diem resulting from this project, the allowable
190.14 appraised value of the nursing facility portion of the existing health care facility physical
190.15 plant prior to the renovation and relocation may not exceed \$2,490,000;

190.16 (s) to license and certify two beds in a facility to replace beds that were voluntarily
190.17 delicensed and decertified on June 28, 1991;

190.18 (t) to allow 16 licensed and certified beds located on July 1, 1994, in a 142-bed nursing
190.19 home and 21-bed boarding care home facility in Minneapolis, notwithstanding the licensure
190.20 and certification after July 1, 1995, of the Minneapolis facility as a 147-bed nursing home
190.21 facility after completion of a construction project approved in 1993 under section 144A.073,
190.22 to be laid away upon 30 days' prior written notice to the commissioner. Beds on layaway
190.23 status shall have the same status as voluntarily delicensed or decertified beds except that
190.24 they shall remain subject to the surcharge in section 256.9657. The 16 beds on layaway
190.25 status may be relicensed as nursing home beds and recertified at any time within five years
190.26 of the effective date of the layaway upon relocation of some or all of the beds to a licensed
190.27 and certified facility located in Watertown, provided that the total project construction costs
190.28 related to the relocation of beds from layaway status for the Watertown facility may not
190.29 exceed the dollar threshold provided in subdivision 2 unless the construction project has
190.30 been approved through the moratorium exception process under section 144A.073.

190.31 The property-related payment rate of the facility placing beds on layaway status must
190.32 be adjusted by the incremental change in its rental per diem after recalculating the rental
190.33 per diem as provided in section 256B.431, subdivision 3a, paragraph (c). The property-related
190.34 payment rate for the facility relicensing and recertifying beds from layaway status must be
190.35 adjusted by the incremental change in its rental per diem after recalculating its rental per

191.1 diem using the number of beds after the relicensing to establish the facility's capacity day
191.2 divisor, which shall be effective the first day of the month following the month in which
191.3 the relicensing and recertification became effective. Any beds remaining on layaway status
191.4 more than five years after the date the layaway status became effective must be removed
191.5 from layaway status and immediately delicensed and decertified;

191.6 (u) to license and certify beds that are moved within an existing area of a facility or to
191.7 a newly constructed addition which is built for the purpose of eliminating three- and four-bed
191.8 rooms and adding space for dining, lounge areas, bathing rooms, and ancillary service areas
191.9 in a nursing home that, as of January 1, 1995, was located in Fridley and had a licensed
191.10 capacity of 129 beds;

191.11 (v) to relocate 36 beds in Crow Wing County and four beds from Hennepin County to
191.12 a 160-bed facility in Crow Wing County, provided all the affected beds are under common
191.13 ownership;

191.14 (w) to license and certify a total replacement project of up to 49 beds located in Norman
191.15 County that are relocated from a nursing home destroyed by flood and whose residents were
191.16 relocated to other nursing homes. The operating cost payment rates for the new nursing
191.17 facility shall be determined based on the interim and settle-up payment provisions of
191.18 ~~Minnesota Rules, part 9549.0057,~~ section 256R.27 and the reimbursement provisions of
191.19 chapter 256R. Property-related reimbursement rates shall be determined under section
191.20 256R.26, taking into account any federal or state flood-related loans or grants provided to
191.21 the facility;

191.22 (x) to license and certify to the licensee of a nursing home in Polk County that was
191.23 destroyed by flood in 1997 replacement projects with a total of up to 129 beds, with at least
191.24 25 beds to be located in Polk County and up to 104 beds distributed among up to three other
191.25 counties. These beds may only be distributed to counties with fewer than the median number
191.26 of age intensity adjusted beds per thousand, as most recently published by the commissioner
191.27 of human services. If the licensee chooses to distribute beds outside of Polk County under
191.28 this paragraph, prior to distributing the beds, the commissioner of health must approve the
191.29 location in which the licensee plans to distribute the beds. The commissioner of health shall
191.30 consult with the commissioner of human services prior to approving the location of the
191.31 proposed beds. The licensee may combine these beds with beds relocated from other nursing
191.32 facilities as provided in section 144A.073, subdivision 3c. The operating payment rates for
191.33 the new nursing facilities shall be determined based on the interim and settle-up payment
191.34 provisions of Minnesota Rules, parts 9549.0010 to 9549.0080. Property-related
191.35 reimbursement rates shall be determined under section 256R.26. If the replacement beds

192.1 permitted under this paragraph are combined with beds from other nursing facilities, the
192.2 rates shall be calculated as the weighted average of rates determined as provided in this
192.3 paragraph and section 256R.50;

192.4 (y) to license and certify beds in a renovation and remodeling project to convert 13
192.5 three-bed wards into 13 two-bed rooms and 13 single-bed rooms, expand space, and add
192.6 improvements in a nursing home that, as of January 1, 1994, met the following conditions:
192.7 the nursing home was located in Ramsey County, was not owned by a hospital corporation,
192.8 had a licensed capacity of 64 beds, and had been ranked among the top 15 applicants by
192.9 the 1993 moratorium exceptions advisory review panel. The total project construction cost
192.10 estimate for this project must not exceed the cost estimate submitted in connection with the
192.11 1993 moratorium exception process;

192.12 (z) to license and certify up to 150 nursing home beds to replace an existing 285 bed
192.13 nursing facility located in St. Paul. The replacement project shall include both the renovation
192.14 of existing buildings and the construction of new facilities at the existing site. The reduction
192.15 in the licensed capacity of the existing facility shall occur during the construction project
192.16 as beds are taken out of service due to the construction process. Prior to the start of the
192.17 construction process, the facility shall provide written information to the commissioner of
192.18 health describing the process for bed reduction, plans for the relocation of residents, and
192.19 the estimated construction schedule. The relocation of residents shall be in accordance with
192.20 the provisions of law and rule;

192.21 (aa) to allow the commissioner of human services to license an additional 36 beds to
192.22 provide residential services for the physically disabled under Minnesota Rules, parts
192.23 9570.2000 to 9570.3400, in a 198-bed nursing home located in Red Wing, provided that
192.24 the total number of licensed and certified beds at the facility does not increase;

192.25 (bb) to license and certify a new facility in St. Louis County with 44 beds constructed
192.26 to replace an existing facility in St. Louis County with 31 beds, which has resident rooms
192.27 on two separate floors and an antiquated elevator that creates safety concerns for residents
192.28 and prevents nonambulatory residents from residing on the second floor. The project shall
192.29 include the elimination of three- and four-bed rooms;

192.30 (cc) to license and certify four beds in a 16-bed certified boarding care home in
192.31 Minneapolis to replace beds that were voluntarily delicensed and decertified on or before
192.32 March 31, 1992. The licensure and certification is conditional upon the facility periodically
192.33 assessing and adjusting its resident mix and other factors which may contribute to a potential
192.34 institution for mental disease declaration. The commissioner of human services shall retain

193.1 the authority to audit the facility at any time and shall require the facility to comply with
193.2 any requirements necessary to prevent an institution for mental disease declaration, including
193.3 delicensure and decertification of beds, if necessary;

193.4 (dd) to license and certify 72 beds in an existing facility in Mille Lacs County with 80
193.5 beds as part of a renovation project. The renovation must include construction of an addition
193.6 to accommodate ten residents with beginning and midstage dementia in a self-contained
193.7 living unit; creation of three resident households where dining, activities, and support spaces
193.8 are located near resident living quarters; designation of four beds for rehabilitation in a
193.9 self-contained area; designation of 30 private rooms; and other improvements;

193.10 (ee) to license and certify beds in a facility that has undergone replacement or remodeling
193.11 as part of a planned closure under section 256R.40;

193.12 (ff) to license and certify a total replacement project of up to 124 beds located in Wilkin
193.13 County that are in need of relocation from a nursing home significantly damaged by flood.
193.14 The operating cost payment rates for the new nursing facility shall be determined based on
193.15 the interim and settle-up payment provisions of ~~Minnesota Rules, part 9549.0057, section~~
193.16 256R.27 and the reimbursement provisions of chapter 256R. Property-related reimbursement
193.17 rates shall be determined under section 256R.26, taking into account any federal or state
193.18 flood-related loans or grants provided to the facility;

193.19 (gg) to allow the commissioner of human services to license an additional nine beds to
193.20 provide residential services for the physically disabled under Minnesota Rules, parts
193.21 9570.2000 to 9570.3400, in a 240-bed nursing home located in Duluth, provided that the
193.22 total number of licensed and certified beds at the facility does not increase;

193.23 (hh) to license and certify up to 120 new nursing facility beds to replace beds in a facility
193.24 in Anoka County, which was licensed for 98 beds as of July 1, 2000, provided the new
193.25 facility is located within four miles of the existing facility and is in Anoka County. Operating
193.26 and property rates shall be determined and allowed under chapter 256R and Minnesota
193.27 Rules, parts 9549.0010 to 9549.0080; or

193.28 (ii) to transfer up to 98 beds of a 129-licensed bed facility located in Anoka County that,
193.29 as of March 25, 2001, is in the active process of closing, to a 122-licensed bed nonprofit
193.30 nursing facility located in the city of Columbia Heights or its affiliate. The transfer is effective
193.31 when the receiving facility notifies the commissioner in writing of the number of beds
193.32 accepted. The commissioner shall place all transferred beds on layaway status held in the
193.33 name of the receiving facility. The layaway adjustment provisions of section 256B.431,
193.34 subdivision 30, do not apply to this layaway. The receiving facility may only remove the

194.1 beds from layaway for recertification and relicensure at the receiving facility's current site,
194.2 or at a newly constructed facility located in Anoka County. The receiving facility must
194.3 receive statutory authorization before removing these beds from layaway status, or may
194.4 remove these beds from layaway status if removal from layaway status is part of a
194.5 moratorium exception project approved by the commissioner under section 144A.073.

194.6 Sec. 8. Minnesota Statutes 2018, section 144A.071, subdivision 4c, is amended to read:

194.7 Subd. 4c. **Exceptions for replacement beds after June 30, 2003.** (a) The commissioner
194.8 of health, in coordination with the commissioner of human services, may approve the
194.9 renovation, replacement, upgrading, or relocation of a nursing home or boarding care home,
194.10 under the following conditions:

194.11 (1) to license and certify an 80-bed city-owned facility in Nicollet County to be
194.12 constructed on the site of a new city-owned hospital to replace an existing 85-bed facility
194.13 attached to a hospital that is also being replaced. The threshold allowed for this project
194.14 under section 144A.073 shall be the maximum amount available to pay the additional
194.15 medical assistance costs of the new facility;

194.16 (2) to license and certify 29 beds to be added to an existing 69-bed facility in St. Louis
194.17 County, provided that the 29 beds must be transferred from active or layaway status at an
194.18 existing facility in St. Louis County that had 235 beds on April 1, 2003.

194.19 The licensed capacity at the 235-bed facility must be reduced to 206 beds, but the payment
194.20 rate at that facility shall not be adjusted as a result of this transfer. The operating payment
194.21 rate of the facility adding beds after completion of this project shall be the same as it was
194.22 on the day prior to the day the beds are licensed and certified. This project shall not proceed
194.23 unless it is approved and financed under the provisions of section 144A.073;

194.24 (3) to license and certify a new 60-bed facility in Austin, provided that: (i) 45 of the new
194.25 beds are transferred from a 45-bed facility in Austin under common ownership that is closed
194.26 and 15 of the new beds are transferred from a 182-bed facility in Albert Lea under common
194.27 ownership; (ii) the commissioner of human services is authorized by the 2004 legislature
194.28 to negotiate budget-neutral planned nursing facility closures; and (iii) money is available
194.29 from planned closures of facilities under common ownership to make implementation of
194.30 this clause budget-neutral to the state. The bed capacity of the Albert Lea facility shall be
194.31 reduced to 167 beds following the transfer. Of the 60 beds at the new facility, 20 beds shall
194.32 be used for a special care unit for persons with Alzheimer's disease or related dementias;

195.1 (4) to license and certify up to 80 beds transferred from an existing state-owned nursing
195.2 facility in Cass County to a new facility located on the grounds of the Ah-Gwah-Ching
195.3 campus. The operating cost payment rates for the new facility shall be determined based
195.4 on the interim and settle-up payment provisions of ~~Minnesota Rules, part 9549.0057, section~~
195.5 256R.27 and the reimbursement provisions of chapter 256R. The property payment rate for
195.6 the first three years of operation shall be \$35 per day. For subsequent years, the property
195.7 payment rate of \$35 per day shall be adjusted for inflation as provided in section 256B.434,
195.8 subdivision 4, paragraph (c), as long as the facility has a contract under section 256B.434;

195.9 (5) to initiate a pilot program to license and certify up to 80 beds transferred from an
195.10 existing county-owned nursing facility in Steele County relocated to the site of a new acute
195.11 care facility as part of the county's Communities for a Lifetime comprehensive plan to create
195.12 innovative responses to the aging of its population. Upon relocation to the new site, the
195.13 nursing facility shall delicense 28 beds. The payment rate for external fixed costs for the
195.14 new facility shall be increased by an amount as calculated according to items (i) to (v):

195.15 (i) compute the estimated decrease in medical assistance residents served by the nursing
195.16 facility by multiplying the decrease in licensed beds by the historical percentage of medical
195.17 assistance resident days;

195.18 (ii) compute the annual savings to the medical assistance program from the delicensure
195.19 of 28 beds by multiplying the anticipated decrease in medical assistance residents, determined
195.20 in item (i), by the existing facility's weighted average payment rate multiplied by 365;

195.21 (iii) compute the anticipated annual costs for community-based services by multiplying
195.22 the anticipated decrease in medical assistance residents served by the nursing facility,
195.23 determined in item (i), by the average monthly elderly waiver service costs for individuals
195.24 in Steele County multiplied by 12;

195.25 (iv) subtract the amount in item (iii) from the amount in item (ii);

195.26 (v) divide the amount in item (iv) by an amount equal to the relocated nursing facility's
195.27 occupancy factor under section 256B.431, subdivision 3f, paragraph (c), multiplied by the
195.28 historical percentage of medical assistance resident days; and

195.29 (6) to consolidate and relocate nursing facility beds to a new site in Goodhue County
195.30 and to integrate these services with other community-based programs and services under a
195.31 communities for a lifetime pilot program and comprehensive plan to create innovative
195.32 responses to the aging of its population. Two nursing facilities, one for 84 beds and one for
195.33 65 beds, in the city of Red Wing licensed on July 1, 2015, shall be consolidated into a newly
195.34 renovated 64-bed nursing facility resulting in the delicensure of 85 beds. Notwithstanding

196.1 the carryforward of the approval authority in section 144A.073, subdivision 11, the funding
196.2 approved in April 2009 by the commissioner of health for a project in Goodhue County
196.3 shall not carry forward. The closure of the 85 beds shall not be eligible for a planned closure
196.4 rate adjustment under section 256R.40. The construction project permitted in this clause
196.5 shall not be eligible for a threshold project rate adjustment under section 256B.434,
196.6 subdivision 4f. The payment rate for external fixed costs for the new facility shall be
196.7 increased by an amount as calculated according to items (i) to (vi):

196.8 (i) compute the estimated decrease in medical assistance residents served by both nursing
196.9 facilities by multiplying the difference between the occupied beds of the two nursing facilities
196.10 for the reporting year ending September 30, 2009, and the projected occupancy of the facility
196.11 at 95 percent occupancy by the historical percentage of medical assistance resident days;

196.12 (ii) compute the annual savings to the medical assistance program from the delicensure
196.13 by multiplying the anticipated decrease in the medical assistance residents, determined in
196.14 item (i), by the hospital-owned nursing facility weighted average payment rate multiplied
196.15 by 365;

196.16 (iii) compute the anticipated annual costs for community-based services by multiplying
196.17 the anticipated decrease in medical assistance residents served by the facilities, determined
196.18 in item (i), by the average monthly elderly waiver service costs for individuals in Goodhue
196.19 County multiplied by 12;

196.20 (iv) subtract the amount in item (iii) from the amount in item (ii);

196.21 (v) multiply the amount in item (iv) by 57.2 percent; and

196.22 (vi) divide the difference of the amount in item (iv) and the amount in item (v) by an
196.23 amount equal to the relocated nursing facility's occupancy factor under section 256B.431,
196.24 subdivision 3f, paragraph (c), multiplied by the historical percentage of medical assistance
196.25 resident days.

196.26 (b) Projects approved under this subdivision shall be treated in a manner equivalent to
196.27 projects approved under subdivision 4a.

196.28 Sec. 9. Minnesota Statutes 2018, section 144A.071, subdivision 5a, is amended to read:

196.29 Subd. 5a. **Cost estimate of a moratorium exception project.** ~~(a)~~ For the purposes of
196.30 this section and section 144A.073, the cost estimate of a moratorium exception project shall
196.31 include the effects of the proposed project on the costs of the state subsidy for
196.32 community-based services, nursing services, and housing in institutional and noninstitutional
196.33 settings. The commissioner of health, in cooperation with the commissioner of human

197.1 services, shall define the method for estimating these costs in the permanent rule
 197.2 implementing section 144A.073. The commissioner of human services shall prepare an
 197.3 estimate of the property-related payment rate to be established upon completion of the
 197.4 project and total state annual long-term costs of each moratorium exception proposal. The
 197.5 property-related payment rate estimate shall be made using the actual cost of the project
 197.6 but the final property rate must be based on the appraisal and subject to the limitations in
 197.7 section 256R.26, subdivision 6.

197.8 ~~(b) The interest rate to be used for estimating the cost of each moratorium exception~~
 197.9 ~~project proposal shall be the lesser of either the prime rate plus two percentage points, or~~
 197.10 ~~the posted yield for standard conventional fixed rate mortgages of the Federal Home Loan~~
 197.11 ~~Mortgage Corporation plus two percentage points as published in the Wall Street Journal~~
 197.12 ~~and in effect 56 days prior to the application deadline. If the applicant's proposal uses this~~
 197.13 ~~interest rate, the commissioner of human services, in determining the facility's actual~~
 197.14 ~~property-related payment rate to be established upon completion of the project must use the~~
 197.15 ~~actual interest rate obtained by the facility for the project's permanent financing up to the~~
 197.16 ~~maximum permitted under Minnesota Rules, part 9549.0060, subpart 6.~~

197.17 ~~The applicant may choose an alternate interest rate for estimating the project's cost. If~~
 197.18 ~~the applicant makes this election, the commissioner of human services, in determining the~~
 197.19 ~~facility's actual property-related payment rate to be established upon completion of the~~
 197.20 ~~project, must use the lesser of the actual interest rate obtained for the project's permanent~~
 197.21 ~~financing or the interest rate which was used to estimate the proposal's project cost. For~~
 197.22 ~~succeeding rate years, the applicant is at risk for financing costs in excess of the interest~~
 197.23 ~~rate selected.~~

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

197.25 Sec. 10. Minnesota Statutes 2018, section 144A.073, subdivision 3c, is amended to read:

197.26 Subd. 3c. **Cost-neutral Relocation projects.** ~~(a)~~ Notwithstanding subdivision 3, the
 197.27 commissioner may at any time accept proposals, or amendments to proposals previously
 197.28 approved under this section, for relocations ~~that are cost neutral with respect to state costs~~
 197.29 ~~as defined in section 144A.071, subdivision 5a.~~ The commissioner, in consultation with the
 197.30 commissioner of human services, shall evaluate proposals according to subdivision 4a,
 197.31 clauses (1), (4), (5), (6), and (8), and other criteria established in rule or law. ~~The~~
 197.32 ~~commissioner of human services shall determine the allowable payment rates of the facility~~
 197.33 ~~receiving the beds in accordance with section 256R.50.~~ The commissioner shall approve or
 197.34 disapprove a project within 90 days.

198.1 ~~(b) For the purposes of paragraph (a), cost neutrality shall be measured over the first~~
 198.2 ~~three 12-month periods of operation after completion of the project.~~

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

198.4 Sec. 11. Minnesota Statutes 2018, section 256B.434, subdivision 1, is amended to read:

198.5 Subdivision 1. ~~Alternative payment demonstration project established~~ Contractual
 198.6 agreements. ~~The commissioner of human services shall establish a contractual alternative~~
 198.7 ~~payment demonstration project for paying for nursing facility services under the medical~~
 198.8 ~~assistance program. A nursing facility may apply to be paid under the contractual alternative~~
 198.9 ~~payment demonstration project instead of the cost-based payment system established under~~
 198.10 ~~section 256B.431. A nursing facility~~ Nursing facilities located in Minnesota ~~electing to use~~
 198.11 ~~the alternative payment demonstration project~~ enroll as a medical assistance provider ~~must~~
 198.12 ~~enter into a contract with the commissioner. Payment rates and procedures for facilities~~
 198.13 ~~electing to use the alternative payment demonstration project are determined and governed~~
 198.14 ~~by this section and by the terms of the contract. The commissioner may negotiate different~~
 198.15 ~~contract terms for different nursing facilities.~~

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

198.17 Sec. 12. Minnesota Statutes 2018, section 256B.434, subdivision 3, is amended to read:

198.18 Subd. 3. **Duration and termination of contracts.** ~~(a) Subject to available resources,~~
 198.19 ~~the commissioner may begin to execute contracts with nursing facilities November 1, 1995.~~

198.20 ~~(b)~~ (a) All contracts entered into under this section are for a term not to exceed four
 198.21 years. Either party may terminate a contract at any time without cause by providing 90
 198.22 calendar days advance written notice to the other party. The decision to terminate a contract
 198.23 is not appealable. ~~Notwithstanding section 16C.05, subdivision 2, paragraph (a), clause (5),~~
 198.24 ~~the contract shall be renegotiated for additional terms of up to four years, unless either party~~
 198.25 ~~provides written notice of termination.~~ The provisions of the contract shall be renegotiated
 198.26 at a minimum of every four years by the parties prior to the expiration date of the contract.
 198.27 The parties may voluntarily ~~renegotiate~~ amend the terms of the contract at any time by
 198.28 mutual agreement.

198.29 ~~(e)~~ (b) If a nursing facility fails to comply with the terms of a contract, the commissioner
 198.30 shall provide reasonable notice regarding the breach of contract and a reasonable opportunity
 198.31 for the facility to come into compliance. If the facility fails to come into compliance or to
 198.32 remain in compliance, the commissioner may terminate the contract. ~~If a contract is~~

199.1 ~~terminated, the contract payment remains in effect for the remainder of the rate year in~~
 199.2 ~~which the contract was terminated, but in all other respects the provisions of this section~~
 199.3 ~~do not apply to that facility effective the date the contract is terminated. The contract shall~~
 199.4 ~~contain a provision governing the transition back to the cost-based reimbursement system~~
 199.5 ~~established under section 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080.~~
 199.6 ~~A contract entered into under this section may be amended by mutual agreement of the~~
 199.7 ~~parties.~~

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

199.9 Sec. 13. **[256M.42] ADULT PROTECTION GRANT ALLOCATIONS.**

199.10 Subdivision 1. **Formula.** (a) The commissioner shall allocate state money appropriated
 199.11 under this section to each county board and tribal government approved by the commissioner
 199.12 to assume county agency duties for adult protective services or as a lead investigative agency
 199.13 under section 626.557 on an annual basis in an amount determined according to the following
 199.14 formula:

199.15 (1) 25 percent must be allocated on the basis of the number of reports of suspected
 199.16 vulnerable adult maltreatment under sections 626.557 and 626.5572, when the county or
 199.17 tribe is responsible as determined by the most recent data of the commissioner; and

199.18 (2) 75 percent must be allocated on the basis of the number of screened-in reports for
 199.19 adult protective services or vulnerable adult maltreatment investigations under sections
 199.20 626.557 and 626.5572, when the county or tribe is responsible as determined by the most
 199.21 recent data of the commissioner.

199.22 (b) The commissioner is precluded from changing the formula under this subdivision
 199.23 or recommending a change to the legislature without public review and input.

199.24 Subd. 2. **Payment.** The commissioner shall make allocations under subdivision 1 to
 199.25 each county board or tribal government each year on or before July 10.

199.26 Subd. 3. **Prohibition on supplanting existing money.** Money received under this section
 199.27 must be used for staffing for protection of vulnerable adults or to expand adult protective
 199.28 services. Money must not be used to supplant current county or tribe expenditures for these
 199.29 purposes.

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

200.1 Sec. 14. Minnesota Statutes 2018, section 256R.02, subdivision 8, is amended to read:

200.2 Subd. 8. **Capital assets.** "Capital assets" means a nursing facility's buildings, ~~attached~~
 200.3 ~~fixtures~~ fixed equipment, land improvements, leasehold improvements, and all additions to
 200.4 or replacements of those assets used directly for resident care.

200.5 Sec. 15. Minnesota Statutes 2018, section 256R.02, subdivision 19, is amended to read:

200.6 Subd. 19. **External fixed costs.** "External fixed costs" means costs related to the nursing
 200.7 home surcharge under section 256.9657, subdivision 1; licensure fees under section 144.122;
 200.8 family advisory council fee under section 144A.33; scholarships under section 256R.37;
 200.9 ~~planned closure rate adjustments under section 256R.40; consolidation rate adjustments~~
 200.10 ~~under section 144A.071, subdivisions 4c, paragraph (a), clauses (5) and (6), and 4d;~~
 200.11 ~~single-bed room incentives under section 256R.41;~~ property taxes, special assessments, and
 200.12 payments in lieu of taxes; employer health insurance costs; quality improvement incentive
 200.13 payment rate adjustments under section 256R.39; performance-based incentive payments
 200.14 under section 256R.38; special dietary needs under section 256R.51; rate adjustments for
 200.15 compensation-related costs for minimum wage changes under section 256R.49 provided
 200.16 on or after January 1, 2018; and Public Employees Retirement Association employer costs.

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

200.18 Sec. 16. Minnesota Statutes 2018, section 256R.02, is amended by adding a subdivision
 200.19 to read:

200.20 Subd. 25a. **Interim payment rates.** "Interim payment rates" means the total operating
 200.21 and external fixed costs payment rates determined by anticipated costs and resident days
 200.22 reported on an interim cost report as described in section 256R.27.

200.23 Sec. 17. Minnesota Statutes 2018, section 256R.02, is amended by adding a subdivision
 200.24 to read:

200.25 Subd. 47a. **Settle up payment rates.** "Settle up payment rates" means the total operating
 200.26 and external fixed costs payment rates determined by actual allowable costs and resident
 200.27 days reported on a settle up cost report as described under section 256R.27.

200.28 Sec. 18. Minnesota Statutes 2018, section 256R.08, subdivision 1, is amended to read:

200.29 Subdivision 1. **Reporting of financial statements.** (a) No later than February 1 of each
 200.30 year, a nursing facility shall:

201.1 (1) provide the state agency with a copy of its audited financial statements or its working
201.2 trial balance;

201.3 (2) provide the state agency with a statement of ownership for the facility;

201.4 (3) provide the state agency with separate, audited financial statements or working trial
201.5 balances for every other facility owned in whole or in part by an individual or entity that
201.6 has an ownership interest in the facility;

201.7 (4) provide the state agency with information regarding whether the licensee, or a general
201.8 partner, director, or officer of the licensee, has an ownership or control interest of five
201.9 percent or more in a related party or related organization that provides any service to the
201.10 skilled nursing facility. If the licensee, or the general partner, director, or officer of the
201.11 licensee has such an interest, the licensee shall disclose all services provided to the skilled
201.12 nursing facility, the number of individuals who provide that service at the skilled nursing
201.13 facility, and any other information requested by the state agency. If goods, fees, and services
201.14 collectively worth \$10,000 or more per year are delivered to the skilled nursing facility, the
201.15 disclosure required pursuant to this subdivision shall include the related party and related
201.16 organization profit and loss statement, and the Payroll-Based Journal public use data;

201.17 ~~(4)~~ (5) upon request, provide the state agency with separate, audited financial statements
201.18 or working trial balances for every organization with which the facility conducts business
201.19 and which is owned in whole or in part by an individual or entity which has an ownership
201.20 interest in the facility;

201.21 ~~(5)~~ (6) provide the state agency with copies of leases, purchase agreements, and other
201.22 documents related to the lease or purchase of the nursing facility; and

201.23 ~~(6)~~ (7) upon request, provide the state agency with copies of leases, purchase agreements,
201.24 and other documents related to the acquisition of equipment, goods, and services which are
201.25 claimed as allowable costs.

201.26 (b) Audited financial statements submitted under paragraph (a) must include a balance
201.27 sheet, income statement, statement of the rate or rates charged to private paying residents,
201.28 statement of retained earnings, statement of cash flows, notes to the financial statements,
201.29 audited applicable supplemental information, and the public accountant's report. Public
201.30 accountants must conduct audits in accordance with chapter 326A. The cost of an audit
201.31 shall not be an allowable cost unless the nursing facility submits its audited financial
201.32 statements in the manner otherwise specified in this subdivision. A nursing facility must
201.33 permit access by the state agency to the public accountant's audit work papers that support
201.34 the audited financial statements submitted under paragraph (a).

202.1 (c) Documents or information provided to the state agency pursuant to this subdivision
202.2 shall be public.

202.3 (d) If the requirements of paragraphs (a) and (b) are not met, the reimbursement rate
202.4 may be reduced to 80 percent of the rate in effect on the first day of the fourth calendar
202.5 month after the close of the reporting period and the reduction shall continue until the
202.6 requirements are met.

202.7 (e) Licensees shall provide the information required in this section to the commissioner
202.8 in a manner prescribed by the commissioner.

202.9 (f) For purposes of this section, the following terms have the meanings given:

202.10 (1) "profit and loss statement" means the most recent annual statement on profits and
202.11 losses finalized by a related party for the most recent year available; and

202.12 (2) "related party" means an organization related to the licensee provider or that is under
202.13 common ownership or control, as defined in Code of Federal Regulations, title 42, section
202.14 413.17(b).

202.15 **EFFECTIVE DATE.** This section is effective November 1, 2019.

202.16 Sec. 19. Minnesota Statutes 2018, section 256R.10, is amended by adding a subdivision
202.17 to read:

202.18 **Subd. 8. Pilot projects for energy-related programs.** (a) The commissioner shall
202.19 develop a pilot project to reduce overall energy consumption and evaluate the financial
202.20 impacts associated with property assessed clean energy (PACE) approved projects in nursing
202.21 facilities.

202.22 (b) Notwithstanding section 256R.02, subdivision 48a, the commissioner may make
202.23 payments to facilities for the allowable costs of special assessments for approved
202.24 energy-related program payments authorized under sections 216C.435 and 216C.436. The
202.25 commissioner shall limit the amount of any payment and the number of contract amendments
202.26 under this subdivision to operate the energy-related program within funds appropriated for
202.27 this purpose.

202.28 (c) The commissioner shall approve proposals through a contract which shall specify
202.29 the level of payment, provided that each facility demonstrates:

202.30 (1) completion of a facility-specific energy assessment or energy audit and recommended
202.31 energy conservation measures that, in aggregate, meet the cost-effectiveness requirements
202.32 of section 216B.241;

203.1 (2) a completed PACE application and recommended approval by a PACE program
203.2 administrator authorized under sections 216C.435 and 216C.436; and

203.3 (3) the facility's reported spending on utilities per resident day since calendar year 2016
203.4 is higher than average for similar facilities.

203.5 (d) Payments to facilities under this subdivision shall be in the form of time-limited rate
203.6 adjustments which shall be included in the external fixed costs payment rate under section
203.7 256R.25. The commissioner shall select from facilities which meet the requirements of
203.8 paragraph (c) using a competitive application process.

203.9 (e) Allowable costs for special assessments for approved energy-related program
203.10 payments cannot exceed the amount of debt service for net expenditures for the project and
203.11 must meet the cost-effective energy improvements requirements described in section
203.12 216C.435, subdivision 3a. Any credits or rebates related to the project must be offset. A
203.13 project cost is not an allowable cost on the cost report as a special assessment if it has been
203.14 or will be used to increase the facility's property rate.

203.15 (f) The external fixed costs payment rate for the PACE allowable costs shall be reduced
203.16 by an amount equal to the utility per diem included in the other operating payment rate
203.17 under section 256R.24, that is associated with the energy project.

203.18 Sec. 20. Minnesota Statutes 2018, section 256R.16, subdivision 1, is amended to read:

203.19 Subdivision 1. **Calculation of a quality score.** (a) The commissioner shall determine
203.20 a quality score for each nursing facility using quality measures established in section
203.21 256B.439, according to methods determined by the commissioner in consultation with
203.22 stakeholders and experts, and using the most recently available data as provided in the
203.23 Minnesota Nursing Home Report Card. These methods shall be exempt from the rulemaking
203.24 requirements under chapter 14.

203.25 (b) For each quality measure, a score shall be determined with the number of points
203.26 assigned as determined by the commissioner using the methodology established according
203.27 to this subdivision. The determination of the quality measures to be used and the methods
203.28 of calculating scores may be revised annually by the commissioner.

203.29 (c) The quality score shall include up to 50 points related to the Minnesota quality
203.30 indicators score derived from the minimum data set, up to 40 points related to the resident
203.31 quality of life score derived from the consumer survey conducted under section 256B.439,
203.32 subdivision 3, and up to ten points related to the state inspection results score.

204.1 (d) The commissioner, in cooperation with the commissioner of health, may adjust the
 204.2 formula in paragraph (c), or the methodology for computing the total quality score, ~~effective~~
 204.3 ~~July 1 of any year~~, with five months advance public notice. In changing the formula, the
 204.4 commissioner shall consider quality measure priorities registered by report card users, advice
 204.5 of stakeholders, and available research.

204.6 Sec. 21. Minnesota Statutes 2018, section 256R.21, is amended by adding a subdivision
 204.7 to read:

204.8 Subd. 5. **Total payment rate for new facilities.** For a new nursing facility created under
 204.9 section 144A.073, subdivision 3c, the total payment rate must be determined according to
 204.10 this section, except:

204.11 (1) the direct care payment rate used in subdivision 2, clause (1), must be determined
 204.12 according to section 256R.27;

204.13 (2) the other care-related payment rate used in subdivision 2, clause (2), must be
 204.14 determined according to section 256R.27;

204.15 (3) the external fixed costs payment rate used in subdivision 4, clause (2), must be
 204.16 determined according to section 256R.27; and

204.17 (4) the property payment rate used in subdivision 4, clause (3), must be determined
 204.18 according to section 256R.26.

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

204.20 Sec. 22. Minnesota Statutes 2018, section 256R.23, subdivision 5, is amended to read:

204.21 Subd. 5. **Determination of total care-related payment rate limits.** The commissioner
 204.22 must determine each facility's total care-related payment rate limit by:

204.23 (1) multiplying the facility's quality score, as determined under section 256R.16,
 204.24 subdivision 1, paragraph (d), by ~~0.5625~~ 2.0;

204.25 (2) ~~adding 89.375 to~~ subtracting 40.0 from the amount determined in clause (1), and
 204.26 dividing the total by 100; ~~and~~

204.27 (3) multiplying the amount determined in clause (2) by the median total care-related
 204.28 cost per day-; and

204.29 (4) multiplying the amount determined in clause (3) by the most-recent available
 204.30 Core-Based Statistical Area wage indices established by the Centers for Medicare and
 204.31 Medicaid Services for the Skilled Nursing Facility Prospective Payment System.

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

205.2 Sec. 23. Minnesota Statutes 2018, section 256R.24, is amended to read:

205.3 **256R.24 OTHER OPERATING PAYMENT RATE.**

205.4 Subdivision 1. **Determination of ~~other operating~~ laundry, housekeeping, and dietary**
205.5 **cost per day.** Each facility's ~~other operating~~ laundry, housekeeping, and dietary cost per
205.6 day is ~~its other operating~~ equal to its laundry, housekeeping, and dietary costs divided by
205.7 the sum of the facility's resident days.

205.8 Subd. 2. **Determination of the ~~median other operating cost per day~~ medians.** The
205.9 commissioner must determine the laundry, housekeeping, and dietary median ~~other operating~~
205.10 cost per resident day using the cost reports from nursing facilities in Anoka, Carver, Dakota,
205.11 Hennepin, Ramsey, Scott, and Washington Counties.

205.12 Subd. 3. **Determination of the ~~other operating~~ payment rate for laundry,**
205.13 **housekeeping, and dietary.** A facility's ~~other operating~~ payment rate for laundry,
205.14 housekeeping, and dietary equals 105 percent of the median ~~other operating cost per day~~
205.15 for laundry, housekeeping, and dietary cost as determined in subdivision 2.

205.16 Subd. 4. **Administrative, maintenance, and plant operations.** (a) The payment rate
205.17 for administrative, maintenance, and plant operations is \$48.57 per day effective January
205.18 1, 2020. For the rate period January 1, 2021, through December 31, 2023, this payment rate
205.19 is increased by one percent annually on January 1.

205.20 (b) For rate years beginning on and after January 1, 2024, this payment rate is adjusted
205.21 by a forecasting market basket and forecasting index. The adjustment factor must come
205.22 from the Information Handling Services Healthcare Cost Review, the Skilled Nursing
205.23 Facility Total Market Basket Index, and the four-quarter moving average percentage change
205.24 line or a comparable index if this index ceases to be published. The commissioner shall use
205.25 the fourth quarter index of the upcoming calendar year from the forecast published for the
205.26 third quarter of the calendar year immediately prior to the rate year for which the rate is
205.27 being determined.

205.28 Subd. 5. **Determination of the other operating payment rate.** A facility's other
205.29 operating payment rate equals the sum of the factors determined in subdivisions 3 and 4.

206.1 Sec. 24. Minnesota Statutes 2018, section 256R.25, is amended to read:

206.2 **256R.25 EXTERNAL FIXED COSTS PAYMENT RATE.**

206.3 (a) The payment rate for external fixed costs is the sum of the amounts in paragraphs
206.4 (b) to ~~(n)~~ (k).

206.5 (b) For a facility licensed as a nursing home, the portion related to the provider surcharge
206.6 under section 256.9657 is equal to \$8.86 per resident day. For a facility licensed as both a
206.7 nursing home and a boarding care home, the portion related to the provider surcharge under
206.8 section 256.9657 is equal to \$8.86 per resident day multiplied by the result of its number
206.9 of nursing home beds divided by its total number of licensed beds.

206.10 (c) The portion related to the licensure fee under section 144.122, paragraph (d), is the
206.11 amount of the fee divided by the sum of the facility's resident days.

206.12 (d) The portion related to development and education of resident and family advisory
206.13 councils under section 144A.33 is \$5 per resident day divided by 365.

206.14 (e) The portion related to scholarships is determined under section 256R.37.

206.15 ~~(f) The portion related to planned closure rate adjustments is as determined under section~~
206.16 ~~256R.40, subdivision 5, and Minnesota Statutes 2010, section 256B.436.~~

206.17 ~~(g) The portion related to consolidation rate adjustments shall be as determined under~~
206.18 ~~section 144A.071, subdivisions 4c, paragraph (a), clauses (5) and (6), and 4d.~~

206.19 ~~(h) The portion related to single-bed room incentives is as determined under section~~
206.20 ~~256R.41.~~

206.21 ~~(i)~~ (f) The portions related to real estate taxes, special assessments, and payments made
206.22 in lieu of real estate taxes directly identified or allocated to the nursing facility are the ~~actual~~
206.23 allowable amounts divided by the sum of the facility's resident days. Allowable costs under
206.24 this paragraph for payments made by a nonprofit nursing facility that are in lieu of real
206.25 estate taxes shall not exceed the amount which the nursing facility would have paid to a
206.26 city or township and county for fire, police, sanitation services, and road maintenance costs
206.27 had real estate taxes been levied on that property for those purposes.

206.28 ~~(j)~~ (g) The portion related to employer health insurance costs is the allowable costs
206.29 divided by the sum of the facility's resident days.

206.30 ~~(k)~~ (h) The portion related to the Public Employees Retirement Association is ~~actual~~
206.31 allowable costs divided by the sum of the facility's resident days.

207.1 ~~(h)~~ (i) The portion related to quality improvement incentive payment rate adjustments
 207.2 is the amount determined under section 256R.39.

207.3 ~~(m)~~ (j) The portion related to performance-based incentive payments is the amount
 207.4 determined under section 256R.38.

207.5 ~~(n)~~ (k) The portion related to special dietary needs is the amount determined under
 207.6 section 256R.51.

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

207.8 Sec. 25. Minnesota Statutes 2018, section 256R.26, is amended to read:

207.9 **256R.26 PROPERTY PAYMENT RATE.**

207.10 Subdivision 1. Generally. The property payment rate for a nursing facility is the property
 207.11 rate established for the facility under sections 256B.431 and 256B.434. (a) For rate years
 207.12 beginning on or after January 1, 2020, the commissioner shall reimburse nursing facilities
 207.13 participating in the medical assistance program for the rental use of real estate and depreciable
 207.14 assets according to this section and sections 256R.261 to 256R.27. The property payment
 207.15 rate made under this methodology is the only payment for costs related to capital assets,
 207.16 including depreciation expense, interest and lease expenses for all depreciable assets, also
 207.17 including depreciable movable equipment, land improvements, and land.

207.18 (b) The commercial valuation system selected by the commissioner must be utilized in
 207.19 all appraisals. The appraisal is not intended to exactly reflect market value, and no
 207.20 adjustments or substitutions are permitted for any alternative analysis of properties than the
 207.21 selected commercial valuation system.

207.22 (c) Based on the valuation of a building and fixed equipment, the property appraisal
 207.23 firm selected by the commissioner must produce a report detailing both the depreciated
 207.24 replacement cost (DRC) and undepreciated replacement cost (URC) of the nursing facility.
 207.25 The valuation excludes depreciable movable equipment, land, or land improvements. The
 207.26 valuation must be adjusted for any shared area included in the DRC and URC not used for
 207.27 nursing facility purposes. Physical plant for central office operations is not included in the
 207.28 appraisal.

207.29 (d) The appraisal initially may include the full value of all shared areas. The DRC, URC,
 207.30 and square footage are established by an appraisal and must be adjusted to reflect only the
 207.31 nursing facility usage of shared areas in the final nursing facility values. The adjustment
 207.32 must be based on a Medicare-approved allocation basis for the type of service provided by

208.1 each area. Shared areas outside the appraised space must be added to the DRC, URC, and
208.2 related square footage using the average of each value from the space in the appraisal.

208.3 Subd. 2. **Appraised value.** For rate years beginning on or after January 1, 2020, the
208.4 DRC and URC are based on the appraisals of a building and attached fixtures as determined
208.5 by the contracted property appraisal firm using a commercial valuation system selected by
208.6 the commissioner.

208.7 Subd. 3. **Initial rate year.** The property payment rate calculated under section 256R.265
208.8 for the initial rate year effective January 1, 2020, must be a per diem amount based on the
208.9 DRC and URC of a nursing facility's building and attached fixtures, as estimated by a
208.10 commercial property appraisal firm in 2016. The initial values for both the DRC and URC,
208.11 adjusted for nonnursing facility space, must be increased by six percent.

208.12 Subd. 4. **Subsequent rate years.** (a) Beginning in calendar year 2020, the commissioner
208.13 shall contract with a property appraisal firm to appraise the building and attached fixtures
208.14 for nursing facilities using the commercial valuation system. Approximately one-third of
208.15 the nursing facilities must be appraised each year.

208.16 (b) If a nursing facility wishes to appeal findings of fact in the appraisal report, the
208.17 nursing facility must request a revision within 20 calendar days after receipt of the appraisal
208.18 report.

208.19 (c) The property payment rate for rate year beginning January 1, 2021, for the one-third
208.20 of nursing facilities that are newly appraised in 2020 must be based upon new DRCs and
208.21 URCs for buildings and attached fixtures as determined by the contracted property appraisal
208.22 firm.

208.23 (d) The property payment rate for rate years beginning January 1, 2021, and January 1,
208.24 2022, for the remainder of the nursing facilities that were not previously appraised, must
208.25 use the net DRC and URC used in the January 1, 2020, property payment rates adjusted for
208.26 inflation before any formula limitations are applied. The index for the inflation adjustment
208.27 must be based on the change in the United States All-Items Consumer Price Index (CPI-U)
208.28 forecasted by the Reports and Forecasts Division of the Department of Human Services in
208.29 the third quarter of the calendar year preceding the rate year. The inflation adjustment must
208.30 be based on the 12-month period from the midpoint of the previous rate year to the midpoint
208.31 of the rate year for which the rate is being determined. Nursing facilities under this paragraph
208.32 must have the property payment rates beginning January 1, 2022, and January 1, 2023,
208.33 based on new replacement costs and depreciated values as determined in appraisals based
208.34 on the three-year cycle.

209.1 (e) For the nursing facilities that have an on-site property appraisal conducted by the
209.2 commissioner's designee after the initial 2016 appraisal, the most recent appraisal must be
209.3 used in subsequent years until a new on-site property appraisal is conducted. In the years
209.4 after the initial appraisal, the most recent DRC and URC must be updated through the
209.5 commercial valuation system. These valuations are updates only and not subject to revisions
209.6 of any of the original valuations or appeal by the nursing facility.

209.7 Subd. 5. **Special reappraisals.** (a) A nursing facility that completes an addition to or
209.8 replacement of a building or attached fixtures as approved in section 144A.073 after January
209.9 1, 2020, may request a property rate adjustment effective the first of January, April, July,
209.10 or October after project completion. The nursing facility must submit all cost data related
209.11 to the project to the commissioner within 90 days of project completion. The commissioner
209.12 must add the nursing facility to the next group of scheduled appraisals. The nursing facility's
209.13 updated appraisal must be used to calculate a revised property rate effective the first of
209.14 January, April, July, or October after project completion. If an updated appraisal cannot be
209.15 scheduled within 90 days of the effective date of the revised property, the commissioner
209.16 must establish an interim valuation which must be adjusted retroactively when the updated
209.17 appraisal is available. For a nursing facility with projects approved under section 144A.073
209.18 prior to January 1, 2020, moratorium project construction adjustments must be calculated
209.19 under Minnesota Statutes 2018, section 256B.434, subdivision 4f, and the adjustment added
209.20 to the nursing facility's hold harmless rate effective the first of January, April, July, or
209.21 October after project completion. This adjustment is in addition to the updated appraisal
209.22 described in this paragraph.

209.23 (b) A nursing facility that completes a threshold construction project after January 1,
209.24 2020, may submit a project rate adjustment request to the commissioner if the building
209.25 improvement or addition costs exceed \$300,000 and the threshold construction project is
209.26 not reflected in an appraisal used for rate setting. The cost must be incurred by the nursing
209.27 facility, or if the nursing facility is leased and the cost is incurred by the lease holder, the
209.28 provider's lease has been increased for the project. Threshold project costs exceeding a total
209.29 of \$1,500,000 within a three-year period, or a prorated amount if the appraisals are less than
209.30 three years apart, must not be recognized. The property payment rate must be updated to
209.31 reflect the new DRC and URC values effective the first of January or July after project
209.32 completion. In subsequent property payment rate calculations, an addition to the DRC and
209.33 URC must be eliminated once a full appraisal is complete for the nursing facility after project
209.34 completion. At the option of the commissioner, the appraisal schedule may be adjusted for

210.1 nursing facilities completing threshold projects. Threshold project costs are not considered
210.2 if the costs were incurred prior to the date of the last appraisal.

210.3 (c) Effective January 1, 2020, a nursing facility new to the medical assistance program
210.4 must have the building and fixed equipment appraised by the property appraisal firm upon
210.5 completion of construction of the nursing facility, or, if not newly constructed, upon entering
210.6 the medical assistance program. If an appraisal cannot be scheduled within 90 days of the
210.7 certification date, the commissioner must establish an interim valuation to be adjusted
210.8 retroactively when the appraisal is available.

210.9 Subd. 6. **Limitation on appraisal valuations.** Effective for appraisals conducted on or
210.10 after January 1, 2020, the increase in the URC is limited to \$500,000 per year since the last
210.11 completed appraisal plus any completed project costs approved under section 144A.073.
210.12 Any limitation to the URC must be applied in the same proportion to the DRC.

210.13 Subd. 7. **Total hold harmless rate.** (a) Total hold harmless rate includes planned closure
210.14 adjustments under Minnesota Statutes 2018, section 256R.40, subdivision 5; consolidation
210.15 adjustments under section 144A.071, subdivisions 4c, paragraph (a), clauses (5) and (6),
210.16 and 4d; equity incentives under sections 256B.431, subdivision 16, and Minnesota Statutes
210.17 2018, 256B.434, subdivision 4f; single-bed incentives under Minnesota Statutes 2018,
210.18 section 256R.41; project construction costs under Minnesota Statutes 2018, section 144A.071,
210.19 subdivision 1a, paragraph (j); and all components of the property payment rate under section
210.20 256R.26 in effect on December 31, 2019.

210.21 (b) For moratorium projects as defined under sections 144A.071 and 144A.073 that are
210.22 eligible for rate adjustments approved prior to January 1, 2020, but not reflected in the rate
210.23 on December 31, 2019, the moratorium rate adjustments determined under Minnesota
210.24 Statutes 2018, sections 256B.431, subdivisions 3f, 17, 17a, 17c, 17d, 17e, 21, 30, and 45,
210.25 and 256B.434, subdivisions 4f and 4j, must be added to the total hold harmless rate in effect
210.26 on the first of January, April, July, or October after project completion.

210.27 (c) Effective January 1, 2020, rate adjustments under Minnesota Statutes 2018, section
210.28 256R.25, paragraphs (f) to (h) from previous rate years shall be included in the total hold
210.29 harmless rate.

210.30 (d) This subdivision expires effective January 1, 2026.

210.31 Subd. 8. **Phase out of hold harmless rate.** (a) For a nursing facility that has a higher
210.32 total hold harmless rate than the rate calculated in section 256R.265, the nursing facility
210.33 must receive 100 percent of the total hold harmless rate for the rate year beginning January
210.34 1, 2020.

211.1 (b) For rate years beginning January 1, 2021, to January 1, 2024, the property payment
 211.2 rate is a blending of the total hold harmless rate and the property rate determined in section
 211.3 256R.265, plus any adjustments issued for construction projects between appraisals, if a
 211.4 higher rate results. If not, the property payment rate is determined according to section
 211.5 256R.265.

211.6 (c) For the rate year beginning January 1, 2021, for eligible nursing facilities, the property
 211.7 payment rate is 80 percent of the total hold harmless rate and 20 percent of the property
 211.8 payment rate calculated in section 256R.265.

211.9 (d) For the rate year beginning January 1, 2022, for eligible nursing facilities, the property
 211.10 payment rate is 60 percent of the total hold harmless rate and 40 percent of the property
 211.11 payment rate calculated in section 256R.265.

211.12 (e) For the rate year beginning January 1, 2023, for eligible nursing facilities, the property
 211.13 payment rate is 40 percent of the total hold harmless rate and 60 percent of the property
 211.14 payment rate calculated in section 256R.265.

211.15 (f) For the rate year beginning January 1, 2024, for eligible nursing facilities, the property
 211.16 payment rate is 20 percent of the total hold harmless rate and 80 percent of the property
 211.17 payment rate calculated in section 256R.265.

211.18 (g) For rate years beginning January 1, 2025, and thereafter, the property payment rate
 211.19 is as calculated under section 256R.265.

211.20 (h) This subdivision expires effective January 1, 2026.

211.21 **Sec. 26. [256R.261] NURSING FACILITY PROPERTY RATE DEFINITIONS.**

211.22 Subdivision 1. **Definitions.** For purposes of sections 256R.26 to 256R.27, the following
 211.23 terms have the meanings given them.

211.24 Subd. 2. **Addition.** "Addition" means an extension, enlargement, or expansion of the
 211.25 nursing facility for the purpose of increasing the number of licensed beds or improving
 211.26 resident care.

211.27 Subd. 3. **Appraisal.** "Appraisal" means an evaluation of the nursing facility's physical
 211.28 real estate conducted by a property appraisal firm selected by the commissioner to establish
 211.29 the valuation of a building and fixed equipment.

211.30 Subd. 4. **Building.** "Building" means the physical plant and fixed equipment used directly
 211.31 for resident care and licensed under chapter 144A or sections 144.50 to 144.56. Building
 211.32 excludes buildings or portions of buildings used by central, affiliated, or corporate offices.

212.1 Subd. 5. **Commercial valuation system.** "Commercial valuation system" means a
212.2 commercially available building valuation system selected by the commissioner.

212.3 Subd. 6. **Depreciable movable equipment.** "Depreciable movable equipment" means
212.4 the standard movable care equipment and support service equipment generally used in
212.5 nursing facilities. Depreciable movable equipment includes equipment specified in the major
212.6 movable equipment table of the depreciation guidelines. The general characteristics of this
212.7 equipment are: (1) a relatively fixed location in the building; (2) capable of being moved
212.8 as distinguished from building equipment; (3) a unit cost sufficient to justify ledger control;
212.9 and (4) sufficient size and identity to make control feasible by means of identification tags.

212.10 Subd. 7. **Depreciated replacement cost or DRC.** "Depreciated replacement cost" or
212.11 "DRC" means the depreciated replacement cost determined by an appraisal using the
212.12 commercial valuation system. DRC excludes costs related to parking structures.

212.13 Subd. 8. **Depreciation expense.** "Depreciation expense" means the portion of a capital
212.14 asset deemed to be consumed or expired over the life of the asset.

212.15 Subd. 9. **Depreciation guidelines.** "Depreciation guidelines" means the most recent
212.16 publication of "Estimated Useful Lives of Depreciable Hospital Assets" issued by the
212.17 American Hospital Association.

212.18 Subd. 10. **Equipment allowance.** "Equipment allowance" means the component of the
212.19 property-related payment rate which is a payment for the use of depreciable movable
212.20 equipment.

212.21 Subd. 11. **Fair rental value system.** "Fair rental value system" means a system that
212.22 establishes a price for the use of a space based on an appraised value of the property. The
212.23 price is established without consideration of the actual accounting cost to construct or
212.24 remodel the property. The price is the nursing facility value, subject to limits, multiplied
212.25 by an established rental rate.

212.26 Subd. 12. **Fixed equipment.** "Fixed equipment" means equipment affixed to the building
212.27 and not subject to transfer, including but not limited to wiring, electrical fixtures, plumbing,
212.28 elevators, and heating and air conditioning systems.

212.29 Subd. 13. **Land improvement.** "Land improvement" means improvement to the land
212.30 surrounding the nursing facility directly used for nursing facility operations as specified in
212.31 the land improvements table of the depreciation guidelines. Land improvement includes
212.32 construction of auxiliary buildings including sheds, garages, storage buildings, and parking
212.33 structures.

213.1 Subd. 14. **Rental rate.** "Rental rate" means the percentage applied to the allowable value
 213.2 of the building and attached fixtures per year in the property payment calculation as
 213.3 determined by the commissioner.

213.4 Subd. 15. **Shared area.** "Shared area" means square footage that a nursing facility shares
 213.5 with a non-nursing facility operation to provide a support service.

213.6 Subd. 16. **Threshold project.** "Threshold project" means additions to a building or fixed
 213.7 equipment that exceed the costs specified in section 256R.26, subdivision 5, paragraph (b).
 213.8 Threshold projects exclude land, land improvements, and depreciable movable equipment
 213.9 purchases.

213.10 Subd. 17. **Undepreciated replacement cost or URC.** "Undepreciated replacement cost"
 213.11 or "URC" means the undepreciated replacement cost determined by the appraisal for building
 213.12 and attached fixtures using a commercial valuation system. URC excludes costs related to
 213.13 parking structures.

213.14 Subd. 18. **Undepreciated replacement cost (URC) per bed limit.** "Undepreciated
 213.15 replacement cost (URC) per bed limit" means the maximum allowed URC per nursing
 213.16 facility bed as established by the commissioner based on values across the industry and
 213.17 compared to an industry standard for reasonableness.

213.18 Sec. 27. **[256R.265] PROPERTY RATE CALCULATION UNDER FAIR RENTAL**
 213.19 **VALUE SYSTEM.**

213.20 Subdivision 1. **Square feet per bed limit.** The square feet per bed limit is calculated as
 213.21 follows:

213.22 (1) the URC of the nursing facility from the appraisal is divided by the total allowable
 213.23 square feet;

213.24 (2) the total allowable square feet per bed is calculated by dividing the actual square
 213.25 feet from the appraisal, after adjustment for non-nursing facility area, by the number of
 213.26 licensed beds three months prior to the beginning of the rate year limited to the following
 213.27 maximum. The allowable square feet maximum is 800 square feet per bed plus 25 percent
 213.28 of the square feet over 800 up to 1,200 square feet per bed. Square feet over 1,200 square
 213.29 feet per bed is not recognized; and

213.30 (3) the total allowable square feet per bed in clause (2) is multiplied by the amount in
 213.31 clause (1) and by the number of licensed beds three months prior to the beginning of the
 213.32 rate year to determine the square feet per bed limit.

214.1 Subd. 2. **Total URC limit.** The total URC limit is calculated as follows:

214.2 (1) the square feet per bed limit as determined in subdivision 1 is divided by the number
214.3 of licensed beds three months prior to the beginning of the rate year to determine allowable
214.4 URC per bed for each nursing facility, adjusted for square feet limitation;

214.5 (2) the allowable URC per bed, adjusted for square feet limitation, for all nursing facilities
214.6 is placed in an array annually to determine the value at the 75th percentile. This is the limit
214.7 for the URC per bed for non-single beds;

214.8 (3) the value determined in clause (2) is multiplied by 115 percent to determine the limit
214.9 for the URC per bed for single beds;

214.10 (4) the number of non-single-licensed beds three months prior to the beginning of the
214.11 rate year is multiplied by the amount in clause (2);

214.12 (5) the number of single-licensed beds three months prior to the beginning of the rate
214.13 year is multiplied by the amount in clause (3); and

214.14 (6) the amounts in clauses (4) and (5) are summed to determine the total URC limit;

214.15 Subd. 3. **Calculation of total property rate.** The total property rate is calculated as
214.16 follows:

214.17 (1) the lower of the allowable URC based on square feet per bed limit as determined
214.18 under subdivision 1 or the total URC limit in subdivision 2 is the final allowed URC;

214.19 (2) the final allowed URC determined in clause (1) is divided by the URC from the
214.20 appraisal to determine the allowed percentage. The allowed percentage is multiplied by the
214.21 depreciated replacement value from the appraisal, adjusted for non-nursing facility area, to
214.22 determine the final allowed depreciated replacement value;

214.23 (3) the number of licensed beds three months prior to the beginning of the rate year is
214.24 multiplied by \$5,305 to determine reimbursement for land and land improvements. There
214.25 is no separate addition to the property rate for parking structures;

214.26 (4) the values in clauses (2) and (3) are summed and then multiplied by the rental rate
214.27 of 5.5 percent to determine allowable property reimbursement;

214.28 (5) the allowable property reimbursement determined in clause (4) is divided by 90
214.29 percent of capacity days to determine the building property rate. Capacity days are determined
214.30 by multiplying the number of licensed beds three months prior to the beginning of the report
214.31 year by 365;

215.1 (6) for the rate year beginning January 1, 2020, the equipment allowance is \$2.77 per
215.2 resident day. For the rate year beginning January 1, 2021, the equipment allowance must
215.3 be adjusted annually for inflation. The index for the inflation adjustment must be based on
215.4 the change in the United States All Items Consumer Price Index (CPI-U) forecasted by the
215.5 Reports and Forecasts Division of the Department of Human Services in the third quarter
215.6 of the calendar year preceding the rate year. The inflation adjustment must be based on the
215.7 12-month period from the midpoint of the previous rate year to the midpoint of the rate year
215.8 for which the rate is being determined; and

215.9 (7) the sum of the building property rate and the equipment allowance is the total property
215.10 rate.

215.11 **Sec. 28. [256R.27] INTERIM AND SETTLE UP PAYMENT RATES.**

215.12 Subdivision 1. **Generally.** (a) The commissioner shall determine the interim payment
215.13 rates and settle up payment rates for a newly constructed nursing facility, or a nursing facility
215.14 with an increase in licensed capacity of 50 percent or more, according to subdivisions 2 and
215.15 3.

215.16 (b) The nursing facility must submit a written application to the commissioner to receive
215.17 interim payment rates. In its application, the nursing facility must state any reasons for
215.18 noncompliance with this chapter.

215.19 (c) The effective date of the interim payment rates is the earlier of either the first day a
215.20 resident is admitted to the newly constructed nursing facility or the date the nursing facility
215.21 bed is certified for the medical assistance program. The interim payment rates must not be
215.22 in effect for more than 17 months.

215.23 (d) The nursing facility must continue to receive the interim payment rates until the
215.24 settle up payment rates are determined under subdivision 3.

215.25 (e) For the 15-month period following the settle up reporting period, the settle up payment
215.26 rates must be determined according to subdivision 3, paragraph (c).

215.27 (f) The settle up payment rates are effective retroactively to the beginning of the interim
215.28 cost reporting period and are effective until the end of the interim rate period.

215.29 (g) The total operating and external fixed costs payment rate for the rate year beginning
215.30 January 1 following the 15-month period in paragraph (e) must be determined under this
215.31 chapter.

216.1 Subd. 2. Determination of interim payment rates. (a) The nursing facility shall submit
216.2 an interim cost report in a format similar to the Minnesota Statistical and Cost Report and
216.3 other supporting information as required by this chapter for the reporting year in which the
216.4 nursing facility plans to begin operation at least 60 days before the first day a resident is
216.5 admitted to the newly constructed nursing facility bed. The interim cost report must include
216.6 the nursing facility's anticipated interim costs and anticipated interim resident days for each
216.7 resident class in the interim cost report. The anticipated interim resident days for each
216.8 resident class is multiplied by the weight for that resident class to determine the anticipated
216.9 interim standardized days as defined in section 256R.02, subdivision 50, and resident days
216.10 as defined in section 256R.02, subdivision 45, for the reporting period.

216.11 (b) The interim total operating costs payment rate is determined according to this section,
216.12 except that:

216.13 (1) the anticipated interim costs and anticipated interim resident days reported on the
216.14 interim cost report and the anticipated interim standardized days as defined by section
216.15 256R.02, subdivision 50, must be used for the interim;

216.16 (2) the commissioner shall use anticipated interim costs and anticipated interim
216.17 standardized days in determining the allowable historical direct care cost per standardized
216.18 day as determined under section 256R.23, subdivision 2;

216.19 (3) the commissioner shall use anticipated interim costs and anticipated interim resident
216.20 days in determining the allowable historical other care-related cost per resident day as
216.21 determined under section 256R.23, subdivision 3;

216.22 (4) the commissioner shall use anticipated interim costs and anticipated interim resident
216.23 days to determine the allowable historical external fixed costs per day under section 256R.25,
216.24 paragraphs (b) to (k);

216.25 (5) the total care-related payment rate limits established in section 256R.23, subdivision
216.26 5, and in effect at the beginning of the interim period, must be increased by ten percent; and

216.27 (6) the other operating payment rate as determined under section 256R.24 in effect for
216.28 the rate year must be used for the other operating cost per day.

216.29 Subd. 3. Determination of settle up payment rates. (a) When the interim payment
216.30 rates begin between May 1 and September 30, the nursing facility shall file settle up cost
216.31 reports for the period from the beginning of the interim payment rates through September
216.32 30 of the following year.

217.1 (b) When the interim payment rates begin between October 1 and April 30, the nursing
 217.2 facility shall file settle up cost reports for the period from the beginning of the interim
 217.3 payment rates to the first September 30 following the beginning of the interim payment
 217.4 rates.

217.5 (c) The settle up total operating payment rate is determined according to this section,
 217.6 except that:

217.7 (1) the allowable costs and resident days reported on the settle up cost report and the
 217.8 standardized days as defined by section 256R.02, subdivision 50, must be used for the
 217.9 interim and settle-up period;

217.10 (2) the commissioner shall use the allowable costs and standardized days in clause (1)
 217.11 to determine the allowable historical direct care cost per standardized day as determined
 217.12 under section 256R.23, subdivision 2;

217.13 (3) the commissioner shall use the allowable costs and the allowable resident days to
 217.14 determine both the allowable historical other care-related cost per resident day as determined
 217.15 under section 256R.23, subdivision 3;

217.16 (4) the commissioner shall use the allowable costs and the allowable resident days to
 217.17 determine the allowable historical external fixed costs per day under section 256R.25,
 217.18 paragraphs (b) to (k);

217.19 (5) the total care-related payment limits established in section 256R.23, subdivision 5,
 217.20 are the limits for the settle up reporting periods. If the interim period includes more than
 217.21 one July 1 date, the commissioner shall use the total care-related payment rate limit
 217.22 established in section 256R.23, subdivision 5, increased by ten percent for the second July
 217.23 1 date; and

217.24 (6) the other operating payment rate as determined under section 256R.24 in effect for
 217.25 the rate year must be used for the other operating cost per day.

217.26 **Sec. 29. [256R.28] INTERIM AND SETTLE UP PAYMENT RATES FOR NEW**
 217.27 **OWNERS AND OPERATORS.**

217.28 Subdivision 1. **Generally.** (a) A nursing facility that undergoes a change of ownership
 217.29 or operator resulting in a change of licensee, as determined by the commissioner of health
 217.30 under chapter 144A, after December 31, 2019, must receive interim payment rates and settle
 217.31 up payment rates according to this section.

218.1 (b) The effective date of the interim rates is the effective date of the new license. The
218.2 interim payment rates must not be in effect for more than 26 months.

218.3 (c) The nursing facility must continue to receive the interim payment rates until the settle
218.4 up payment rates are determined under subdivision 3.

218.5 (d) The settle up payment rates are effective retroactively to the effective date of the
218.6 new license and remain effective until the end of the interim rate period.

218.7 (e) For the 15-month period following the settle up payment, rates must be determined
218.8 according to subdivision 3, paragraph (c).

218.9 (f) The total operating and external fixed costs payment rates for the rate year beginning
218.10 January 1 following the 15-month period in paragraph (e) must be determined under section
218.11 256R.21.

218.12 Subd. 2. **Determination of interim payment rates.** The interim total payment rates
218.13 must be the rates established under section 256R.21.

218.14 Subd. 3. **Determination of settle up payment rates.** (a) When the interim payment
218.15 rates begin between May 1 and September 30, the nursing facility shall file settle up cost
218.16 reports for the period from the beginning of the interim payment rates through September
218.17 30 of the following year.

218.18 (b) When the interim payment rates begin between October 1 and April 30, the nursing
218.19 facility shall file settle up cost reports for the period from the beginning of the interim
218.20 payment rates to the first September 30 following the beginning of the interim payment
218.21 rates.

218.22 (c) The settle up total payment rates are determined according to section 256R.21, except
218.23 that the commissioner shall:

218.24 (1) use the allowable costs and the resident days from the settle up cost reports to
218.25 determine the allowable external fixed costs payment rate; and

218.26 (2) use the allowable costs and the resident days from the settle up cost reports to
218.27 determine the total care-related payment rate.

219.1 Sec. 30. Minnesota Statutes 2018, section 256R.44, is amended to read:

219.2 **256R.44 RATE ADJUSTMENT FOR PRIVATE ROOMS FOR MEDICAL**
 219.3 **NECESSITY.**

219.4 The amount paid for a private room is ~~41.5~~ 110 percent of the established total payment
 219.5 rate for a resident if the resident is a medical assistance recipient and the private room is
 219.6 considered a medical necessity for the resident or others who are affected by the resident's
 219.7 condition, ~~except as provided in Minnesota Rules, part 9549.0060, subpart 11, item C.~~
 219.8 Conditions requiring a private room must be determined by the resident's attending physician
 219.9 and submitted to the commissioner for approval or denial by the commissioner on the basis
 219.10 of medical necessity.

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

219.12 Sec. 31. Minnesota Statutes 2018, section 256R.47, is amended to read:

219.13 **256R.47 RATE ADJUSTMENT FOR CRITICAL ACCESS NURSING**
 219.14 **FACILITIES.**

219.15 (a) The commissioner, in consultation with the commissioner of health, may designate
 219.16 certain nursing facilities as critical access nursing facilities. The designation shall be granted
 219.17 on a competitive basis, within the limits of funds appropriated for this purpose.

219.18 (b) The commissioner shall request proposals from nursing facilities every two years.
 219.19 Proposals must be submitted in the form and according to the timelines established by the
 219.20 commissioner. In selecting applicants to designate, the commissioner, in consultation with
 219.21 the commissioner of health, and with input from stakeholders, shall develop criteria designed
 219.22 to preserve access to nursing facility services in isolated areas, rebalance long-term care,
 219.23 and improve quality. To the extent practicable, the commissioner shall ensure an even
 219.24 distribution of designations across the state.

219.25 (c) The commissioner shall allow the benefits in clauses (1) to (5) for nursing facilities
 219.26 designated as critical access nursing facilities:

219.27 (1) partial rebasing, with the commissioner allowing a designated facility operating
 219.28 payment rates being the sum of up to 60 percent of the operating payment rate determined
 219.29 in accordance with section 256R.21, subdivision 3, and at least 40 percent, with the sum of
 219.30 the two portions being equal to 100 percent, of the operating payment rate that would have
 219.31 been allowed had the facility not been designated. The commissioner may adjust these
 219.32 percentages by up to 20 percent and may approve a request for less than the amount allowed;

220.1 (2) enhanced payments for leave days. Notwithstanding section 256R.43, upon
220.2 designation as a critical access nursing facility, the commissioner shall limit payment for
220.3 leave days to 60 percent of that nursing facility's total payment rate for the involved resident,
220.4 and shall allow this payment only when the occupancy of the nursing facility, inclusive of
220.5 bed hold days, is equal to or greater than 90 percent;

220.6 (3) two designated critical access nursing facilities, with up to 100 beds in active service,
220.7 may jointly apply to the commissioner of health for a waiver of Minnesota Rules, part
220.8 4658.0500, subpart 2, in order to jointly employ a director of nursing. The commissioner
220.9 of health shall consider each waiver request independently based on the criteria under
220.10 Minnesota Rules, part 4658.0040;

220.11 (4) the minimum threshold under section 256B.431, subdivision 15, paragraph (e), shall
220.12 be 40 percent of the amount that would otherwise apply; and

220.13 (5) the quality-based rate limits under section 256R.23, subdivisions 5 to 7, apply to
220.14 designated critical access nursing facilities.

220.15 (d) Designation of a critical access nursing facility is for a period of two years, after
220.16 which the benefits allowed under paragraph (c) shall be removed. Designated facilities may
220.17 apply for continued designation.

220.18 (e) This section is suspended and no state or federal funding shall be appropriated or
220.19 allocated for the purposes of this section from January 1, 2016, to ~~December 31, 2019,~~
220.20 through December 31, 2023.

220.21 Sec. 32. Minnesota Statutes 2018, section 256R.50, subdivision 6, is amended to read:

220.22 Subd. 6. **Determination of rate adjustment.** (a) If the amount determined in subdivision
220.23 5 is less than or equal to the amount determined in subdivision 4, the commissioner shall
220.24 allow a total payment rate equal to the amount used in subdivision 5, clause (3).

220.25 (b) If the amount determined in subdivision 5 is greater than the amount determined in
220.26 subdivision 4, the commissioner shall allow a rate with a case mix index of 1.0 that when
220.27 used in subdivision 5, clause (3), results in the amount determined in subdivision 5 being
220.28 equal to the amount determined in subdivision 4.

220.29 (c) If the commissioner relies upon provider estimates in subdivision 5, clause (1) or
220.30 (2), then annually, for three years after the rates determined in this section take effect, the
220.31 commissioner shall determine the accuracy of the alternative factors of medical assistance
220.32 case load and the facility average case mix index used in this section and shall reduce the
220.33 total payment rate if the factors used result in medical assistance costs exceeding the amount

221.1 in subdivision 4. If the actual medical assistance costs exceed the estimates by more than
 221.2 five percent, the commissioner shall also recover the difference between the estimated costs
 221.3 in subdivision 5 and the actual costs according to section 256B.0641. The commissioner
 221.4 may require submission of data from the receiving facility needed to implement this
 221.5 paragraph.

221.6 (d) When beds approved for relocation are put into active service at the destination
 221.7 facility, rates determined in this section must be adjusted by any adjustment amounts that
 221.8 were implemented after the date of the letter of approval.

221.9 (e) Rate adjustments determined under this subdivision expire after three full rate years
 221.10 following the effective date of the rate adjustment. This subdivision expires when the final
 221.11 rate adjustment determined under this subdivision expires.

221.12 Sec. 33. **DIRECTION TO COMMISSIONER; MORATORIUM EXCEPTION**
 221.13 **FUNDING.**

221.14 In fiscal year 2019, the commissioner of health may approve moratorium exception
 221.15 projects under Minnesota Statutes, section 144A.073, for which the full annualized state
 221.16 share of medical assistance costs does not exceed \$1,500,000 plus any carryover of previous
 221.17 appropriations for this purpose.

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

221.19 Sec. 34. **REVISOR INSTRUCTION.**

221.20 In Minnesota Statutes, the revisor of statutes shall renumber the nursing facility
 221.21 contracting provisions that are currently coded as section 256B.434, subdivisions 1 and 3,
 221.22 as amended by this act, as a section in chapter 256R and revise any statutory cross-references
 221.23 consistent with that recoding.

221.24 Sec. 35. **REPEALER.**

221.25 (a) Minnesota Statutes 2018, sections 144A.071, subdivision 4d; 256R.40; and 256R.41,
 221.26 are repealed effective July 1, 2019.

221.27 (b) Minnesota Statutes 2018, sections 256B.431, subdivisions 3a, 3f, 3g, 3i, 10, 13, 15,
 221.28 16, 17, 17a, 17c, 17d, 17e, 18, 21, 22, 30, and 45; 256B.434, subdivisions 4, 4f, 4i, and 4j;
 221.29 and 256R.36, and Minnesota Rules, parts 9549.0057; and 9549.0060, subparts 4, 5, 6, 7,
 221.30 10, 11, and 14, are repealed effective January 1, 2020.

222.1 (c) Minnesota Statutes 2018, section 256B.434, subdivisions 6 and 10, are repealed
222.2 effective the day following final enactment.

222.3 **ARTICLE 5**
222.4 **DISABILITY SERVICES**

222.5 Section 1. Minnesota Statutes 2018, section 237.50, subdivision 4a, is amended to read:

222.6 Subd. 4a. **Deaf.** "Deaf" means a hearing loss of such severity that the ~~individual~~ person
222.7 must depend primarily upon visual communication such as writing, lip reading, sign language,
222.8 and gestures.

222.9 **EFFECTIVE DATE.** This section is effective July 1, 2019, and must be implemented
222.10 by October 1, 2019.

222.11 Sec. 2. Minnesota Statutes 2018, section 237.50, is amended by adding a subdivision to
222.12 read:

222.13 Subd. 4c. **Discounted telecommunications or Internet services.** "Discounted
222.14 telecommunications or Internet services" means private, nonprofit, and public programs
222.15 intended to subsidize or reduce the monthly costs of telecommunications or Internet services
222.16 for a person who meets a program's eligibility requirements.

222.17 **EFFECTIVE DATE.** This section is effective July 1, 2019, and must be implemented
222.18 by October 1, 2019.

222.19 Sec. 3. Minnesota Statutes 2018, section 237.50, subdivision 6a, is amended to read:

222.20 Subd. 6a. **Hard-of-hearing.** "Hard-of-hearing" means a hearing loss resulting in a
222.21 functional limitation, but not to the extent that the ~~individual~~ person must depend primarily
222.22 upon visual communication in all interactions.

222.23 **EFFECTIVE DATE.** This section is effective July 1, 2019, and must be implemented
222.24 by October 1, 2019.

222.25 Sec. 4. Minnesota Statutes 2018, section 237.50, is amended by adding a subdivision to
222.26 read:

222.27 Subd. 6b. **Interconnectivity product.** "Interconnectivity product" means a device,
222.28 accessory, or application for which the primary function is use with a telecommunications
222.29 device. Interconnectivity product may include a cell phone amplifier, hearing aid streamer,

223.1 Bluetooth-enabled device that connects to a wireless telecommunications device, advanced
223.2 communications application for a smartphone, or other applicable technology.

223.3 **EFFECTIVE DATE.** This section is effective July 1, 2019, and must be implemented
223.4 by October 1, 2019.

223.5 Sec. 5. Minnesota Statutes 2018, section 237.50, subdivision 10a, is amended to read:

223.6 Subd. 10a. **Telecommunications device.** "Telecommunications device" means a device
223.7 that (1) allows a person with a communication disability to have access to
223.8 telecommunications services as defined in subdivision 13, and (2) is specifically selected
223.9 by the Department of Human Services for its capacity to allow persons with communication
223.10 disabilities to use telecommunications services in a manner that is functionally equivalent
223.11 to the ability of ~~an individual~~ a person who does not have a communication disability. A
223.12 telecommunications device may include a ring signaler, an amplified telephone, a hands-free
223.13 telephone, a text telephone, a captioned telephone, a wireless device, a device that produces
223.14 Braille output for use with a telephone, and any other device the Department of Human
223.15 Services deems appropriate.

223.16 **EFFECTIVE DATE.** This section is effective July 1, 2019, and must be implemented
223.17 by October 1, 2019.

223.18 Sec. 6. Minnesota Statutes 2018, section 237.50, subdivision 11, is amended to read:

223.19 Subd. 11. **Telecommunications Relay Services.** "Telecommunications Relay Services"
223.20 or "TRS" means the telecommunications transmission services required under Federal
223.21 Communications Commission regulations at Code of Federal Regulations, title 47, sections
223.22 64.604 to 64.606. TRS allows ~~an individual~~ a person who has a communication disability
223.23 to use telecommunications services in a manner that is functionally equivalent to the ability
223.24 of ~~an individual~~ a person who does not have a communication disability.

223.25 **EFFECTIVE DATE.** This section is effective July 1, 2019, and must be implemented
223.26 by October 1, 2019.

223.27 Sec. 7. Minnesota Statutes 2018, section 237.51, subdivision 1, is amended to read:

223.28 Subdivision 1. **Creation.** (a) The commissioner of commerce shall:

223.29 (1) administer through interagency agreement with the commissioner of human services
223.30 a program to distribute telecommunications devices and interconnectivity products to eligible
223.31 persons who have communication disabilities; and

224.1 (2) contract with one or more qualified vendors that serve persons who have
 224.2 communication disabilities to provide telecommunications relay services.

224.3 (b) For purposes of sections 237.51 to 237.56, the Department of Commerce and any
 224.4 organization with which it contracts pursuant to this section or section 237.54, subdivision
 224.5 2, are not telephone companies or telecommunications carriers as defined in section 237.01.

224.6 **EFFECTIVE DATE.** This section is effective July 1, 2019, and must be implemented
 224.7 by October 1, 2019.

224.8 Sec. 8. Minnesota Statutes 2018, section 237.51, subdivision 5a, is amended to read:

224.9 Subd. 5a. **Commissioner of human services duties.** (a) In addition to any duties specified
 224.10 elsewhere in sections 237.51 to 237.56, the commissioner of human services shall:

224.11 (1) define economic hardship, special needs, and household criteria so as to determine
 224.12 the priority of eligible applicants for initial distribution of devices and products and to
 224.13 determine circumstances necessitating provision of more than one telecommunications
 224.14 device per household;

224.15 (2) establish a method to verify eligibility requirements;

224.16 (3) establish specifications for telecommunications devices and interconnectivity products
 224.17 to be provided under section 237.53, subdivision 3;

224.18 (4) inform the public and specifically persons who have communication disabilities of
 224.19 the program; ~~and~~

224.20 (5) provide devices and products based on the assessed need of eligible applicants; and

224.21 (6) assist a person with completing an application for discounted telecommunications
 224.22 or Internet services.

224.23 (b) The commissioner may establish an advisory board to advise the department in
 224.24 carrying out the duties specified in this section and to advise the commissioner of commerce
 224.25 in carrying out duties under section 237.54. If so established, the advisory board must
 224.26 include, at a minimum, the following persons:

224.27 (1) at least one member who is deaf;

224.28 (2) at least one member who has a speech disability;

224.29 (3) at least one member who has a physical disability that makes it difficult or impossible
 224.30 for the person to access telecommunications services; and

224.31 (4) at least one member who is hard-of-hearing.

225.1 (c) The membership terms, compensation, and removal of members and the filling of
225.2 membership vacancies are governed by section 15.059. Advisory board meetings shall be
225.3 held at the discretion of the commissioner.

225.4 **EFFECTIVE DATE.** This section is effective July 1, 2019, and must be implemented
225.5 by October 1, 2019.

225.6 Sec. 9. Minnesota Statutes 2018, section 237.52, subdivision 5, is amended to read:

225.7 Subd. 5. **Expenditures.** (a) Money in the fund may only be used for:

225.8 (1) expenses of the Department of Commerce, including personnel cost, public relations,
225.9 advisory board members' expenses, preparation of reports, and other reasonable expenses
225.10 not to exceed ten percent of total program expenditures;

225.11 (2) reimbursing the commissioner of human services for purchases made or services
225.12 provided pursuant to section 237.53; and

225.13 (3) contracting for the provision of TRS required by section 237.54.

225.14 (b) All costs directly associated with the establishment of the program, the purchase and
225.15 distribution of telecommunications devices, and interconnectivity products, and the provision
225.16 of TRS are either reimbursable or directly payable from the fund after authorization by the
225.17 commissioner of commerce. The commissioner of commerce shall contract with one or
225.18 more TRS providers to indemnify the telecommunications service providers for any fines
225.19 imposed by the Federal Communications Commission related to the failure of the relay
225.20 service to comply with federal service standards. Notwithstanding section 16A.41, the
225.21 commissioner may advance money to the TRS providers if the providers establish to the
225.22 commissioner's satisfaction that the advance payment is necessary for the provision of the
225.23 service. The advance payment may be used only for working capital reserve for the operation
225.24 of the service. The advance payment must be offset or repaid by the end of the contract
225.25 fiscal year together with interest accrued from the date of payment.

225.26 **EFFECTIVE DATE.** This section is effective July 1, 2019, and must be implemented
225.27 by October 1, 2019.

226.1 Sec. 10. Minnesota Statutes 2018, section 237.53, is amended to read:

226.2 **237.53 TELECOMMUNICATIONS ~~DEVICE~~ DEVICES AND**
 226.3 **INTERCONNECTIVITY PRODUCTS.**

226.4 Subdivision 1. **Application.** A person applying for a telecommunications device or
 226.5 interconnectivity product under this section must apply to the program administrator on a
 226.6 form prescribed by the Department of Human Services.

226.7 Subd. 2. **Eligibility.** To be eligible to obtain a telecommunications device or
 226.8 interconnectivity product under this section, a person must:

226.9 (1) be able to benefit from and use the equipment for its intended purpose;

226.10 (2) have a communication disability;

226.11 (3) be a resident of the state;

226.12 (4) be a resident in a household that has a median income at or below the applicable
 226.13 median household income in the state, except a person who is deafblind applying for a
 226.14 Braille device may reside in a household that has a median income no more than 150 percent
 226.15 of the applicable median household income in the state; and

226.16 (5) be a resident in a household that has telecommunications service or that has made
 226.17 application for service and has been assigned a telephone number; or a resident in a residential
 226.18 care facility, such as a nursing home or group home where telecommunications service is
 226.19 not included as part of overall service provision.

226.20 **Subd. 2a. Assessment of needs.** After a person is determined to be eligible for the
 226.21 program, the commissioner of human services shall assess the person's telecommunications
 226.22 needs to determine: (1) the type of telecommunications device that provides the person with
 226.23 functionally equivalent access to telecommunications services; and (2) appropriate
 226.24 interconnectivity products for the person.

226.25 Subd. 3. **Distribution.** The commissioner of human services shall (1) purchase ~~and~~
 226.26 ~~distribute~~ a sufficient number of telecommunications devices and interconnectivity products
 226.27 so that each eligible household receives appropriate devices and products as determined
 226.28 under section 237.51, subdivision 5a. ~~The commissioner of human services shall, and (2)~~
 226.29 distribute the devices and products to eligible households free of charge.

226.30 Subd. 4. **Training; information; maintenance.** The commissioner of human services
 226.31 shall maintain the telecommunications devices and interconnectivity products until the
 226.32 warranty period expires, and provide training, without charge, to first-time users of the

227.1 devices- and products. The commissioner shall provide information about assistive
 227.2 communications devices and products that may benefit a program participant and about
 227.3 where a person may obtain or purchase assistive communications devices and products.
 227.4 Assistive communications devices and products include a pocket talker for a person who
 227.5 is hard-of-hearing, a communication board for a person with a speech disability, a one-to-one
 227.6 video communication application for a person who is deaf, and other devices and products
 227.7 designed to facilitate effective communication for a person with a communication disability.

227.8 Subd. 6. **Ownership.** Telecommunications devices and interconnectivity products
 227.9 purchased pursuant to subdivision 3, clause (1), are the property of the state of Minnesota.
 227.10 Policies and procedures for the return of distributed devices ~~from individuals who withdraw~~
 227.11 ~~from the program or whose eligibility status changes~~ and products shall be determined by
 227.12 the commissioner of human services.

227.13 Subd. 7. **Standards.** The telecommunications devices distributed under this section must
 227.14 comply with the electronic industries alliance standards and be approved by the Federal
 227.15 Communications Commission. The commissioner of human services must provide each
 227.16 eligible person a choice of several models of devices, the retail value of which may not
 227.17 exceed \$600 for a text telephone, and a retail value of \$7,000 for a Braille device, or an
 227.18 amount authorized by the Department of Human Services for all other telecommunications
 227.19 devices ~~and~~, auxiliary equipment, and interconnectivity products it deems cost-effective
 227.20 and appropriate to distribute according to sections 237.51 to 237.56.

227.21 Subd. 9. **Discounted telecommunications or Internet services assistance.** The
 227.22 commissioner of human services shall assist a person who is applying for telecommunication
 227.23 devices and products in applying for discounted telecommunications or Internet services.

227.24 **EFFECTIVE DATE.** This section is effective July 1, 2019, and must be implemented
 227.25 by October 1, 2019.

227.26 Sec. 11. Minnesota Statutes 2018, section 245C.03, is amended by adding a subdivision
 227.27 to read:

227.28 Subd. 13. **Early intensive developmental and behavioral intervention providers.** The
 227.29 commissioner shall conduct background studies according to this chapter when initiated by
 227.30 an early intensive developmental and behavioral intervention provider under section
 227.31 256B.0949.

228.1 Sec. 12. Minnesota Statutes 2018, section 245C.10, is amended by adding a subdivision
228.2 to read:

228.3 Subd. 14. **Early intensive developmental and behavioral intervention providers.** The
228.4 commissioner shall recover the cost of background studies required under section 245C.03,
228.5 subdivision 13, for the purposes of early intensive developmental and behavioral intervention
228.6 under section 256B.0949, through a fee of no more than \$32 per study charged to the enrolled
228.7 agency. Fees collected under this subdivision are appropriated to the commissioner for the
228.8 purpose of conducting background studies.

228.9 Sec. 13. Minnesota Statutes 2018, section 245D.03, subdivision 1, is amended to read:

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

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

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

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

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

228.32 (4) 24-hour emergency assistance, personal emergency response as defined under the
228.33 community access for disability inclusion and developmental disability waiver plans;

- 229.1 (5) night supervision services as defined under the brain injury waiver plan;
- 229.2 (6) homemaker services as defined under the community access for disability inclusion,
 229.3 brain injury, community alternative care, developmental disability, and elderly waiver plans,
 229.4 excluding providers licensed by the Department of Health under chapter 144A and those
 229.5 providers providing cleaning services only; ~~and~~
- 229.6 (7) individual community living support under section 256B.0915, subdivision 3j; and
- 229.7 (8) individualized home supports services as defined under the brain injury, community
 229.8 alternative care, and community access for disability inclusion, and developmental disability
 229.9 waiver plans.
- 229.10 (c) Intensive support services provide assistance, supervision, and care that is necessary
 229.11 to ensure the health and welfare of the person and services specifically directed toward the
 229.12 training, habilitation, or rehabilitation of the person. Intensive support services include:
- 229.13 (1) intervention services, including:
- 229.14 (i) behavioral support services as defined under the brain injury and community access
 229.15 for disability inclusion waiver plans;
- 229.16 (ii) in-home or out-of-home crisis respite services as defined under the developmental
 229.17 disability waiver plan; and
- 229.18 (iii) specialist services as defined under the current developmental disability waiver
 229.19 plan;
- 229.20 (2) in-home support services, including:
- 229.21 (i) in-home family support and supported living services as defined under the
 229.22 developmental disability waiver plan;
- 229.23 (ii) independent living services training as defined under the brain injury and community
 229.24 access for disability inclusion waiver plans;
- 229.25 (iii) semi-independent living services; ~~and~~
- 229.26 ~~(iv) individualized home supports services as defined under the brain injury, community~~
 229.27 ~~alternative care, and community access for disability inclusion waiver plans;~~
- 229.28 (iv) individualized home support with training services as defined under the brain injury,
 229.29 community alternative care, community access for disability inclusion, and developmental
 229.30 disability waiver plans; and

230.1 (v) individualized home support with family training services as defined under the brain
 230.2 injury, community alternative care, community access for disability inclusion, and
 230.3 developmental disability waiver plans;

230.4 (3) residential supports and services, including:

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

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

230.12 (iii) community residential services as defined under the brain injury, community
 230.13 alternative care, community access for disability inclusion, and developmental disability
 230.14 waiver plans provided in a corporate child foster care residence, a community residential
 230.15 setting, or a supervised living facility;

230.16 (iv) family residential services as defined in the brain injury, community alternative
 230.17 care, community access for disability inclusion, and developmental disability waiver plans
 230.18 provided in a family child foster care residence or a family adult foster care residence; and

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

230.21 (4) day services, including:

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

230.23 (ii) day services under sections 252.41 to 252.46, and as defined under the brain injury,
 230.24 community alternative care, community access for disability inclusion, and developmental
 230.25 disability waiver plans;

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

230.28 ~~(iii)~~ (iv) prevocational services as defined under the brain injury ~~and~~, community
 230.29 alternative care, community access for disability inclusion, and developmental disability
 230.30 waiver plans; and

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

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

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

231.10 (8) integrated community support as defined under the brain injury and community
 231.11 access for disability inclusion waiver plans beginning January 1, 2021, and community
 231.12 alternative care and developmental disability waiver plans beginning January 1, 2023.

231.13 **EFFECTIVE DATE.** This section is effective January 1, 2021, or upon federal approval,
 231.14 whichever is later. The commissioner of human services shall notify the revisor of statutes
 231.15 when federal approval is obtained.

231.16 Sec. 14. Minnesota Statutes 2018, section 245D.071, subdivision 1, is amended to read:

231.17 Subdivision 1. **Requirements for intensive support services.** Except for services
 231.18 identified in section 245D.03, subdivision 1, paragraph (c), clauses (1) and (2), item (ii), a
 231.19 license holder providing intensive support services identified in section 245D.03, subdivision
 231.20 1, paragraph (c), must comply with the requirements in this section and section 245D.07,
 231.21 subdivisions 1, 1a, and 3. Services identified in section 245D.03, subdivision 1, paragraph
 231.22 (c), clauses (1) and (2), item (ii), must comply with the requirements in section 245D.07,
 231.23 subdivision 2.

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

231.25 Sec. 15. **[245D.12] INTEGRATED COMMUNITY SUPPORTS; SETTING**
 231.26 **CAPACITY REPORT.**

231.27 (a) The license holder providing integrated community support, as defined in section
 231.28 245D.03, subdivision 1, paragraph (c), clause (8), must submit a setting capacity report to
 231.29 the commissioner to ensure the identified location of service delivery meets the criteria of
 231.30 the home and community-based service requirements as specified in section 256B.492.

231.31 (b) The license holder shall provide the setting capacity report on the forms and in the
 231.32 manner prescribed by the commissioner. The report must include:

232.1 (1) the address of the multifamily housing building where the license holder delivers
 232.2 integrated community supports and owns, leases, or has a direct or indirect financial
 232.3 relationship with the property owner;

232.4 (2) the total number of living units in the multifamily housing building described in
 232.5 clause (1) where integrated community supports are delivered;

232.6 (3) the total number of living units in the multifamily housing building described in
 232.7 clause (1), including the living units identified in clause (2); and

232.8 (4) the percentage of living units that are controlled by the license holder in the
 232.9 multifamily housing building by dividing clause (2) by clause (3).

232.10 (c) Only one license holder may deliver integrated community supports at the address
 232.11 of the multifamily housing building.

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

232.15 Sec. 16. Minnesota Statutes 2018, section 252.27, subdivision 2a, is amended to read:

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

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

232.28 (1) if the adjusted gross income is equal to or greater than 275 percent of federal poverty
 232.29 guidelines and less than or equal to 545 percent of federal poverty guidelines, the parental
 232.30 contribution shall be determined using a sliding fee scale established by the commissioner
 232.31 of human services which begins at ~~1.94~~ 1.65 percent of adjusted gross income at 275 percent
 232.32 of federal poverty guidelines and increases to ~~5.29~~ 4.5 percent of adjusted gross income for
 232.33 those with adjusted gross income up to 545 percent of federal poverty guidelines;

233.1 (2) if the adjusted gross income is greater than 545 percent of federal poverty guidelines
233.2 and less than 675 percent of federal poverty guidelines, the parental contribution shall be
233.3 ~~5.29~~ 4.5 percent of adjusted gross income;

233.4 (3) if the adjusted gross income is equal to or greater than 675 percent of federal poverty
233.5 guidelines and less than 975 percent of federal poverty guidelines, the parental contribution
233.6 shall be determined using a sliding fee scale established by the commissioner of human
233.7 services which begins at ~~5.29~~ 4.5 percent of adjusted gross income at 675 percent of federal
233.8 poverty guidelines and increases to ~~7.05~~ 5.99 percent of adjusted gross income for those
233.9 with adjusted gross income up to 975 percent of federal poverty guidelines; and

233.10 (4) if the adjusted gross income is equal to or greater than 975 percent of federal poverty
233.11 guidelines, the parental contribution shall be ~~8.81~~ 7.49 percent of adjusted gross income.

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

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

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

233.27 (e) The contribution shall be explained in writing to the parents at the time eligibility
233.28 for services is being determined. The contribution shall be made on a monthly basis effective
233.29 with the first month in which the child receives services. Annually upon redetermination
233.30 or at termination of eligibility, if the contribution exceeded the cost of services provided,
233.31 the local agency or the state shall reimburse that excess amount to the parents, either by
233.32 direct reimbursement if the parent is no longer required to pay a contribution, or by a
233.33 reduction in or waiver of parental fees until the excess amount is exhausted. All
233.34 reimbursements must include a notice that the amount reimbursed may be taxable income

234.1 if the parent paid for the parent's fees through an employer's health care flexible spending
234.2 account under the Internal Revenue Code, section 125, and that the parent is responsible
234.3 for paying the taxes owed on the amount reimbursed.

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

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

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

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

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

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

234.31 (2) the insurer denied insurance;

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

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

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

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

235.12 Sec. 17. Minnesota Statutes 2018, section 252.275, subdivision 3, is amended to read:

235.13 Subd. 3. **Reimbursement.** Counties shall be reimbursed for all expenditures made
 235.14 pursuant to subdivision 1 at a rate of ~~70~~ 85 percent, up to the allocation determined pursuant
 235.15 to subdivisions 4 and 4b. However, the commissioner shall not reimburse costs of services
 235.16 for any person if the costs exceed the state share of the average medical assistance costs for
 235.17 services provided by intermediate care facilities for a person with a developmental disability
 235.18 for the same fiscal year, and shall not reimburse costs of a onetime living allowance for any
 235.19 person if the costs exceed \$1,500 in a state fiscal year. The commissioner may make
 235.20 payments to each county in quarterly installments. The commissioner may certify an advance
 235.21 of up to 25 percent of the allocation. Subsequent payments shall be made on a reimbursement
 235.22 basis for reported expenditures and may be adjusted for anticipated spending patterns.

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

235.24 Sec. 18. Minnesota Statutes 2018, section 252.41, subdivision 3, is amended to read:

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

235.28 (1) include supervision, training, assistance, support, center-based facility-based
 235.29 work-related activities, or other community-integrated activities designed and implemented
 235.30 in accordance with the ~~individual service and individual habilitation plans~~ coordinated
 235.31 service and support plan and coordinated service and support plan addendum required under
 235.32 sections 245D.02, subdivision 4, paragraphs (a) and (b), and 256B.092, subdivision 1b, and

236.1 Minnesota Rules, ~~parts part~~ 9525.0004 to 9525.0036, subpart 12, to help an adult reach and
 236.2 maintain the highest possible level of independence, productivity, and integration into the
 236.3 community; ~~and~~

236.4 (2) include day support services, prevocational services, day training and habilitation
 236.5 services, structured day services, and adult day services as defined in Minnesota's federally
 236.6 approved disability waiver plans; and

236.7 (3) are provided by a vendor licensed under sections 245A.01 to 245A.16 ~~and~~, 245D.27
 236.8 to 245D.31, 252.28, subdivision 2, and 252.41 to 252.46, and Minnesota Rules, parts
 236.9 9525.1200 to 9525.1330, to provide day ~~training and habilitation~~ services.

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

236.15 (c) Day ~~training and habilitation~~ services do not include employment exploration,
 236.16 employment development, or employment support services as defined in the home and
 236.17 community-based services waivers for people with disabilities authorized under sections
 236.18 256B.092 and 256B.49.

236.19 **EFFECTIVE DATE.** This section is effective January 1, 2021, or upon federal approval,
 236.20 whichever is later. The commissioner of human services shall notify the revisor of statutes
 236.21 when federal approval is obtained.

236.22 Sec. 19. Minnesota Statutes 2018, section 252.41, subdivision 4, is amended to read:

236.23 Subd. 4. **Independence.** "Independence" means the extent to which persons with
 236.24 ~~developmental~~ disabilities exert control and choice over their own lives.

236.25 **EFFECTIVE DATE.** This section is effective January 1, 2021.

236.26 Sec. 20. Minnesota Statutes 2018, section 252.41, subdivision 5, is amended to read:

236.27 Subd. 5. **Integration.** "Integration" means that persons with ~~developmental~~ disabilities:

236.28 (1) use the same community resources that are used by and available to individuals who
 236.29 are not disabled;

236.30 (2) participate in the same community activities in which nondisabled individuals
 236.31 participate; and

237.1 (3) regularly interact and have contact with nondisabled individuals.

237.2 **EFFECTIVE DATE.** This section is effective January 1, 2021.

237.3 Sec. 21. Minnesota Statutes 2018, section 252.41, subdivision 6, is amended to read:

237.4 Subd. 6. **Productivity.** "Productivity" means that persons with ~~developmental~~ disabilities:

237.5 (1) engage in income-producing work designed to improve their income level,

237.6 employment status, or job advancement; or

237.7 (2) engage in activities that contribute to a business, household, or community.

237.8 **EFFECTIVE DATE.** This section is effective January 1, 2021.

237.9 Sec. 22. Minnesota Statutes 2018, section 252.41, subdivision 7, is amended to read:

237.10 Subd. 7. **Regional center.** "Regional center" means any state-operated facility under

237.11 the direct administrative authority of the commissioner that serves persons with

237.12 ~~developmental~~ disabilities.

237.13 **EFFECTIVE DATE.** This section is effective January 1, 2021.

237.14 Sec. 23. Minnesota Statutes 2018, section 252.41, subdivision 9, is amended to read:

237.15 Subd. 9. **Vendor.** "Vendor" means a ~~nonprofit~~ legal entity that:

237.16 (1) is licensed under sections 245A.01 to 245A.16 ~~and~~, 245D.27 to 245D.31, 252.28,

237.17 subdivision 2, and 252.41 to 252.46, and Minnesota Rules, parts 9525.1200 to 9525.1330,

237.18 to provide day ~~training and habilitation~~ services to adults with ~~developmental~~ disabilities;

237.19 and

237.20 (2) does not have a financial interest in the legal entity that provides residential services

237.21 to the same person or persons to whom it provides day ~~training and habilitation~~ services.

237.22 This clause does not apply to regional treatment centers, state-operated, community-based

237.23 programs operating according to section 252.50 until July 1, 2000, or vendors licensed prior

237.24 to April 15, 1983.

237.25 **EFFECTIVE DATE.** This section is effective January 1, 2021.

238.1 Sec. 24. Minnesota Statutes 2018, section 252.42, is amended to read:

238.2 **252.42 SERVICE PRINCIPLES.**

238.3 The design and delivery of services eligible for reimbursement should reflect the
238.4 following principles:

238.5 (1) services must suit a person's chronological age and be provided in the least restrictive
238.6 environment possible, consistent with the needs identified in the person's ~~individual service~~
238.7 ~~and individual habilitation plans under~~ coordinated service and support plan and coordinated
238.8 service and support plan addendum required under sections 256B.092, subdivision 1b, and
238.9 245D.02, subdivision 4, paragraphs (a) and (b), and Minnesota Rules, parts 9525.0004 to
238.10 9525.0036, subpart 12;

238.11 (2) a person with a ~~developmental~~ disability whose ~~individual service and individual~~
238.12 ~~habilitation plans~~ coordinated service and support plans and coordinated service and support
238.13 plan addendums authorize employment or employment-related activities shall be given the
238.14 opportunity to participate in employment and employment-related activities in which
238.15 nondisabled persons participate;

238.16 (3) a person with a ~~developmental~~ disability participating in work shall be paid wages
238.17 commensurate with the rate for comparable work and productivity except as regional centers
238.18 are governed by section 246.151;

238.19 (4) a person with a ~~developmental~~ disability shall receive services which include services
238.20 offered in settings used by the general public and designed to increase the person's active
238.21 participation in ordinary community activities;

238.22 (5) a person with a ~~developmental~~ disability shall participate in the patterns, conditions,
238.23 and rhythms of everyday living and working that are consistent with the norms of the
238.24 mainstream of society.

238.25 **EFFECTIVE DATE.** This section is effective January 1, 2021.

238.26 Sec. 25. Minnesota Statutes 2018, section 252.43, is amended to read:

238.27 **252.43 COMMISSIONER'S DUTIES.**

238.28 The commissioner shall supervise ~~county boards'~~ lead agencies' provision of day ~~training~~
238.29 ~~and habilitation~~ services to adults with ~~developmental~~ disabilities. The commissioner shall:

238.30 (1) determine the need for day ~~training and habilitation~~ services under section ~~252.28~~
238.31 256B.4914;

239.1 (2) establish payment rates as provided under section 256B.4914;

239.2 (3) add transportation costs to the day services payment rate;

239.3 (4) adopt rules for the administration and provision of day ~~training and habilitation~~
 239.4 services under ~~sections 252.41 to 252.46 and~~ sections 245A.01 to 245A.16 and, 252.28,
 239.5 subdivision 2, and 252.41 to 252.46, and Minnesota Rules, parts 9525.1200 to 9525.1330;

239.6 (4) (5) enter into interagency agreements necessary to ensure effective coordination and
 239.7 provision of day ~~training and habilitation~~ services;

239.8 (5) (6) monitor and evaluate the costs and effectiveness of day ~~training and habilitation~~
 239.9 services; and

239.10 (6) (7) provide information and technical help to ~~county boards~~ lead agencies and vendors
 239.11 in their administration and provision of day ~~training and habilitation~~ services.

239.12 **EFFECTIVE DATE.** This section is effective January 1, 2021.

239.13 Sec. 26. Minnesota Statutes 2018, section 252.44, is amended to read:

239.14 **252.44 ~~COUNTY~~ LEAD AGENCY BOARD RESPONSIBILITIES.**

239.15 When the need for day ~~training and habilitation~~ services in a county or tribe has been
 239.16 determined under section 252.28, the board of commissioners for that ~~county~~ lead agency
 239.17 shall:

239.18 (1) authorize the delivery of services according to the ~~individual service and habilitation~~
 239.19 ~~plans~~ coordinated service and support plans and coordinated service and support plan
 239.20 addendums required as part of the ~~county's~~ lead agency's provision of case management
 239.21 services under sections 256B.0913, subdivision 8; 256B.0915, subdivision 6; 256B.092,
 239.22 subdivision 1b; and 256B.49, subdivision 15, and Minnesota Rules, parts 9525.0004 to
 239.23 9525.0036. ~~For calendar years for which section 252.46, subdivisions 2 to 10, apply, the~~
 239.24 ~~county board shall not authorize a change in service days from the number of days authorized~~
 239.25 ~~for the previous calendar year unless there is documentation for the change in the individual~~
 239.26 ~~service plan. An increase in service days must also be supported by documentation that the~~
 239.27 ~~goals and objectives assigned to the vendor cannot be met more economically and effectively~~
 239.28 ~~by other available community services and that without the additional days of service the~~
 239.29 ~~individual service plan could not be implemented in a manner consistent with the service~~
 239.30 ~~principles in section 252.42;~~

239.31 (2) ensure that transportation is provided or arranged by the vendor in the most efficient
 239.32 and reasonable way possible; and

240.1 (3) monitor and evaluate the cost and effectiveness of the services.

240.2 **EFFECTIVE DATE.** This section is effective January 1, 2021.

240.3 Sec. 27. Minnesota Statutes 2018, section 252.45, is amended to read:

240.4 **252.45 VENDOR'S DUTIES.**

240.5 A day service vendor enrolled with the commissioner is responsible for items under
 240.6 clauses (1), (2), and (3), and extends only to the provision of services that are reimbursable
 240.7 under state and federal law. A vendor providing day ~~training and habilitation~~ services shall:

240.8 (1) provide the amount and type of services authorized in the individual service plan
 240.9 under coordinated service and support plan and coordinated service and support plan
 240.10 addendum required under sections 245D.02, subdivision 4, paragraphs (a) and (b), and
 240.11 256B.092, subdivision 1b, and Minnesota Rules, ~~parts part~~ 9525.0004 to 9525.0036, subpart
 240.12 12;

240.13 (2) design the services to achieve the outcomes assigned to the vendor in the ~~individual~~
 240.14 ~~service plan~~ coordinated service and support plan and coordinated service and support plan
 240.15 addendum required under sections 245D.02, subdivision 4, paragraphs (a) and (b), and
 240.16 256B.092, subdivision 1b, and Minnesota Rules, part 9525.0004, subpart 12;

240.17 (3) provide or arrange for transportation of persons receiving services to and from service
 240.18 sites;

240.19 (4) enter into agreements with community-based intermediate care facilities for persons
 240.20 with developmental disabilities to ensure compliance with applicable federal regulations;
 240.21 and

240.22 (5) comply with state and federal law.

240.23 **EFFECTIVE DATE.** This section is effective January 1, 2021.

240.24 Sec. 28. Minnesota Statutes 2018, section 256.9365, is amended to read:

240.25 **256.9365 PURCHASE OF ~~CONTINUATION~~ HEALTH CARE COVERAGE FOR**
 240.26 **AIDS PATIENTS PEOPLE LIVING WITH HIV.**

240.27 Subdivision 1. **Program established.** The commissioner of human services shall establish
 240.28 a program to pay ~~private~~ the cost of health plan premiums and cost sharing for prescriptions,
 240.29 including co-payments, deductibles, and coinsurance for persons who have contracted human
 240.30 immunodeficiency virus (HIV) to enable them to continue coverage under or enroll in a
 240.31 group or individual health plan. If a person is determined to be eligible under subdivision

241.1 2, the commissioner shall pay the ~~portion of the group plan premium for which the individual~~
 241.2 ~~is responsible, if the individual is responsible for at least 50 percent of the cost of the~~
 241.3 ~~premium, or pay the individual plan premium~~ health insurance premiums and prescription
 241.4 cost sharing, including co-payments and deductibles required under section 256B.0631.
 241.5 The commissioner shall not pay for that portion of a premium that is attributable to other
 241.6 family members or dependents or is paid by the individual's employer.

241.7 Subd. 2. **Eligibility requirements.** To be eligible for the program, an applicant must
 241.8 ~~satisfy the following requirements:~~ meet all eligibility requirements for and enroll in Part
 241.9 B of the Ryan White HIV/AIDS Treatment Extension Act of 2009, Public Law 111-87.

241.10 ~~(1) the applicant must provide a physician's, advanced practice registered nurse's, or~~
 241.11 ~~physician assistant's statement verifying that the applicant is infected with HIV and is, or~~
 241.12 ~~within three months is likely to become, too ill to work in the applicant's current employment~~
 241.13 ~~because of HIV-related disease;~~

241.14 ~~(2) the applicant's monthly gross family income must not exceed 300 percent of the~~
 241.15 ~~federal poverty guidelines, after deducting medical expenses and insurance premiums;~~

241.16 ~~(3) the applicant must not own assets with a combined value of more than \$25,000; and~~

241.17 ~~(4) if applying for payment of group plan premiums, the applicant must be covered by~~
 241.18 ~~an employer's or former employer's group insurance plan.~~

241.19 Subd. 3. **Cost-effective coverage.** Requirements for the payment of individual plan
 241.20 premiums under subdivision 2, ~~clause (5),~~ must be designed to ensure that the state cost of
 241.21 paying an individual plan premium does not exceed the estimated state cost that would
 241.22 otherwise be incurred in the medical assistance program. The commissioner shall purchase
 241.23 the most cost-effective coverage available for eligible individuals.

241.24 Sec. 29. Minnesota Statutes 2018, section 256B.0658, is amended to read:

241.25 **256B.0658 HOUSING ACCESS GRANTS.**

241.26 The commissioner of human services shall award through a competitive process contracts
 241.27 for grants to public and private agencies to support and assist individuals ~~eligible for publicly~~
 241.28 ~~funded home and community-based services, including state plan home care~~ with a disability
 241.29 as defined in section 256B.051, subdivision 2, paragraph (e), to access housing. Grants may
 241.30 be awarded to agencies that may include, but are not limited to, the following supports:
 241.31 assessment to ensure suitability of housing, accompanying an individual to look at housing,
 241.32 filling out applications and rental agreements, meeting with landlords, helping with Section

242.1 8 or other program applications, helping to develop a budget, obtaining furniture and
242.2 household goods, if necessary, and assisting with any problems that may arise with housing.

242.3 Sec. 30. Minnesota Statutes 2018, section 256B.0659, subdivision 21, is amended to read:

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

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

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

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

242.18 (4) proof of workers' compensation insurance coverage;

242.19 (5) proof of liability insurance;

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

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

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

242.30 (i) a copy of the personal care assistance provider agency's time sheet if the time sheet
242.31 varies from the standard time sheet for personal care assistance services approved by the

243.1 commissioner, and a letter requesting approval of the personal care assistance provider
243.2 agency's nonstandard time sheet;

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

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

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

243.9 (10) documentation that the personal care assistance provider agency and staff have
243.10 successfully completed all the training required by this section;

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

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

243.14 (13) documentation that the agency will use the following percentages of revenue
243.15 generated from the medical assistance rate paid for personal care assistance services for
243.16 employee personal care assistant wages and benefits: 72.5 percent of revenue in the personal
243.17 care assistance choice option and 72.5 percent of revenue from other personal care assistance
243.18 providers, except for other personal care assistance providers, all of the revenue generated
243.19 by a medical assistance rate increase due to a collective bargaining agreement under section
243.20 179A.54 must be used for employee personal care assistant wages and benefits. The revenue
243.21 generated by the qualified professional and the reasonable costs associated with the qualified
243.22 professional shall not be used in making this calculation; and

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

243.29 (b) Personal care assistance provider agencies shall provide the information specified
243.30 in paragraph (a) to the commissioner at the time the personal care assistance provider agency
243.31 enrolls as a vendor or upon request from the commissioner. The commissioner shall collect
243.32 the information specified in paragraph (a) from all personal care assistance providers
243.33 beginning July 1, 2009.

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

244.23 Sec. 31. **[256B.0715] DIRECT CARE WORKFORCE REPORT.**

244.24 The commissioner of human services shall annually assess the direct care workforce
 244.25 and publish findings in a direct care workforce report each August beginning August 1,
 244.26 2020. This report shall consider the number of workers employed, the number of regular
 244.27 hours worked, the number of overtime hours worked, the regular wages and benefits paid,
 244.28 the overtime wages paid, retention rates, and job vacancies across providers of home and
 244.29 community-based services disability waiver services, state plan home care services, state
 244.30 plan personal care assistance services, and community first services and supports.

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

245.1 Sec. 32. Minnesota Statutes 2018, section 256B.0915, subdivision 3a, is amended to read:

245.2 Subd. 3a. **Elderly waiver cost limits.** (a) Effective on the first day of the state fiscal
245.3 year in which the resident assessment system as described in section 256R.17 for nursing
245.4 home rate determination is implemented and the first day of each subsequent state fiscal
245.5 year, the monthly limit for the cost of waived services to an individual elderly waiver
245.6 client shall be the monthly limit of the case mix resident class to which the waiver client
245.7 would be assigned under Minnesota Rules, parts 9549.0051 to 9549.0059, in effect on the
245.8 last day of the previous state fiscal year, adjusted by any legislatively adopted home and
245.9 community-based services percentage rate adjustment. If a legislatively authorized increase
245.10 is service-specific, the monthly cost limit shall be adjusted based on the overall average
245.11 increase to the elderly waiver program.

245.12 (b) The monthly limit for the cost of waived services under paragraph (a) to an
245.13 individual elderly waiver client assigned to a case mix classification A with:

245.14 (1) no dependencies in activities of daily living; or

245.15 (2) up to two dependencies in bathing, dressing, grooming, walking, and eating when
245.16 the dependency score in eating is three or greater as determined by an assessment performed
245.17 under section 256B.0911 shall be \$1,750 per month effective on July 1, 2011, for all new
245.18 participants enrolled in the program on or after July 1, 2011. This monthly limit shall be
245.19 applied to all other participants who meet this criteria at reassessment. This monthly limit
245.20 shall be increased annually as described in paragraphs (a) and (e).

245.21 (c) If extended medical supplies and equipment or environmental modifications are or
245.22 will be purchased for an elderly waiver client, the costs may be prorated for up to 12
245.23 consecutive months beginning with the month of purchase. If the monthly cost of a recipient's
245.24 waived services exceeds the monthly limit established in paragraph (a), (b), (d), or (e),
245.25 the annual cost of all waived services shall be determined. In this event, the annual cost
245.26 of all waived services shall not exceed 12 times the monthly limit of waived services
245.27 as described in paragraph (a), (b), (d), or (e).

245.28 (d) Effective July 1, 2013, the monthly cost limit of waiver services, including any
245.29 necessary home care services described in section 256B.0651, subdivision 2, for individuals
245.30 who meet the criteria as ventilator-dependent given in section 256B.0651, subdivision 1,
245.31 paragraph (g), shall be the average of the monthly medical assistance amount established
245.32 for home care services as described in section 256B.0652, subdivision 7, and the annual
245.33 average contracted amount established by the commissioner for nursing facility services

246.1 for ventilator-dependent individuals. This monthly limit shall be increased annually as
246.2 described in paragraphs (a) and (e).

246.3 (e) Effective January 1, 2018, and each January 1 thereafter, the monthly cost limits for
246.4 elderly waiver services in effect on the previous December 31 shall be increased by the
246.5 difference between any legislatively adopted home and community-based provider rate
246.6 increases effective on January 1 or since the previous January 1 and the average statewide
246.7 percentage increase in nursing facility operating payment rates under chapter 256R, effective
246.8 the previous January 1. This paragraph shall only apply if the average statewide percentage
246.9 increase in nursing facility operating payment rates is greater than any legislatively adopted
246.10 home and community-based provider rate increases effective on January 1, or occurring
246.11 since the previous January 1.

246.12 (f) The commissioner shall approve an exception to the monthly case mix budget cap
246.13 in paragraph (a) to pay for an enhanced rate for personal care services as described in section
246.14 256B.0659. The exception shall not exceed 107.5 percent of the budget otherwise available
246.15 to the individual. The exception must be reapproved on an annual basis at the time of a
246.16 participant's annual reassessment.

246.17 **EFFECTIVE DATE.** This section is effective July 1, 2019, or upon federal approval,
246.18 whichever is later. The commissioner of human services shall notify the revisor of statutes
246.19 when federal approval is obtained.

246.20 Sec. 33. Minnesota Statutes 2018, section 256B.0949, is amended by adding a subdivision
246.21 to read:

246.22 Subd. 16a. **Background studies.** The requirements for background studies under this
246.23 section shall be met by an early intensive developmental and behavioral intervention services
246.24 agency through the commissioner's NETStudy system as provided under sections 245C.03,
246.25 subdivision 13, and 245C.10, subdivision 14.

246.26 Sec. 34. Minnesota Statutes 2018, section 256B.4913, subdivision 4a, is amended to read:

246.27 Subd. 4a. **Rate stabilization adjustment.** (a) For purposes of this subdivision,
246.28 "implementation period" means the period beginning January 1, 2014, and ending on the
246.29 last day of the month in which the rate management system is populated with the data
246.30 necessary to calculate rates for substantially all individuals receiving home and
246.31 community-based waiver services under sections 256B.092 and 256B.49. "Banding period"
246.32 means the time period beginning on January 1, 2014, and ending upon the expiration of the
246.33 12-month period defined in paragraph (c), clause (5).

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

247.4 (1) for a day service recipient who was not authorized to receive these waiver services
247.5 prior to January 1, 2014; added a new service or services on or after January 1, 2014; or
247.6 changed providers on or after January 1, 2014, the historical rate must be the weighted
247.7 average authorized rate for the provider number in the county of service, effective December
247.8 1, 2013; or

247.9 (2) for a unit-based service with programming or a unit-based service without
247.10 programming recipient who was not authorized to receive these waiver services prior to
247.11 January 1, 2014; added a new service or services on or after January 1, 2014; or changed
247.12 providers on or after January 1, 2014, the historical rate must be the weighted average
247.13 authorized rate for each provider number in the county of service, effective December 1,
247.14 2013; or

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

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

247.21 (1) 0.5 percent from the historical rate for the implementation period;

247.22 (2) 0.5 percent from the rate in effect in clause (1), for the 12-month period immediately
247.23 following the time period of clause (1);

247.24 (3) 0.5 percent from the rate in effect in clause (2), for the 12-month period immediately
247.25 following the time period of clause (2);

247.26 (4) 1.0 percent from the rate in effect in clause (3), for the 12-month period immediately
247.27 following the time period of clause (3);

247.28 (5) 1.0 percent from the rate in effect in clause (4), for the 12-month period immediately
247.29 following the time period of clause (4); and

247.30 (6) no adjustment to the rate in effect in clause (5) for the 12-month period immediately
247.31 following the time period of clause (5). During this banding rate period, the commissioner
247.32 shall not enforce any rate decrease or increase that would otherwise result from the end of

248.1 the banding period. ~~The commissioner shall, upon enactment, seek federal approval for the~~
 248.2 ~~addition of this banding period; and~~

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

248.5 (d) The commissioner shall review all changes to rates that were in effect on December
 248.6 1, 2013, to verify that the rates in effect produce the equivalent level of spending and service
 248.7 unit utilization on an annual basis as those in effect on October 31, 2013.

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

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

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

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

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

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

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

248.25 Sec. 35. Minnesota Statutes 2018, section 256B.4913, subdivision 5, is amended to read:

248.26 Subd. 5. **Stakeholder consultation and county training.** (a) The commissioner shall
 248.27 continue consultation on regular intervals with the existing stakeholder group established
 248.28 as part of the rate-setting methodology process and others, to gather input, concerns, and
 248.29 data, to assist in the ~~full implementation~~ ongoing administration of the ~~new~~ rate payment
 248.30 system and to make pertinent information available to the public through the department's
 248.31 website.

249.1 (b) The commissioner shall offer training at least annually for county personnel
 249.2 responsible for administering the rate-setting framework in a manner consistent with this
 249.3 section and section 256B.4914.

249.4 (c) The commissioner shall maintain an online instruction manual explaining the
 249.5 rate-setting framework. The manual shall be consistent with this section and section
 249.6 256B.4914, and shall be accessible to all stakeholders including recipients, representatives
 249.7 of recipients, county or tribal agencies, and license holders.

249.8 (d) The commissioner shall not defer to the county or tribal agency on matters of technical
 249.9 application of the rate-setting framework, and a county or tribal agency shall not set rates
 249.10 in a manner that conflicts with this section or section 256B.4914.

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

249.12 Sec. 36. Minnesota Statutes 2018, section 256B.4914, subdivision 2, is amended to read:

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

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

249.16 (c) "Comparable occupations" means the occupations, excluding direct care staff, as
 249.17 represented by the Bureau of Labor Statistics standard occupational classification codes
 249.18 that have the same classification for:

249.19 (1) typical education needed for entry;

249.20 (2) work experience in a related occupation; and

249.21 (3) typical on-the-job training competency as the most predominant classification for
 249.22 direct care staff.

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

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

249.28 (f) "Direct care staff" means employees providing direct service to people receiving
 249.29 services under this section. Direct care staff excludes executive, managerial, and
 249.30 administrative staff.

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

250.4 ~~(f)~~ (h) "Individual staffing" means the time spent as a one-to-one interaction specific to
250.5 an individual recipient by staff to provide direct support and assistance with activities of
250.6 daily living, instrumental activities of daily living, and training to participants, and is based
250.7 on the requirements in each individual's coordinated service and support plan under section
250.8 245D.02, subdivision 4b; any coordinated service and support plan addendum under section
250.9 245D.02, subdivision 4c; and an assessment tool. Provider observation of an individual's
250.10 needs must also be considered.

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

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

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

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

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

250.22 ~~(l)~~ (n) "Shared staffing" means time spent by employees, not defined under paragraph
250.23 (f), providing or available to provide more than one individual with direct support and
250.24 assistance with activities of daily living as defined under section 256B.0659, subdivision
250.25 1, paragraph (b); instrumental activities of daily living as defined under section 256B.0659,
250.26 subdivision 1, paragraph (i); ancillary activities needed to support individual services; and
250.27 training to participants, and is based on the requirements in each individual's coordinated
250.28 service and support plan under section 245D.02, subdivision 4b; any coordinated service
250.29 and support plan addendum under section 245D.02, subdivision 4c; an assessment tool; and
250.30 provider observation of an individual's service need. Total shared staffing hours are divided
250.31 proportionally by the number of individuals who receive the shared service provisions.

250.32 ~~(m)~~ (o) "Staffing ratio" means the number of recipients a service provider employee
250.33 supports during a unit of service based on a uniform assessment tool, provider observation,

251.1 case history, and the recipient's services of choice, and not based on the staffing ratios under
251.2 section 245D.31.

251.3 ~~(n)~~ (p) "Unit of service" means the following:

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

251.7 (2) for day services under subdivision 7:

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

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

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

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

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

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

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

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

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

251.24 (4) for unit-based services without programming under subdivision 9, a unit of service
251.25 is 15 minutes.

251.26 Sec. 37. Minnesota Statutes 2018, section 256B.4914, subdivision 4, is amended to read:

251.27 Subd. 4. **Data collection for rate determination.** (a) Rates for applicable home and
251.28 community-based waived services, including rate exceptions under subdivision 12, are
251.29 set by the rates management system.

252.1 ~~(b) Data for services under section 256B.4913, subdivision 4a, shall be collected in a~~
 252.2 ~~manner prescribed by the commissioner.~~

252.3 ~~(e)~~ (b) Data and information in the rates management system may be used to calculate
 252.4 an individual's rate.

252.5 ~~(d)~~ (c) Service providers, with information from the community support plan and
 252.6 oversight by lead agencies, shall provide values and information needed to calculate an
 252.7 individual's rate into the rates management system. The determination of service levels must
 252.8 be part of a discussion with members of the support team as defined in section 245D.02,
 252.9 subdivision 34. This discussion must occur prior to the final establishment of each individual's
 252.10 rate. The values and information include:

252.11 (1) shared staffing hours;

252.12 (2) individual staffing hours;

252.13 (3) direct registered nurse hours;

252.14 (4) direct licensed practical nurse hours;

252.15 (5) staffing ratios;

252.16 (6) information to document variable levels of service qualification for variable levels
 252.17 of reimbursement in each framework;

252.18 (7) shared or individualized arrangements for unit-based services, including the staffing
 252.19 ratio;

252.20 (8) number of trips and miles for transportation services; and

252.21 (9) service hours provided through monitoring technology.

252.22 ~~(e)~~ (d) Updates to individual data must include:

252.23 (1) data for each individual that is updated annually when renewing service plans; and

252.24 (2) requests by individuals or lead agencies to update a rate whenever there is a change
 252.25 in an individual's service needs, with accompanying documentation.

252.26 ~~(f)~~ (e) Lead agencies shall review and approve all services reflecting each individual's
 252.27 needs, and the values to calculate the final payment rate for services with variables under
 252.28 subdivisions 6, 7, 8, and 9 for each individual. Lead agencies must notify the individual and
 252.29 the service provider of the final agreed-upon values and rate, and provide information that
 252.30 is identical to what was entered into the rates management system. If a value used was
 252.31 mistakenly or erroneously entered and used to calculate a rate, a provider may petition lead

253.1 agencies to correct it. Lead agencies must respond to these requests. When responding to
 253.2 the request, the lead agency must consider:

253.3 (1) meeting the health and welfare needs of the individual or individuals receiving
 253.4 services by service site, identified in their coordinated service and support plan under section
 253.5 245D.02, subdivision 4b, and any addendum under section 245D.02, subdivision 4c;

253.6 (2) meeting the requirements for staffing under subdivision 2, paragraphs ~~(h)~~ (h), ~~(i)~~ (n),
 253.7 and ~~(m)~~ (o); and meeting or exceeding the licensing standards for staffing required under
 253.8 section 245D.09, subdivision 1; and

253.9 (3) meeting the staffing ratio requirements under subdivision 2, paragraph ~~(n)~~ (o), and
 253.10 meeting or exceeding the licensing standards for staffing required under section 245D.31.

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

253.12 Sec. 38. Minnesota Statutes 2018, section 256B.4914, subdivision 5, is amended to read:

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

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

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

253.25 (ii) 85 percent of the subtotal of 20 percent of the median wage for home health aide
 253.26 (SOC code 31-1011); 20 percent of the median wage for personal and home health aide
 253.27 (SOC code 39-9021); 20 percent of the median wage for nursing assistant (SOC code
 253.28 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053);
 253.29 and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

253.30 (2) for day services, 20 percent of the median wage for nursing assistant (SOC code
 253.31 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053);
 253.32 and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

254.1 (3) for residential asleep-overnight staff, the wage is the minimum wage in Minnesota
254.2 for large employers, except in a family foster care setting, the wage is 36 percent of the
254.3 minimum wage in Minnesota for large employers;

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

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

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

254.10 (7) for supportive living services staff, 20 percent of the median wage for nursing assistant
254.11 (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code
254.12 29-2053); and 60 percent of the median wage for social and human services aide (SOC code
254.13 21-1093);

254.14 (8) for housing access coordination staff, 100 percent of the median wage for community
254.15 and social services specialist (SOC code 21-1099);

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

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

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

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

254.31 (13) for supported employment staff, 20 percent of the median wage for nursing assistant
254.32 (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code

255.1 29-2053); and 60 percent of the median wage for social and human services aide (SOC code
255.2 21-1093);

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

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

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

255.12 (17) for adult companion staff, 50 percent of the median wage for personal and home
255.13 care aide (SOC code 39-9021); and 50 percent of the median wage for nursing assistant
255.14 (SOC code 31-1014);

255.15 (18) for night supervision staff, 20 percent of the median wage for home health aide
255.16 (SOC code 31-1011); 20 percent of the median wage for personal and home health aide
255.17 (SOC code 39-9021); 20 percent of the median wage for nursing assistant (SOC code
255.18 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053);
255.19 and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

255.20 (19) for respite staff, 50 percent of the median wage for personal and home care aide
255.21 (SOC code 39-9021); and 50 percent of the median wage for nursing assistant (SOC code
255.22 31-1014);

255.23 (20) for personal support staff, 50 percent of the median wage for personal and home
255.24 care aide (SOC code 39-9021); and 50 percent of the median wage for nursing assistant
255.25 (SOC code 31-1014);

255.26 (21) for supervisory staff, 100 percent of the median wage for community and social
255.27 services specialist (SOC code 21-1099), with the exception of the supervisor of behavior
255.28 professional, behavior analyst, and behavior specialists, which is 100 percent of the median
255.29 wage for clinical counseling and school psychologist (SOC code 19-3031);

255.30 (22) for registered nurse staff, 100 percent of the median wage for registered nurses
255.31 (SOC code 29-1141); and

255.32 (23) for licensed practical nurse staff, 100 percent of the median wage for licensed
255.33 practical nurses (SOC code 29-2061).

- 256.1 (b) Component values for residential support services are:
- 256.2 (1) competitive workforce factor: 4.7 percent;
- 256.3 ~~(1)~~ (2) supervisory span of control ratio: 11 percent;
- 256.4 ~~(2)~~ (3) employee vacation, sick, and training allowance ratio: 8.71 percent;
- 256.5 ~~(3)~~ (4) employee-related cost ratio: 23.6 percent;
- 256.6 ~~(4)~~ (5) general administrative support ratio: 13.25 percent;
- 256.7 ~~(5)~~ (6) program-related expense ratio: 1.3 percent; and
- 256.8 ~~(6)~~ (7) absence and utilization factor ratio: 3.9 percent.
- 256.9 (c) Component values for family foster care are:
- 256.10 (1) competitive workforce factor: 4.7 percent;
- 256.11 ~~(1)~~ (2) supervisory span of control ratio: 11 percent;
- 256.12 ~~(2)~~ (3) employee vacation, sick, and training allowance ratio: 8.71 percent;
- 256.13 ~~(3)~~ (4) employee-related cost ratio: 23.6 percent;
- 256.14 ~~(4)~~ (5) general administrative support ratio: 3.3 percent;
- 256.15 ~~(5)~~ (6) program-related expense ratio: 1.3 percent; and
- 256.16 ~~(6)~~ (7) absence factor: 1.7 percent.
- 256.17 (d) Component values for day services for all services are:
- 256.18 (1) competitive workforce factor: 4.7 percent;
- 256.19 ~~(1)~~ (2) supervisory span of control ratio: 11 percent;
- 256.20 ~~(2)~~ (3) employee vacation, sick, and training allowance ratio: 8.71 percent;
- 256.21 ~~(3)~~ (4) employee-related cost ratio: 23.6 percent;
- 256.22 ~~(4)~~ (5) program plan support ratio: 5.6 percent;
- 256.23 ~~(5)~~ (6) client programming and support ratio: ten percent;
- 256.24 ~~(6)~~ (7) general administrative support ratio: 13.25 percent;
- 256.25 ~~(7)~~ (8) program-related expense ratio: 1.8 percent; and
- 256.26 ~~(8)~~ (9) absence and utilization factor ratio: 9.4 percent.
- 256.27 (e) Component values for unit-based services with programming are:

- 257.1 (1) competitive workforce factor: 4.7 percent;
- 257.2 ~~(1)~~ (2) supervisory span of control ratio: 11 percent;
- 257.3 ~~(2)~~ (3) employee vacation, sick, and training allowance ratio: 8.71 percent;
- 257.4 ~~(3)~~ (4) employee-related cost ratio: 23.6 percent;
- 257.5 ~~(4)~~ (5) program plan supports ratio: 15.5 percent;
- 257.6 ~~(5)~~ (6) client programming and supports ratio: 4.7 percent;
- 257.7 ~~(6)~~ (7) general administrative support ratio: 13.25 percent;
- 257.8 ~~(7)~~ (8) program-related expense ratio: 6.1 percent; and
- 257.9 ~~(8)~~ (9) absence and utilization factor ratio: 3.9 percent.
- 257.10 (f) Component values for unit-based services without programming except respite are:
- 257.11 (1) competitive workforce factor: 4.7 percent;
- 257.12 ~~(1)~~ (2) supervisory span of control ratio: 11 percent;
- 257.13 ~~(2)~~ (3) employee vacation, sick, and training allowance ratio: 8.71 percent;
- 257.14 ~~(3)~~ (4) employee-related cost ratio: 23.6 percent;
- 257.15 ~~(4)~~ (5) program plan support ratio: 7.0 percent;
- 257.16 ~~(5)~~ (6) client programming and support ratio: 2.3 percent;
- 257.17 ~~(6)~~ (7) general administrative support ratio: 13.25 percent;
- 257.18 ~~(7)~~ (8) program-related expense ratio: 2.9 percent; and
- 257.19 ~~(8)~~ (9) absence and utilization factor ratio: 3.9 percent.
- 257.20 (g) Component values for unit-based services without programming for respite are:
- 257.21 (1) competitive workforce factor: 4.7 percent;
- 257.22 ~~(1)~~ (2) supervisory span of control ratio: 11 percent;
- 257.23 ~~(2)~~ (3) employee vacation, sick, and training allowance ratio: 8.71 percent;
- 257.24 ~~(3)~~ (4) employee-related cost ratio: 23.6 percent;
- 257.25 ~~(4)~~ (5) general administrative support ratio: 13.25 percent;
- 257.26 ~~(5)~~ (6) program-related expense ratio: 2.9 percent; and
- 257.27 ~~(6)~~ (7) absence and utilization factor ratio: 3.9 percent.

258.1 ~~(h) On July 1, 2017, the commissioner shall update the base wage index in paragraph~~
 258.2 ~~(a) based on the wage data by standard occupational code (SOC) from the Bureau of Labor~~
 258.3 ~~Statistics available on December 31, 2016. The commissioner shall publish these updated~~
 258.4 ~~values and load them into the rate management system. On July 1, 2022, and every five two~~
 258.5 years thereafter, the commissioner shall update the base wage index in paragraph (a) based
 258.6 on the most recently available wage data by SOC from the Bureau of Labor Statistics. The
 258.7 commissioner shall publish these updated values and load them into the rate management
 258.8 system.

258.9 (i) On July 1, 2022, and July 1, 2024, the commissioner shall increase paragraph (b),
 258.10 clause (1); paragraph (c), clause (1); paragraph (d), clause (1); paragraph (e), clause (1);
 258.11 paragraph (f), clause (1); and paragraph (g), clause (1), by two percentage points.

258.12 (j) Beginning January 1, 2026, the commissioner shall report to the chairs and ranking
 258.13 minority members of the legislative committees and divisions with jurisdiction over health
 258.14 and human services policy and finance an analysis of the competitive workforce factor. The
 258.15 report must include recommendations to update the competitive workforce factor using:

258.16 (1) the most recently available wage data by SOC code for the weighted average wage
 258.17 for direct care staff for residential services and direct care staff for day services;

258.18 (2) the most recently available wage data by SOC code of the weighted average wage
 258.19 of comparable occupations; and

258.20 (3) workforce data as required under subdivision 10a, paragraph (g).

258.21 The commissioner shall not recommend an increase or decrease of the competitive workforce
 258.22 factor from the current value by more than two percentage points. If, after a biennial analysis
 258.23 for the next report, the competitive workforce factor is less than or equal to zero, the
 258.24 commissioner shall recommend a competitive workforce factor of zero.

258.25 ~~(i) On July 1, 2017, the commissioner shall update the framework components in~~
 258.26 ~~paragraph (d), clause (5); paragraph (e), clause (5); and paragraph (f), clause (5); subdivision~~
 258.27 ~~6, clauses (8) and (9); and subdivision 7, clauses (10), (16), and (17), for changes in the~~
 258.28 ~~Consumer Price Index. The commissioner will adjust these values higher or lower by the~~
 258.29 ~~percentage change in the Consumer Price Index-All Items, United States city average~~
 258.30 ~~(CPI-U) from January 1, 2014, to January 1, 2017. The commissioner shall publish these~~
 258.31 ~~updated values and load them into the rate management system. (k) On July 1, 2022, and~~
 258.32 every five two years thereafter, the commissioner shall update the framework components
 258.33 in paragraph (d), clause (5); paragraph (e), clause (5); and paragraph (f), clause (5);
 258.34 subdivision 6, clauses (8) and (9); and subdivision 7, clauses (10), (16), and (17), for changes

259.1 in the Consumer Price Index. The commissioner shall adjust these values higher or lower
 259.2 by the percentage change in the CPI-U from the date of the previous update to the ~~date of~~
 259.3 ~~the~~ data most recently available prior to the scheduled update. The commissioner shall
 259.4 publish these updated values and load them into the rate management system.

259.5 (l) Upon the implementation of the updates under paragraphs (h) and (k), rate adjustments
 259.6 authorized under section 256B.439, subdivision 7; Laws 2013, chapter 108, article 7, section
 259.7 60; and Laws 2014, chapter 312, article 27, section 75, shall be removed from service rates
 259.8 calculated under this section.

259.9 (m) Any rate adjustments applied to the service rates calculated under this section outside
 259.10 of the cost components and rate methodology specified in this section shall be removed
 259.11 from rate calculations upon implementation of the updates under paragraphs (h) and (k).

259.12 (n) In this subdivision, if Bureau of Labor Statistics occupational codes or Consumer
 259.13 Price Index items are unavailable in the future, the commissioner shall recommend to the
 259.14 legislature codes or items to update and replace missing component values.

259.15 **EFFECTIVE DATE.** This section is effective January 1, 2020, or upon federal approval,
 259.16 except:

259.17 (1) paragraphs (h) and (k) are effective July 1, 2022, or upon federal approval, whichever
 259.18 is later; and

259.19 (2) paragraph (l) is effective retroactively from July 1, 2018.

259.20 The commissioner of human services shall notify the revisor of statutes when federal approval
 259.21 is obtained or denied.

259.22 Sec. 39. Minnesota Statutes 2018, section 256B.4914, is amended by adding a subdivision
 259.23 to read:

259.24 Subd. 5a. **Direct care staff; compensation.** (a) A provider paid with rates determined
 259.25 under subdivision 6 must use a minimum of 66 percent of the revenue generated by rates
 259.26 determined under subdivision 6 for direct care staff compensation.

259.27 (b) A provider paid with rates determined under subdivision 7 must use a minimum of
 259.28 45 percent of the revenue generated by rates determined under subdivision 7 for direct care
 259.29 staff compensation.

259.30 (c) A provider paid with rates determined under subdivision 8 or 9 must use a minimum
 259.31 of 55 percent of the revenue generated by rates determined under subdivisions 8 and 9 for
 259.32 direct care staff compensation.

260.1 (d) Applicable compensation under this subdivision includes:

260.2 (1) wages;

260.3 (2) Social Security and Medicare taxes;

260.4 (3) federal unemployment insurance tax;

260.5 (4) state unemployment insurance tax;

260.6 (5) workers' compensation insurance;

260.7 (6) health insurance;

260.8 (7) dental insurance;

260.9 (8) vision insurance;

260.10 (9) life insurance;

260.11 (10) short-term disability insurance;

260.12 (11) long-term disability insurance;

260.13 (12) retirement spending;

260.14 (13) tuition reimbursement;

260.15 (14) wellness programs;

260.16 (15) paid vacation time;

260.17 (16) paid sick time; or

260.18 (17) other items of monetary value provided to direct care staff.

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

260.20 Sec. 40. Minnesota Statutes 2018, section 256B.4914, subdivision 6, is amended to read:

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

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

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

261.1 (3) except for subdivision 5, paragraph (a), clauses (3) and (21) to (23), multiply the
 261.2 result of clause (2) by the product of one plus the competitive workforce factor in subdivision
 261.3 5, paragraph (b), clause (1);

261.4 ~~(3)~~ (4) for a recipient requiring customization for deaf and hard-of-hearing language
 261.5 accessibility under subdivision 12, add the customization rate provided in subdivision 12
 261.6 to the result of clause ~~(2)~~ (3). ~~This is defined as the customized direct care rate;~~

261.7 ~~(4)~~ (5) multiply the number of shared and individual direct staff hours provided on site
 261.8 or through monitoring technology and nursing hours by the appropriate staff wages ~~in~~
 261.9 ~~subdivision 5, paragraph (a), or the customized direct care rate;~~

261.10 ~~(5)~~ (6) multiply the number of shared and individual direct staff hours provided on site
 261.11 or through monitoring technology and nursing hours by the product of the supervision span
 261.12 of control ratio in subdivision 5, paragraph (b), clause ~~(4)~~ (2), and the appropriate supervision
 261.13 wage in subdivision 5, paragraph (a), clause (21);

261.14 ~~(6)~~ (7) combine the results of clauses ~~(4) and (5)~~ and (6), excluding any shared and
 261.15 individual direct staff hours provided through monitoring technology, and multiply the
 261.16 result by one plus the employee vacation, sick, and training allowance ratio in subdivision
 261.17 5, paragraph (b), clause ~~(2)~~ (3). This is defined as the direct staffing cost;

261.18 ~~(7)~~ (8) for employee-related expenses, multiply the direct staffing cost, excluding any
 261.19 shared and individual direct staff hours provided through monitoring technology, by one
 261.20 plus the employee-related cost ratio in subdivision 5, paragraph (b), clause ~~(3)~~ (4);

261.21 ~~(8)~~ (9) for client programming and supports, the commissioner shall add \$2,179; and

261.22 ~~(9)~~ (10) for transportation, if provided, the commissioner shall add \$1,680, or \$3,000 if
 261.23 customized for adapted transport, based on the resident with the highest assessed need.

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

261.25 (1) subtotal paragraph (a), clauses ~~(7) to (9)~~ (8) to (10), and the direct staffing cost of
 261.26 any shared and individual direct staff hours provided through monitoring technology that
 261.27 was excluded in clause ~~(7)~~ (8);

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

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

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

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

262.7 ~~(d) For individuals enrolled prior to January 1, 2014, the days of service authorized must~~
 262.8 ~~meet or exceed the days of service used to convert service agreements in effect on December~~
 262.9 ~~1, 2013, and must not result in a reduction in spending or service utilization due to conversion~~
 262.10 ~~during the implementation period under section 256B.4913, subdivision 4a. If during the~~
 262.11 ~~implementation period, an individual's historical rate, including adjustments required under~~
 262.12 ~~section 256B.4913, subdivision 4a, paragraph (c), is equal to or greater than the rate~~
 262.13 ~~determined in this subdivision, the number of days authorized for the individual is 365.~~

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

262.16 **EFFECTIVE DATE.** This section is effective January 1, 2020, or upon federal approval,
 262.17 whichever is later. The commissioner of human services shall notify the revisor of statutes
 262.18 when federal approval is obtained.

262.19 Sec. 41. Minnesota Statutes 2018, section 256B.4914, subdivision 7, is amended to read:

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

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

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

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

262.28 (2) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics
 262.29 Minnesota-specific rates or rates derived by the commissioner as provided in subdivision
 262.30 5;

263.1 (3) except for subdivision 5, paragraph (a), clauses (3) and (21) to (23), multiply the
 263.2 result of clause (2) by the product of one plus the competitive workforce factor in subdivision
 263.3 5, paragraph (d), clause (1);

263.4 ~~(3)~~ (4) for a recipient requiring customization for deaf and hard-of-hearing language
 263.5 accessibility under subdivision 12, add the customization rate provided in subdivision 12
 263.6 to the result of clause ~~(2)~~ (3). ~~This is defined as the customized direct care rate;~~

263.7 ~~(4)~~ (5) multiply the number of day program direct staff hours and nursing hours by the
 263.8 appropriate staff wage ~~in subdivision 5, paragraph (a), or the customized direct care rate;~~

263.9 ~~(5)~~ (6) multiply the number of day direct staff hours by the product of the supervision
 263.10 span of control ratio in subdivision 5, paragraph (d), clause ~~(1)~~ (2), and the appropriate
 263.11 supervision wage in subdivision 5, paragraph (a), clause (21);

263.12 ~~(6)~~ (7) combine the results of clauses ~~(4)~~ and (5) ~~and (6)~~, and multiply the result by one
 263.13 plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph
 263.14 (d), clause ~~(2)~~ (3). This is defined as the direct staffing rate;

263.15 ~~(7)~~ (8) for program plan support, multiply the result of clause ~~(6)~~ (7) by one plus the
 263.16 program plan support ratio in subdivision 5, paragraph (d), clause ~~(4)~~ (5);

263.17 ~~(8)~~ (9) for employee-related expenses, multiply the result of clause ~~(7)~~ (8) by one plus
 263.18 the employee-related cost ratio in subdivision 5, paragraph (d), clause ~~(3)~~ (4);

263.19 ~~(9)~~ (10) for client programming and supports, multiply the result of clause ~~(8)~~ (9) by
 263.20 one plus the client programming and support ratio in subdivision 5, paragraph (d), clause
 263.21 ~~(5)~~ (6);

263.22 ~~(10)~~ (11) for program facility costs, add \$19.30 per week with consideration of staffing
 263.23 ratios to meet individual needs;

263.24 ~~(11)~~ (12) for adult day bath services, add \$7.01 per 15 minute unit;

263.25 ~~(12)~~ (13) this is the subtotal rate;

263.26 ~~(13)~~ (14) sum the standard general and administrative rate, the program-related expense
 263.27 ratio, and the absence and utilization factor ratio;

263.28 ~~(14)~~ (15) divide the result of clause ~~(12)~~ (13) by one minus the result of clause ~~(13)~~ (14).
 263.29 This is the total payment amount;

263.30 ~~(15)~~ (16) adjust the result of clause ~~(14)~~ (15) by a factor to be determined by the
 263.31 commissioner to adjust for regional differences in the cost of providing services;

264.1 ~~(16)~~ (17) for transportation provided as part of day training and habilitation for an
 264.2 individual who does not require a lift, add:

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

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

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

264.12 (iv) \$33.50 for a trip of 51 miles or more for a nonshared ride in a vehicle without a lift,
 264.13 \$16.50 for a shared ride in a vehicle without a lift, and \$20.75 for a shared ride in a vehicle
 264.14 with a lift;

264.15 ~~(17)~~ (18) for transportation provided as part of day training and habilitation for an
 264.16 individual who does require a lift, add:

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

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

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

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

264.25 **EFFECTIVE DATE.** This section is effective January 1, 2020, or upon federal approval,
 264.26 whichever is later. The commissioner of human services shall notify the revisor of statutes
 264.27 when federal approval is obtained.

264.28 Sec. 42. Minnesota Statutes 2018, section 256B.4914, subdivision 8, is amended to read:

264.29 Subd. 8. **Payments for unit-based services with programming.** Payments for unit-based
 264.30 services with programming, including behavior programming, housing access coordination,
 264.31 in-home family support, independent living skills training, independent living skills specialist
 264.32 services, individualized home supports, hourly supported living services, employment

265.1 exploration services, employment development services, supported employment, and
 265.2 employment support services provided to an individual outside of any day or residential
 265.3 service plan must be calculated as follows, unless the services are authorized separately
 265.4 under subdivision 6 or 7:

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

265.6 (2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics
 265.7 Minnesota-specific rates or rates derived by the commissioner as provided in subdivision
 265.8 5;

265.9 (3) except for subdivision 5, paragraph (a), clauses (3) and (21) to (23), multiply the
 265.10 result of clause (2) by the product of one plus the competitive workforce factor in subdivision
 265.11 5, paragraph (e), clause (1);

265.12 ~~(3)~~ (4) for a recipient requiring customization for deaf and hard-of-hearing language
 265.13 accessibility under subdivision 12, add the customization rate provided in subdivision 12
 265.14 to the result of clause ~~(2)~~ (3). ~~This is defined as the customized direct care rate;~~

265.15 ~~(4)~~ (5) multiply the number of direct staff hours by the appropriate staff wage ~~in~~
 265.16 ~~subdivision 5, paragraph (a), or the customized direct care rate;~~

265.17 ~~(5)~~ (6) multiply the number of direct staff hours by the product of the supervision span
 265.18 of control ratio in subdivision 5, paragraph (e), clause ~~(1)~~ (2), and the appropriate supervision
 265.19 wage in subdivision 5, paragraph (a), clause (21);

265.20 ~~(6)~~ (7) combine the results of clauses ~~(4)~~ and (5) and ~~(6)~~ (6), and multiply the result by one
 265.21 plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph
 265.22 (e), clause ~~(2)~~ (3). This is defined as the direct staffing rate;

265.23 ~~(7)~~ (8) for program plan support, multiply the result of clause ~~(6)~~ (7) by one plus the
 265.24 program plan supports ratio in subdivision 5, paragraph (e), clause ~~(4)~~ (5);

265.25 ~~(8)~~ (9) for employee-related expenses, multiply the result of clause ~~(7)~~ (8) by one plus
 265.26 the employee-related cost ratio in subdivision 5, paragraph (e), clause ~~(3)~~ (4);

265.27 ~~(9)~~ (10) for client programming and supports, multiply the result of clause ~~(8)~~ (9) by
 265.28 one plus the client programming and supports ratio in subdivision 5, paragraph (e), clause
 265.29 ~~(5)~~ (6);

265.30 ~~(10)~~ (11) this is the subtotal rate;

265.31 ~~(11)~~ (12) sum the standard general and administrative rate, the program-related expense
 265.32 ratio, and the absence and utilization factor ratio;

266.1 ~~(12)~~ (13) divide the result of clause ~~(10)~~ (11) by one minus the result of clause ~~(11)~~ (12).

266.2 This is the total payment amount;

266.3 ~~(13)~~ (14) for supported employment provided in a shared manner, divide the total payment
 266.4 amount in clause ~~(12)~~ (13) by the number of service recipients, not to exceed three. For
 266.5 employment support services provided in a shared manner, divide the total payment amount
 266.6 in clause ~~(12)~~ (13) by the number of service recipients, not to exceed six. For independent
 266.7 living skills training and individualized home supports provided in a shared manner, divide
 266.8 the total payment amount in clause ~~(12)~~ (13) by the number of service recipients, not to
 266.9 exceed two; and

266.10 ~~(14)~~ (15) adjust the result of clause ~~(13)~~ (14) by a factor to be determined by the
 266.11 commissioner to adjust for regional differences in the cost of providing services.

266.12 **EFFECTIVE DATE.** This section is effective January 1, 2020, or upon federal approval,
 266.13 whichever is later. The commissioner of human services shall notify the revisor of statutes
 266.14 when federal approval is obtained.

266.15 Sec. 43. Minnesota Statutes 2018, section 256B.4914, subdivision 9, is amended to read:

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

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

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

266.25 (3) except for subdivision 5, paragraph (a), clauses (3) and (21) to (23), multiply the
 266.26 result of clause (2) by the product of one plus the competitive workforce factor in subdivision
 266.27 5, paragraph (f), clause (1);

266.28 ~~(3)~~ (4) for a recipient requiring customization for deaf and hard-of-hearing language
 266.29 accessibility under subdivision 12, add the customization rate provided in subdivision 12
 266.30 to the result of clause ~~(2)~~ (3). ~~This is defined as the customized direct care rate;~~

266.31 ~~(4)~~ (5) multiply the number of direct staff hours by the appropriate staff wage ~~in~~
 266.32 ~~subdivision 5 or the customized direct care rate;~~

267.1 ~~(5)~~ (6) multiply the number of direct staff hours by the product of the supervision span
 267.2 of control ratio in subdivision 5, paragraph (f), clause ~~(1)~~ (2), and the appropriate supervision
 267.3 wage in subdivision 5, paragraph (a), clause (21);

267.4 ~~(6)~~ (7) combine the results of clauses ~~(4)~~ and (5) and (6), and multiply the result by one
 267.5 plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph
 267.6 (f), clause ~~(2)~~ (3). This is defined as the direct staffing rate;

267.7 ~~(7)~~ (8) for program plan support, multiply the result of clause ~~(6)~~ (7) by one plus the
 267.8 program plan support ratio in subdivision 5, paragraph (f), clause ~~(4)~~ (5);

267.9 ~~(8)~~ (9) for employee-related expenses, multiply the result of clause ~~(7)~~ (8) by one plus
 267.10 the employee-related cost ratio in subdivision 5, paragraph (f), clause ~~(3)~~ (4);

267.11 ~~(9)~~ (10) for client programming and supports, multiply the result of clause ~~(8)~~ (9) by
 267.12 one plus the client programming and support ratio in subdivision 5, paragraph (f), clause
 267.13 ~~(5)~~ (6);

267.14 ~~(10)~~ (11) this is the subtotal rate;

267.15 ~~(11)~~ (12) sum the standard general and administrative rate, the program-related expense
 267.16 ratio, and the absence and utilization factor ratio;

267.17 ~~(12)~~ (13) divide the result of clause ~~(10)~~ (11) by one minus the result of clause ~~(11)~~ (12).
 267.18 This is the total payment amount;

267.19 ~~(13)~~ (14) for respite services, determine the number of day units of service to meet an
 267.20 individual's needs;

267.21 ~~(14)~~ (15) personnel hourly wage rates must be based on the 2009 Bureau of Labor
 267.22 Statistics Minnesota-specific rate or rates derived by the commissioner as provided in
 267.23 subdivision 5;

267.24 (16) except for subdivision 5, paragraph (a), clauses (3) and (21) to (23), multiply the
 267.25 result of clause (15) by the product of one plus the competitive workforce factor in
 267.26 subdivision 5, paragraph (g), clause (1);

267.27 ~~(15)~~ (17) for a recipient requiring deaf and hard-of-hearing customization under
 267.28 subdivision 12, add the customization rate provided in subdivision 12 to the result of clause
 267.29 ~~(14)~~ (16). ~~This is defined as the customized direct care rate;~~

267.30 ~~(16)~~ (18) multiply the number of direct staff hours by the appropriate staff wage in
 267.31 ~~subdivision 5, paragraph (a);~~

268.1 ~~(17)~~ (19) multiply the number of direct staff hours by the product of the supervisory
 268.2 span of control ratio in subdivision 5, paragraph (g), clause ~~(1)~~ (2), and the appropriate
 268.3 supervision wage in subdivision 5, paragraph (a), clause (21);

268.4 ~~(18)~~ (20) combine the results of clauses ~~(16)~~ (18) and ~~(17)~~ (19), and multiply the result
 268.5 by one plus the employee vacation, sick, and training allowance ratio in subdivision 5,
 268.6 paragraph (g), clause ~~(2)~~ (3). This is defined as the direct staffing rate;

268.7 ~~(19)~~ (21) for employee-related expenses, multiply the result of clause ~~(18)~~ (20) by one
 268.8 plus the employee-related cost ratio in subdivision 5, paragraph (g), clause ~~(3)~~ (4);

268.9 ~~(20)~~ (22) this is the subtotal rate;

268.10 ~~(21)~~ (23) sum the standard general and administrative rate, the program-related expense
 268.11 ratio, and the absence and utilization factor ratio;

268.12 ~~(22)~~ (24) divide the result of clause ~~(20)~~ (22) by one minus the result of clause ~~(21)~~ (23).
 268.13 This is the total payment amount; and

268.14 ~~(23)~~ (25) adjust the result of clauses ~~(12)~~ (13) and ~~(22)~~ (24) by a factor to be determined
 268.15 by the commissioner to adjust for regional differences in the cost of providing services.

268.16 **EFFECTIVE DATE.** This section is effective January 1, 2020, or upon federal approval,
 268.17 whichever is later. The commissioner of human services shall notify the revisor of statutes
 268.18 when federal approval is obtained.

268.19 Sec. 44. Minnesota Statutes 2018, section 256B.4914, subdivision 10, is amended to read:

268.20 Subd. 10. **Updating payment values and additional information.** ~~(a) From January~~
 268.21 ~~1, 2014, through December 31, 2017, the commissioner shall develop and implement uniform~~
 268.22 ~~procedures to refine terms and adjust values used to calculate payment rates in this section.~~

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

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

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

269.1 (3) the distinct underlying costs for services provided by a license holder under sections
 269.2 245D.05, 245D.06, 245D.07, 245D.071, 245D.081, and 245D.09, and for services provided
 269.3 by a license holder certified under section 245D.33.

269.4 ~~(c) Beginning January 1, 2014, through December 31, 2018, using a statistically valid~~
 269.5 ~~set of rates management system data, the commissioner, in consultation with stakeholders,~~
 269.6 ~~shall analyze for each service the average difference in the rate on December 31, 2013, and~~
 269.7 ~~the framework rate at the individual, provider, lead agency, and state levels. The~~
 269.8 ~~commissioner shall issue semiannual reports to the stakeholders on the difference in rates~~
 269.9 ~~by service and by county during the banding period under section 256B.4913, subdivision~~
 269.10 ~~4a. The commissioner shall issue the first report by October 1, 2014, and the final report~~
 269.11 ~~shall be issued by December 31, 2018.~~

269.12 ~~(d)~~ (b) No later than July 1, 2014, the commissioner, in consultation with stakeholders,
 269.13 shall begin the review and evaluation of the following values already in subdivisions 6 to
 269.14 9, or issues that impact all services, including, but not limited to:

269.15 (1) values for transportation rates;

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

269.17 (3) values for indirect services;

269.18 (4) values for nursing;

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

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

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

269.23 (8) direct care workforce labor market measures;

269.24 (9) any changes in state or federal law with a direct impact on the underlying cost of
 269.25 providing home and community-based services; and

269.26 ~~(9)~~ (10) outcome measures, determined by the commissioner, for home and
 269.27 community-based services rates determined under this section.

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

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

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

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

270.5 ~~(4) January 15, 2020 2021, with another a full report, and a full report once every four~~
 270.6 ~~years thereafter.~~

270.7 ~~(f) The commissioner shall implement a regional adjustment factor to all rate calculations~~
 270.8 ~~in subdivisions 6 to 9, effective no later than January 1, 2015. (d) Beginning July 1, 2017,~~
 270.9 ~~January 1, 2022, the commissioner shall renew analysis and implement changes to the~~
 270.10 ~~regional adjustment factors when adjustments required under subdivision 5, paragraph (h),~~
 270.11 ~~occur once every six years. Prior to implementation, the commissioner shall consult with~~
 270.12 ~~stakeholders on the methodology to calculate the adjustment.~~

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

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

270.18 (2) service utilization;

270.19 (3) county and tribal allocation changes; and

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

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

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

270.28 ~~(i) The commissioner shall study the underlying cost of absence and utilization for day~~
 270.29 ~~services. Based on the commissioner's evaluation of the data collected under this paragraph,~~
 270.30 ~~the commissioner shall make recommendations to the legislature by January 15, 2018, for~~
 270.31 ~~changes, if any, to the absence and utilization factor ratio component value for day services.~~

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

271.3 (h) The commissioner, in consultation with stakeholders, shall study value-based models
 271.4 and outcome-based payment strategies for fee-for-service home and community-based
 271.5 services and report to the legislative committees with jurisdiction over the disability waiver
 271.6 rate system by October 1, 2020, with recommended strategies to improve the quality,
 271.7 efficiency, and effectiveness of services.

271.8 **EFFECTIVE DATE.** This section is effective the day following final enactment, except
 271.9 for paragraph (f), which is effective January 1, 2020.

271.10 Sec. 45. Minnesota Statutes 2018, section 256B.4914, subdivision 10a, is amended to
 271.11 read:

271.12 Subd. 10a. **Reporting and analysis of cost data.** (a) The commissioner must ensure
 271.13 that wage values and component values in subdivisions 5 to 9 reflect the cost to provide the
 271.14 service. As determined by the commissioner, in consultation with stakeholders identified
 271.15 in section 256B.4913, subdivision 5, a provider enrolled to provide services with rates
 271.16 determined under this section must submit requested cost data to the commissioner to support
 271.17 research on the cost of providing services that have rates determined by the disability waiver
 271.18 rates system. Requested cost data may include, but is not limited to:

271.19 (1) worker wage costs;

271.20 (2) benefits paid;

271.21 (3) supervisor wage costs;

271.22 (4) executive wage costs;

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

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

271.25 (7) administrative costs paid;

271.26 (8) program costs paid;

271.27 (9) transportation costs paid;

271.28 (10) vacancy rates; and

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

272.1 (b) At least once in any five-year period, a provider must submit cost data for a fiscal
272.2 year that ended not more than 18 months prior to the submission date. The commissioner
272.3 shall provide each provider a 90-day notice prior to its submission due date. If a provider
272.4 fails to submit required reporting data, the commissioner shall provide notice to providers
272.5 that have not provided required data 30 days after the required submission date, and a second
272.6 notice for providers who have not provided required data 60 days after the required
272.7 submission date. The commissioner shall temporarily suspend payments to the provider if
272.8 cost data is not received 90 days after the required submission date. Withheld payments
272.9 shall be made once data is received by the commissioner.

272.10 (c) The commissioner shall conduct a random validation of data submitted under
272.11 paragraph (a) to ensure data accuracy. The commissioner shall analyze cost documentation
272.12 in paragraph (a) and provide recommendations for adjustments to cost components.

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

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

272.26 (f) Beginning November 1, 2019, providers enrolled to provide services with rates
272.27 determined under this section shall submit labor market data to the commissioner annually,
272.28 including but not limited to:

272.29 (1) number of direct care staff;

272.30 (2) wages of direct care staff;

272.31 (3) overtime wages of direct care staff;

272.32 (4) hours worked by direct care staff;

272.33 (5) overtime hours worked by direct care staff;

273.1 (6) benefits provided to direct care staff;

273.2 (7) direct care staff job vacancies; and

273.3 (8) direct care staff retention rates.

273.4 (g) Beginning February 1, 2020, the commissioner shall publish annual reports on
 273.5 provider and state-level labor market data, including but not limited to the data obtained
 273.6 under paragraph (f).

273.7 (h) The commissioner shall temporarily suspend payments to the provider if data
 273.8 requested under paragraph (f) is not received 90 days after the required submission date.
 273.9 The commissioner shall make withheld payments once data is received by the commissioner.

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

273.11 Sec. 46. Minnesota Statutes 2018, section 256B.4914, subdivision 14, is amended to read:

273.12 Subd. 14. **Exceptions.** (a) In a format prescribed by the commissioner, lead agencies
 273.13 must identify individuals with exceptional needs that cannot be met under the disability
 273.14 waiver rate system. The commissioner shall use that information to evaluate and, if necessary,
 273.15 approve an alternative payment rate for those individuals. Whether granted, denied, or
 273.16 modified, the commissioner shall respond to all exception requests in writing. The
 273.17 commissioner shall include in the written response the basis for the action and provide
 273.18 notification of the right to appeal under paragraph (h).

273.19 (b) Lead agencies must act on an exception request within 30 days and notify the initiator
 273.20 of the request of their recommendation in writing. A lead agency shall submit all exception
 273.21 requests along with its recommendation to the commissioner.

273.22 (c) An application for a rate exception may be submitted for the following criteria:

273.23 (1) an individual has service needs that cannot be met through additional units of service;

273.24 (2) an individual's rate determined under subdivisions 6, 7, 8, and 9 is so insufficient
 273.25 that it has resulted in an individual receiving a notice of discharge from the individual's
 273.26 provider; or

273.27 (3) an individual's service needs, including behavioral changes, require a level of service
 273.28 which necessitates a change in provider or which requires the current provider to propose
 273.29 service changes beyond those currently authorized.

273.30 (d) Exception requests must include the following information:

274.1 (1) the service needs required by each individual that are not accounted for in subdivisions
274.2 6, 7, 8, and 9;

274.3 (2) the service rate requested and the difference from the rate determined in subdivisions
274.4 6, 7, 8, and 9;

274.5 (3) a basis for the underlying costs used for the rate exception and any accompanying
274.6 documentation; and

274.7 (4) any contingencies for approval.

274.8 (e) Approved rate exceptions shall be managed within lead agency allocations under
274.9 sections 256B.092 and 256B.49.

274.10 (f) Individual disability waiver recipients, an interested party, or the license holder that
274.11 would receive the rate exception increase may request that a lead agency submit an exception
274.12 request. A lead agency that denies such a request shall notify the individual waiver recipient,
274.13 interested party, or license holder of its decision and the reasons for denying the request in
274.14 writing no later than 30 days after the request has been made and shall submit its denial to
274.15 the commissioner in accordance with paragraph (b). The reasons for the denial must be
274.16 based on the failure to meet the criteria in paragraph (c).

274.17 (g) The commissioner shall determine whether to approve or deny an exception request
274.18 no more than 30 days after receiving the request. If the commissioner denies the request,
274.19 the commissioner shall notify the lead agency and the individual disability waiver recipient,
274.20 the interested party, and the license holder in writing of the reasons for the denial.

274.21 (h) The individual disability waiver recipient may appeal any denial of an exception
274.22 request by either the lead agency or the commissioner, pursuant to sections 256.045 and
274.23 256.0451. When the denial of an exception request results in the proposed demission of a
274.24 waiver recipient from a residential or day habilitation program, the commissioner shall issue
274.25 a temporary stay of demission, when requested by the disability waiver recipient, consistent
274.26 with the provisions of section 256.045, subdivisions 4a and 6, paragraph (c). The temporary
274.27 stay shall remain in effect until the lead agency can provide an informed choice of
274.28 appropriate, alternative services to the disability waiver.

274.29 (i) Providers may petition lead agencies to update values that were entered incorrectly
274.30 or erroneously into the rate management system, based on past service level discussions
274.31 and determination in subdivision 4, without applying for a rate exception.

274.32 (j) The starting date for the rate exception will be the later of the date of the recipient's
274.33 change in support or the date of the request to the lead agency for an exception.

275.1 (k) The commissioner shall track all exception requests received and their dispositions.
 275.2 The commissioner shall issue quarterly public exceptions statistical reports, including the
 275.3 number of exception requests received and the numbers granted, denied, withdrawn, and
 275.4 pending. The report shall include the average amount of time required to process exceptions.

275.5 ~~(l) No later than January 15, 2016, the commissioner shall provide research findings on~~
 275.6 ~~the estimated fiscal impact, the primary cost drivers, and common population characteristics~~
 275.7 ~~of recipients with needs that cannot be met by the framework rates.~~

275.8 ~~(m) No later than July 1, 2016, the commissioner shall develop and implement, in~~
 275.9 ~~consultation with stakeholders, a process to determine eligibility for rate exceptions for~~
 275.10 ~~individuals with rates determined under the methodology in section 256B.4913, subdivision~~
 275.11 ~~4a. Determination of eligibility for an exception will occur as annual service renewals are~~
 275.12 ~~completed.~~

275.13 ~~(n) (l) Approved rate exceptions will be implemented at such time that the individual's~~
 275.14 ~~rate is no longer banded and remain in effect in all cases until an individual's needs change~~
 275.15 ~~as defined in paragraph (c).~~

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

275.17 Sec. 47. Minnesota Statutes 2018, section 256B.4914, subdivision 15, is amended to read:

275.18 Subd. 15. **County or tribal allocations.** ~~(a) Upon implementation of the disability waiver~~
 275.19 ~~rates management system on January 1, 2014,~~ The commissioner shall establish a method
 275.20 of tracking and reporting the fiscal impact of the disability waiver rates management system
 275.21 on individual lead agencies.

275.22 ~~(b) Beginning January 1, 2014,~~ The commissioner shall make annual adjustments to
 275.23 lead agencies' home and community-based waived service budget allocations to adjust
 275.24 for rate differences and the resulting impact on county allocations upon implementation of
 275.25 the disability waiver rates system.

275.26 (c) Lead agencies exceeding their allocations shall be subject to the provisions under
 275.27 sections 256B.0916, subdivision 11, and 256B.49, subdivision 26.

275.28 Sec. 48. Minnesota Statutes 2018, section 256B.85, subdivision 3, is amended to read:

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

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

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

276.2 (3) is a waiver participant as defined under section 256B.0915, 256B.092, 256B.093, or
276.3 256B.49; or

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

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

276.8 (1) require assistance and be determined dependent in one activity of daily living or
276.9 Level I behavior based on assessment under section 256B.0911; and

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

276.11 (c) A pregnant woman eligible for medical assistance under section 256B.055, subdivision
276.12 6, is eligible for CFSS without federal financial participation if the woman: (1) is eligible
276.13 for CFSS under paragraphs (a) and (b); and (2) does not meet institutional level of care, as
276.14 determined under section 256B.0911.

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

276.16 Sec. 49. Minnesota Statutes 2018, section 256B.85, subdivision 11, is amended to read:

276.17 Subd. 11. **Agency-provider model.** (a) The agency-provider model includes services
276.18 provided by support workers and staff providing worker training and development services
276.19 who are employed by an agency-provider that meets the criteria established by the
276.20 commissioner, including required training.

276.21 (b) The agency-provider shall allow the participant to have a significant role in the
276.22 selection and dismissal of the support workers for the delivery of the services and supports
276.23 specified in the participant's CFSS service delivery plan.

276.24 (c) A participant may use authorized units of CFSS services as needed within a service
276.25 agreement that is not greater than 12 months. Using authorized units in a flexible manner
276.26 in either the agency-provider model or the budget model does not increase the total amount
276.27 of services and supports authorized for a participant or included in the participant's CFSS
276.28 service delivery plan.

276.29 (d) A participant may share CFSS services. Two or three CFSS participants may share
276.30 services at the same time provided by the same support worker.

277.1 (e) The agency-provider must use a minimum of 72.5 percent of the revenue generated
277.2 by the medical assistance payment for CFSS for support worker wages and benefits, except
277.3 all of the revenue generated by a medical assistance rate increase due to a collective
277.4 bargaining agreement under section 179A.54 must be used for support worker wages and
277.5 benefits. The agency-provider must document how this requirement is being met. The
277.6 revenue generated by the worker training and development services and the reasonable costs
277.7 associated with the worker training and development services must not be used in making
277.8 this calculation.

277.9 (f) The agency-provider model must be used by individuals who are restricted by the
277.10 Minnesota restricted recipient program under Minnesota Rules, parts 9505.2160 to
277.11 9505.2245.

277.12 (g) Participants purchasing goods under this model, along with support worker services,
277.13 must:

277.14 (1) specify the goods in the CFSS service delivery plan and detailed budget for
277.15 expenditures that must be approved by the consultation services provider, case manager, or
277.16 care coordinator; and

277.17 (2) use the FMS provider for the billing and payment of such goods.

277.18 Sec. 50. Minnesota Statutes 2018, section 256B.85, subdivision 12, is amended to read:

277.19 Subd. 12. **Requirements for enrollment of CFSS agency-providers.** (a) All CFSS
277.20 agency-providers must provide, at the time of enrollment, reenrollment, and revalidation
277.21 as a CFSS agency-provider in a format determined by the commissioner, information and
277.22 documentation that includes, but is not limited to, the following:

277.23 (1) the CFSS agency-provider's current contact information including address, telephone
277.24 number, and e-mail address;

277.25 (2) proof of surety bond coverage. Upon new enrollment, or if the agency-provider's
277.26 Medicaid revenue in the previous calendar year is less than or equal to \$300,000, the
277.27 agency-provider must purchase a surety bond of \$50,000. If the agency-provider's Medicaid
277.28 revenue in the previous calendar year is greater than \$300,000, the agency-provider must
277.29 purchase a surety bond of \$100,000. The surety bond must be in a form approved by the
277.30 commissioner, must be renewed annually, and must allow for recovery of costs and fees in
277.31 pursuing a claim on the bond;

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

- 278.1 (4) proof of workers' compensation insurance coverage;
- 278.2 (5) proof of liability insurance;
- 278.3 (6) a description of the CFSS agency-provider's organization identifying the names of
278.4 all owners, managing employees, staff, board of directors, and the affiliations of the directors
278.5 and owners to other service providers;
- 278.6 (7) a copy of the CFSS agency-provider's written policies and procedures including:
278.7 hiring of employees; training requirements; service delivery; and employee and consumer
278.8 safety, including the process for notification and resolution of participant grievances, incident
278.9 response, identification and prevention of communicable diseases, and employee misconduct;
- 278.10 (8) copies of all other forms the CFSS agency-provider uses in the course of daily
278.11 business including, but not limited to:
- 278.12 (i) a copy of the CFSS agency-provider's time sheet; and
- 278.13 (ii) a copy of the participant's individual CFSS service delivery plan;
- 278.14 (9) a list of all training and classes that the CFSS agency-provider requires of its staff
278.15 providing CFSS services;
- 278.16 (10) documentation that the CFSS agency-provider and staff have successfully completed
278.17 all the training required by this section;
- 278.18 (11) documentation of the agency-provider's marketing practices;
- 278.19 (12) disclosure of ownership, leasing, or management of all residential properties that
278.20 are used or could be used for providing home care services;
- 278.21 (13) documentation that the agency-provider will use at least the following percentages
278.22 of revenue generated from the medical assistance rate paid for CFSS services for CFSS
278.23 support worker wages and benefits: 72.5 percent of revenue from CFSS providers, except
278.24 100 percent of the revenue generated by a medical assistance rate increase due to a collective
278.25 bargaining agreement under section 179A.54 must be used for support worker wages and
278.26 benefits. The revenue generated by the worker training and development services and the
278.27 reasonable costs associated with the worker training and development services shall not be
278.28 used in making this calculation; and
- 278.29 (14) documentation that the agency-provider does not burden participants' free exercise
278.30 of their right to choose service providers by requiring CFSS support workers to sign an
278.31 agreement not to work with any particular CFSS participant or for another CFSS

279.1 agency-provider after leaving the agency and that the agency is not taking action on any
279.2 such agreements or requirements regardless of the date signed.

279.3 (b) CFSS agency-providers shall provide to the commissioner the information specified
279.4 in paragraph (a).

279.5 (c) All CFSS agency-providers shall require all employees in management and
279.6 supervisory positions and owners of the agency who are active in the day-to-day management
279.7 and operations of the agency to complete mandatory training as determined by the
279.8 commissioner. Employees in management and supervisory positions and owners who are
279.9 active in the day-to-day operations of an agency who have completed the required training
279.10 as an employee with a CFSS agency-provider do not need to repeat the required training if
279.11 they are hired by another agency, if they have completed the training within the past three
279.12 years. CFSS agency-provider billing staff shall complete training about CFSS program
279.13 financial management. Any new owners or employees in management and supervisory
279.14 positions involved in the day-to-day operations are required to complete mandatory training
279.15 as a requisite of working for the agency.

279.16 (d) The commissioner shall send annual review notifications to agency-providers 30
279.17 days prior to renewal. The notification must:

279.18 (1) list the materials and information the agency-provider is required to submit;

279.19 (2) provide instructions on submitting information to the commissioner; and

279.20 (3) provide a due date by which the commissioner must receive the requested information.

279.21 Agency-providers shall submit all required documentation for annual review within 30 days
279.22 of notification from the commissioner. If an agency-provider fails to submit all the required
279.23 documentation, the commissioner may take action under subdivision 23a.

279.24 Sec. 51. Laws 2017, First Special Session chapter 6, article 1, section 45, is amended to
279.25 read:

279.26 Sec. 45. **CONSUMER-DIRECTED COMMUNITY SUPPORTS BUDGET**
279.27 **METHODOLOGY EXCEPTION FOR PERSONS LEAVING INSTITUTIONS AND**
279.28 **CRISIS RESIDENTIAL SETTINGS.**

279.29 Subdivision 1. Exception for persons leaving institutions and crisis residential
279.30 settings. (a) By September 30, 2017, the commissioner shall establish an institutional and
279.31 crisis bed consumer-directed community supports budget exception process in the home

280.1 and community-based services waivers under Minnesota Statutes, sections 256B.092 and
280.2 256B.49. This budget exception process shall be available for any individual who:

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

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

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

280.14 Subd. 2. Shared services. (a) Medical assistance payments for shared services under
280.15 consumer-directed community supports are limited to this subdivision.

280.16 (b) For purposes of this subdivision, "shared services" means services provided at the
280.17 same time by the same direct care worker for individuals who have entered into an agreement
280.18 to share consumer-directed community support services.

280.19 (c) Shared services may include services in the personal assistance category as outlined
280.20 in the consumer-directed community supports community support plan and shared services
280.21 agreement, except:

280.22 (1) services for more than three individuals provided by one worker at one time;

280.23 (2) use of more than one worker for the shared services; and

280.24 (3) a child care program licensed under chapter 245A or operated by a local school
280.25 district or private school.

280.26 (d) The individuals or, as needed, their representatives shall develop the plan for shared
280.27 services when developing or amending the consumer-directed community supports plan,
280.28 and must follow the consumer-directed community supports process for approval of the
280.29 plan by the lead agency. The plan for shared services in an individual's consumer-directed
280.30 community supports plan shall include the intention to utilize shared services based on
280.31 individuals' needs and preferences.

281.1 (e) Individuals sharing services must use the same financial management services
281.2 provider.

281.3 (f) Individuals whose consumer-directed community supports community support plans
281.4 include the intention to utilize shared services must also jointly develop, with the support
281.5 of their representatives as needed, a shared services agreement. This agreement must include:

281.6 (1) the names of the individuals receiving shared services;

281.7 (2) the individuals' representative, if identified in their consumer-directed community
281.8 supports plans, and their duties;

281.9 (3) the names of the case managers;

281.10 (4) the financial management services provider;

281.11 (5) the shared services that must be provided;

281.12 (6) the schedule for shared services;

281.13 (7) the location where shared services must be provided;

281.14 (8) the training specific to each individual served;

281.15 (9) the training specific to providing shared services to the individuals identified in the
281.16 agreement;

281.17 (10) instructions to follow all required documentation for time and services provided;

281.18 (11) a contingency plan for each of the individuals that accounts for service provision
281.19 and billing in the absence of one of the individuals in a shared services setting due to illness
281.20 or other circumstances;

281.21 (12) signatures of all parties involved in the shared services; and

281.22 (13) agreement by each of the individuals who are sharing services on the number of
281.23 shared hours for services provided.

281.24 (g) Any individual or any individual's representative may withdraw from participating
281.25 in a shared services agreement at any time.

281.26 (h) The lead agency for each individual must authorize the use of the shared services
281.27 option based on the criteria that the shared service is appropriate to meet the needs, health,
281.28 and safety of each individual for whom they provide case management or care coordination.

281.29 (i) Nothing in this subdivision must be construed to reduce the total authorized
281.30 consumer-directed community supports budget for an individual.

282.1 (j) No later than September 30, 2019, the commissioner of human services shall:

282.2 (1) submit an amendment to the Centers for Medicare and Medicaid Services for the
 282.3 home and community-based services waivers authorized under Minnesota Statutes, sections
 282.4 256B.092 and 256B.49, to allow for a shared services option under consumer-directed
 282.5 community supports; and

282.6 (2) with stakeholder input, develop guidance for shared services in consumer-directed
 282.7 community-supports within the Community Based Services Manual. Guidance must include:

282.8 (i) recommendations for negotiating payment for one-to-two and one-to-three services;
 282.9 and

282.10 (ii) a template of the shared services agreement.

282.11 **EFFECTIVE DATE.** This section is effective October 1, 2019, or upon federal approval,
 282.12 whichever is later, except for subdivision 2, paragraph (j), which is effective the day
 282.13 following final enactment. The commissioner of human services shall notify the revisor of
 282.14 statutes when federal approval is obtained.

282.15 Sec. 52. Laws 2017, First Special Session chapter 6, article 3, section 49, is amended to
 282.16 read:

282.17 Sec. 49. **ELECTRONIC SERVICE DELIVERY DOCUMENTATION SYSTEM**
 282.18 **VISIT VERIFICATION.**

282.19 Subdivision 1. **Documentation; establishment.** The commissioner of human services
 282.20 shall establish implementation requirements and standards for ~~an electronic service delivery~~
 282.21 ~~documentation system~~ visit verification to comply with the 21st Century Cures Act, Public
 282.22 Law 114-255. Within available appropriations, the commissioner shall take steps to comply
 282.23 with the electronic visit verification requirements in the 21st Century Cures Act, Public
 282.24 Law 114-255.

282.25 Subd. 2. **Definitions.** (a) For purposes of this section, the terms in this subdivision have
 282.26 the meanings given them.

282.27 (b) "~~Electronic service delivery documentation~~ visit verification" means the electronic
 282.28 documentation of the:

282.29 (1) type of service performed;

282.30 (2) individual receiving the service;

282.31 (3) date of the service;

283.1 (4) location of the service delivery;

283.2 (5) individual providing the service; and

283.3 (6) time the service begins and ends.

283.4 (c) "~~Electronic service delivery documentation~~ visit verification system" means a system
283.5 that provides electronic ~~service delivery documentation~~ verification of services that complies
283.6 with the 21st Century Cures Act, Public Law 114-255, and the requirements of subdivision
283.7 3.

283.8 (d) "Service" means one of the following:

283.9 (1) personal care assistance services as defined in Minnesota Statutes, section 256B.0625,
283.10 subdivision 19a, and provided according to Minnesota Statutes, section 256B.0659; ~~or~~

283.11 (2) community first services and supports under Minnesota Statutes, section 256B.85;

283.12 (3) home health services under Minnesota Statutes, section 256B.0625, subdivision 6a;

283.13 or

283.14 (4) other medical supplies and equipment or home and community-based services that
283.15 are required to be electronically verified by the 21st Century Cures Act, Public Law 114-255.

283.16 Subd. 3. **Requirements.** (a) In developing implementation requirements for ~~an electronic~~
283.17 ~~service delivery documentation system~~ visit verification, the commissioner shall ~~consider~~
283.18 ~~electronic visit verification systems and other electronic service delivery documentation~~
283.19 ~~methods. The commissioner shall convene stakeholders that will be impacted by an electronic~~
283.20 ~~service delivery system, including service providers and their representatives, service~~
283.21 ~~recipients and their representatives, and, as appropriate, those with expertise in the~~
283.22 ~~development and operation of an electronic service delivery documentation system, to ensure~~
283.23 that the requirements:

283.24 (1) are minimally administratively and financially burdensome to a provider;

283.25 (2) are minimally burdensome to the service recipient and the least disruptive to the
283.26 service recipient in receiving and maintaining allowed services;

283.27 (3) consider existing best practices and use of electronic ~~service delivery documentation~~
283.28 visit verification;

283.29 (4) are conducted according to all state and federal laws;

283.30 (5) are effective methods for preventing fraud when balanced against the requirements
283.31 of clauses (1) and (2); and

284.1 (6) are consistent with the Department of Human Services' policies related to covered
284.2 services, flexibility of service use, and quality assurance.

284.3 (b) The commissioner shall make training available to providers on the electronic service
284.4 ~~delivery documentation~~ visit verification system requirements.

284.5 (c) The commissioner shall establish baseline measurements related to preventing fraud
284.6 and establish measures to determine the effect of electronic ~~service-delivery documentation~~
284.7 visit verification requirements on program integrity.

284.8 (d) The commissioner shall make a state-selected electronic visit verification system
284.9 available to providers of services.

284.10 Subd. 3a. **Provider requirements.** (a) A provider of services may select any electronic
284.11 visit verification system that meets the requirements established by the commissioner.

284.12 (b) All electronic visit verification systems used by providers to comply with the
284.13 requirements established by the commissioner must provide data to the commissioner in a
284.14 format and at a frequency to be established by the commissioner.

284.15 (c) Providers must implement the electronic visit verification systems required under
284.16 this section by a date established by the commissioner to be set after the state-selected
284.17 electronic visit verification systems for personal care services and home health services are
284.18 in production. For purposes of this paragraph, "personal care services" and "home health
284.19 services" have the meanings given in United States Code, title 42, section 1396b(1)(5).

284.20 ~~Subd. 4. **Legislative report.** (a) The commissioner shall submit a report by January 15,~~
284.21 ~~2018, to the chairs and ranking minority members of the legislative committees with~~
284.22 ~~jurisdiction over human services with recommendations, based on the requirements of~~
284.23 ~~subdivision 3, to establish electronic service-delivery documentation system requirements~~
284.24 ~~and standards. The report shall identify:~~

284.25 (1) ~~the essential elements necessary to operationalize a base-level electronic service~~
284.26 ~~delivery documentation system to be implemented by January 1, 2019; and~~

284.27 (2) ~~enhancements to the base-level electronic service-delivery documentation system to~~
284.28 ~~be implemented by January 1, 2019, or after, with projected operational costs and the costs~~
284.29 ~~and benefits for system enhancements.~~

284.30 (b) ~~The report must also identify current regulations on service providers that are either~~
284.31 ~~inefficient, minimally effective, or will be unnecessary with the implementation of an~~
284.32 ~~electronic service-delivery documentation system.~~

285.1 **Sec. 53. INDIVIDUAL PROVIDERS OF DIRECT SUPPORT SERVICES.**

285.2 The labor agreement between the state of Minnesota and the Service Employees
285.3 International Union Healthcare Minnesota, submitted to the Legislative Coordinating
285.4 Commission on March 11, 2019, is ratified.

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

285.6 **Sec. 54. RATE INCREASE FOR DIRECT SUPPORT SERVICES PROVIDERS**
285.7 **WORKFORCE NEGOTIATIONS.**

285.8 (a) Effective July 1, 2019, if the labor agreement between the state of Minnesota and
285.9 the Service Employees International Union Healthcare Minnesota under Minnesota Statutes,
285.10 section 179A.54, is approved pursuant to Minnesota Statutes, section 3.855, the commissioner
285.11 of human services shall:

285.12 (1) increase reimbursement rates, individual budgets, grants, or allocations by 2.37
285.13 percent for services provided on or after July 1, 2019, to implement the minimum hourly
285.14 wage, holiday, and paid time off provisions of that agreement; and

285.15 (2) for services provided on or after July 1, 2019, to eligible service recipients, provide
285.16 an enhanced rate of 7.5 percent for personal care assistance and community first services
285.17 and supports and an enhanced budget increased by 7.5 percent for consumer-directed
285.18 community supports and the consumer support grant. Eligible service recipients are persons
285.19 identified by the state through assessment who are eligible for at least 12 hours of personal
285.20 care assistance each day and are served by workers who have completed designated training
285.21 approved by the commissioner. The enhanced rate and enhanced budget includes, and is
285.22 not in addition to, any previously implemented enhanced rates or enhanced budgets for
285.23 eligible service recipients.

285.24 (b) The rate changes described in this section apply to direct support services provided
285.25 through a covered program, as defined in Minnesota Statutes, section 256B.0711, subdivision
285.26 1.

285.27 **Sec. 55. DIRECTION TO COMMISSIONER; SKILLED NURSE VISIT RATES.**

285.28 The commissioner of human services shall ensure that skilled nurse visits reimbursed
285.29 under Minnesota Statutes, section 256B.0653, are coded, specific to the category of the
285.30 nurse performing the visit, using code sets compliant with the Health Insurance Portability
285.31 and Accountability Act, Public Law 104-191. "Skilled nurse visit" has the meaning given
285.32 in Minnesota Statutes, section 256B.0653, subdivision 2, paragraph (j).

286.1 Sec. 56. **DIRECTION TO COMMISSIONER; INTERAGENCY AGREEMENTS.**

286.2 By October 1, 2019, the Department of Commerce, Public Utilities Commission, and
286.3 Department of Human Services must amend all interagency agreements necessary to
286.4 implement sections 1 to 10.

286.5 Sec. 57. **DIRECTION TO COMMISSIONER; FEDERAL AUTHORITY FOR**
286.6 **RECONFIGURED WAIVER SERVICES.**

286.7 The commissioner of human services shall seek necessary federal authority to implement
286.8 new and reconfigured waiver services under section 58. The commissioner of human services
286.9 shall notify the revisor of statutes when federal approval is obtained and when new services
286.10 are fully implemented.

286.11 Sec. 58. **DISABILITY WAIVER RECONFIGURATION.**

286.12 Subdivision 1. **Intent.** It is the intent of the legislature to reform the medical assistance
286.13 waiver programs for people with disabilities to simplify administration of the programs,
286.14 encourage person-centered supports, enhance each person's personal authority over the
286.15 person's service choice, align benefits across waivers, encourage equity across programs
286.16 and populations, and promote long-term sustainability of needed services.

286.17 Subd. 2. **Report.** By January 15, 2021, the commissioner of human services shall submit
286.18 a report to the members of the legislative committees with jurisdiction over human services
286.19 on any necessary waivers, state plan amendments, requests for new funding or realignment
286.20 of existing funds, any changes to state statute or rule, and any other federal authority
286.21 necessary to implement this section.

286.22 Subd. 3. **Proposal.** By January 15, 2021, the commissioner shall develop a proposal to
286.23 reconfigure the medical assistance waivers provided in sections 256B.092 and 256B.49.
286.24 The proposal shall include all necessary plans for implementing two home and
286.25 community-based services waiver programs, as authorized under section 1915(c) of the
286.26 Social Security Act that serve persons who are determined to require the levels of care
286.27 provided in a nursing home, a hospital, a neurobehavioral hospital, or an intermediate care
286.28 facility for persons with developmental disabilities.

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

287.1 **Sec. 59. DIRECT CARE WORKFORCE RATE METHODOLOGY STUDY.**

287.2 The commissioner of human services, in consultation with stakeholders, shall evaluate
287.3 the feasibility of developing a rate methodology for the personal care assistance program,
287.4 under Minnesota Statutes, section 256B.0659, and community first services and supports,
287.5 under Minnesota Statutes, section 256B.85, similar to the disability waiver rate system
287.6 under Minnesota Statutes, section 256B.4914, including determining the component values
287.7 and factors to include in such a rate methodology; consider aligning any rate methodology
287.8 with the collective bargaining agreement and negotiation cycle under Minnesota Statutes,
287.9 section 179A.54; recommend strategies for ensuring adequate, competitive wages for direct
287.10 care workers; develop methods and determine the necessary resources for the commissioner
287.11 to more consistently collect and audit data from the direct care industry; and report
287.12 recommendations, including proposed legislation, to the chairs and ranking minority members
287.13 of the legislative committees with jurisdiction over human services policy and finance by
287.14 February 1, 2020.

287.15 **Sec. 60. DIRECTION TO COMMISSIONER OF HUMAN SERVICES; TEFRA**
287.16 **OPTION IMPROVEMENT MEASURES.**

287.17 (a) The commissioner of human services shall, using existing appropriations, develop
287.18 content to be included on the MNsure website explaining the TEFRA option under medical
287.19 assistance for applicants who indicate during the application process that a child in the
287.20 family has a disability.

287.21 (b) The commissioner shall develop a cover letter explaining the TEFRA option under
287.22 medical assistance, as well as the application and renewal process, to be disseminated with
287.23 the DHS-6696A form to applicants who may qualify for medical assistance under the TEFRA
287.24 option. The commissioner shall provide the content and the form to the executive director
287.25 of MNsure for inclusion on the MNsure website. The commissioner shall also develop and
287.26 implement education and training for lead agency staff statewide to improve understanding
287.27 of the medical assistance TEFRA enrollment and renewal processes and procedures.

287.28 (c) The commissioner shall convene a stakeholder group that shall consider improvements
287.29 to the TEFRA option enrollment and renewal processes, including but not limited to revisions
287.30 to, or the development of, application and renewal paperwork specific to the TEFRA option;
287.31 possible technology solutions; and county processes.

287.32 (d) The stakeholder group must include representatives from the Department of Human
287.33 Services Health Care Division, MNsure, representatives from at least two counties in the
287.34 metropolitan area and from at least one county in greater Minnesota, the Arc Minnesota,

288.1 Gillette Children's Specialty Healthcare, the Autism Society of Minnesota, Proof Alliance,
288.2 the Minnesota Consortium for Citizens with Disabilities, and other interested stakeholders
288.3 as identified by the commissioner of human services.

288.4 (e) The stakeholder group shall submit a report of the group's recommended
288.5 improvements and any associated costs to the commissioner by December 31, 2020. The
288.6 group shall also provide copies of the report to each stakeholder group member. The
288.7 commissioner shall provide a copy of the report to the legislative committees with jurisdiction
288.8 over medical assistance.

288.9 **Sec. 61. DIRECTION TO COMMISSIONER; DIRECT CARE STAFF**
288.10 **COMPENSATION REPORT.**

288.11 By January 15, 2022, the commissioner of human services, in consultation with
288.12 stakeholders, shall report to the chairs and ranking minority members of the legislative
288.13 committees and divisions with jurisdiction over health and human services policy and finance
288.14 with recommendations for:

288.15 (1) the implementation of penalties for providers who do not meet the compensation
288.16 levels identified in Minnesota Statutes, section 256B.4914, subdivision 5a;

288.17 (2) the implementation of good cause exemptions for providers who have not met the
288.18 compensation levels identified in Minnesota Statutes, section 256B.4914, subdivision 5a;
288.19 and

288.20 (3) the rebasing of compensation levels identified in Minnesota Statutes, section
288.21 256B.4914, subdivision 5a, using data reported under Minnesota Statutes, section 256B.4914,
288.22 subdivision 10a.

288.23 **Sec. 62. REVISOR INSTRUCTION.**

288.24 The revisor of statutes, in consultation with the House Research Department, Office of
288.25 Senate Counsel, Research and Fiscal Analysis, and Department of Human Services, shall
288.26 prepare legislation for the 2020 legislative session to codify laws governing
288.27 consumer-directed community supports in Minnesota Statutes, chapter 256B.

288.28 **Sec. 63. REVISOR INSTRUCTION.**

288.29 The revisor of statutes shall renumber Minnesota Statutes, section 256B.4913, subdivision
288.30 5, as a subdivision in Minnesota Statutes, section 256B.4914. The revisor shall also make
288.31 necessary cross-reference changes in Minnesota Statutes consistent with the renumbering.

289.1 Sec. 64. **REPEALER.**

289.2 (a) Minnesota Statutes 2018, section 256B.0705, is repealed.

289.3 (b) Minnesota Statutes 2018, sections 252.431; and 252.451, are repealed.

289.4 (c) Minnesota Statutes 2018, sections 252.41, subdivision 8; and 256B.4913, subdivisions
 289.5 4a, 6, and 7, are repealed.

289.6 **EFFECTIVE DATE.** Paragraph (a) is effective the day following final enactment.

289.7 Paragraph (b) is effective September 1, 2019. Paragraph (c) is effective January 1, 2020.

289.8 ARTICLE 6

289.9 CHEMICAL AND MENTAL HEALTH

289.10 Section 1. Minnesota Statutes 2018, section 245.4661, subdivision 9, is amended to read:

289.11 Subd. 9. **Services and programs.** (a) The following ~~three~~ four distinct grant programs
 289.12 are funded under this section:

289.13 (1) mental health crisis services;

289.14 (2) housing with supports for adults with serious mental illness; ~~and~~

289.15 (3) projects for assistance in transitioning from homelessness (PATH program); and

289.16 (4) culturally specific mental health and substance use disorder provider consultation.

289.17 (b) In addition, the following are eligible for grant funds:

289.18 (1) community education and prevention;

289.19 (2) client outreach;

289.20 (3) early identification and intervention;

289.21 (4) adult outpatient diagnostic assessment and psychological testing;

289.22 (5) peer support services;

289.23 (6) community support program services (CSP);

289.24 (7) adult residential crisis stabilization;

289.25 (8) supported employment;

289.26 (9) assertive community treatment (ACT);

289.27 (10) housing subsidies;

289.28 (11) basic living, social skills, and community intervention;

- 290.1 (12) emergency response services;
- 290.2 (13) adult outpatient psychotherapy;
- 290.3 (14) adult outpatient medication management;
- 290.4 (15) adult mobile crisis services;
- 290.5 (16) adult day treatment;
- 290.6 (17) partial hospitalization;
- 290.7 (18) adult residential treatment;
- 290.8 (19) adult mental health targeted case management;
- 290.9 (20) intensive community rehabilitative services (ICRS); and
- 290.10 (21) transportation.
- 290.11 Sec. 2. Minnesota Statutes 2018, section 245.4889, subdivision 1, is amended to read:
- 290.12 Subdivision 1. **Establishment and authority.** (a) The commissioner is authorized to
- 290.13 make grants from available appropriations to assist:
- 290.14 (1) counties;
- 290.15 (2) Indian tribes;
- 290.16 (3) children's collaboratives under section 124D.23 or 245.493; or
- 290.17 (4) mental health service providers.
- 290.18 (b) The following services are eligible for grants under this section:
- 290.19 (1) services to children with emotional disturbances as defined in section 245.4871,
- 290.20 subdivision 15, and their families;
- 290.21 (2) transition services under section 245.4875, subdivision 8, for young adults under
- 290.22 age 21 and their families;
- 290.23 (3) respite care services for children with severe emotional disturbances who are at risk
- 290.24 of out-of-home placement;
- 290.25 (4) children's mental health crisis services;
- 290.26 (5) mental health services for people from cultural and ethnic minorities;
- 290.27 (6) children's mental health screening and follow-up diagnostic assessment and treatment;

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

291.3 (8) school-linked mental health services, ~~including transportation for children receiving~~
 291.4 ~~school-linked mental health services when school is not in session~~ under section 245.4901;

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

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

291.8 (11) mental health first aid training;

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

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

291.14 (14) early childhood mental health consultation;

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

291.18 (16) psychiatric consultation for primary care practitioners; and

291.19 (17) providers to begin operations and meet program requirements when establishing a
 291.20 new children's mental health program. These may be start-up grants.

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

291.25 (d) As a condition of receiving grant funds, a grantee shall obtain all available third-party
 291.26 reimbursement sources, if applicable.

291.27 **EFFECTIVE DATE.** This section is effective the day following final enactment.

291.28 **Sec. 3. [245.4901] SCHOOL-LINKED MENTAL HEALTH GRANTS.**

291.29 **Subdivision 1. Establishment.** The commissioner of human services shall establish a
 291.30 school-linked mental health grant program to provide early identification and intervention

292.1 for students with mental health needs and to build the capacity of schools to support students
292.2 with mental health needs in the classroom.

292.3 Subd. 2. **Eligible applicants.** An eligible applicant for school-linked mental health grants
292.4 is an entity that is:

292.5 (1) certified under Minnesota Rules, parts 9520.0750 to 9520.0870;

292.6 (2) a community mental health center under section 256B.0625, subdivision 5;

292.7 (3) an Indian health service facility or a facility owned and operated by a tribe or tribal
292.8 organization operating under United States Code, title 25, section 5321;

292.9 (4) a provider of children's therapeutic services and supports as defined in section
292.10 256B.0943; or

292.11 (5) enrolled in medical assistance as a mental health or substance use disorder provider
292.12 agency and employs at least two full-time equivalent mental health professionals qualified
292.13 according to section 245I.16, subdivision 2, or two alcohol and drug counselors licensed or
292.14 exempt from licensure under chapter 148F who are qualified to provide clinical services to
292.15 children and families.

292.16 Subd. 3. **Allowable grant activities and related expenses.** (a) Allowable grant activities
292.17 and related expenses may include but are not limited to:

292.18 (1) identifying and diagnosing mental health conditions of students;

292.19 (2) delivering mental health treatment and services to students and their families,
292.20 including via telemedicine consistent with section 256B.0625, subdivision 3b;

292.21 (3) supporting families in meeting their child's needs, including navigating health care,
292.22 social service, and juvenile justice systems;

292.23 (4) providing transportation for students receiving school-linked mental health services
292.24 when school is not in session;

292.25 (5) building the capacity of schools to meet the needs of students with mental health
292.26 concerns, including school staff development activities for licensed and nonlicensed staff;
292.27 and

292.28 (6) purchasing equipment, connection charges, on-site coordination, set-up fees, and
292.29 site fees in order to deliver school-linked mental health services via telemedicine.

292.30 (b) Grantees shall obtain all available third-party reimbursement sources as a condition
292.31 of receiving a grant. For purposes of this grant program, a third-party reimbursement source

293.1 excludes a public school as defined in section 120A.20, subdivision 1. Grantees shall serve
 293.2 students regardless of health coverage status or ability to pay.

293.3 Subd. 4. **Data collection and outcome measurement.** Grantees shall provide data to
 293.4 the commissioner for the purpose of evaluating the effectiveness of the school-linked mental
 293.5 health grant program.

293.6 **EFFECTIVE DATE.** This section is effective the day following final enactment.

293.7 Sec. 4. Minnesota Statutes 2018, section 245.735, subdivision 3, is amended to read:

293.8 Subd. 3. **Certified community behavioral health clinics.** (a) The commissioner shall
 293.9 establish a state certification process for certified community behavioral health clinics
 293.10 (CCBHCs) ~~to be eligible for the prospective payment system in paragraph (f).~~ Entities that
 293.11 choose to be CCBHCs must:

293.12 (1) comply with the CCBHC criteria published by the United States Department of
 293.13 Health and Human Services;

293.14 (2) employ or contract for clinic staff who have backgrounds in diverse disciplines,
 293.15 including licensed mental health professionals and licensed alcohol and drug counselors,
 293.16 and staff who are culturally and linguistically trained to ~~serve~~ meet the needs of the ~~clinic's~~
 293.17 ~~patient~~ population the clinic serves;

293.18 (3) ensure that clinic services are available and accessible to ~~patients~~ individuals and
 293.19 families of all ages and genders and that crisis management services are available 24 hours
 293.20 per day;

293.21 (4) establish fees for clinic services for ~~nonmedical assistance patients~~ individuals who
 293.22 are not enrolled in medical assistance using a sliding fee scale that ensures that services to
 293.23 patients are not denied or limited due to ~~a patient's~~ an individual's inability to pay for services;

293.24 (5) comply with quality assurance reporting requirements and other reporting
 293.25 requirements, including any required reporting of encounter data, clinical outcomes data,
 293.26 and quality data;

293.27 (6) provide crisis mental health and substance use services, withdrawal management
 293.28 services, emergency crisis intervention services, and stabilization services; screening,
 293.29 assessment, and diagnosis services, including risk assessments and level of care
 293.30 determinations; ~~patient-centered~~ person- and family-centered treatment planning; outpatient
 293.31 mental health and substance use services; targeted case management; psychiatric
 293.32 rehabilitation services; peer support and counselor services and family support services;

294.1 and intensive community-based mental health services, including mental health services
 294.2 for members of the armed forces and veterans;

294.3 (7) provide coordination of care across settings and providers to ensure seamless
 294.4 transitions for ~~patients~~ individuals being served across the full spectrum of health services,
 294.5 including acute, chronic, and behavioral needs. Care coordination may be accomplished
 294.6 through partnerships or formal contracts with:

294.7 (i) counties, health plans, pharmacists, pharmacies, rural health clinics, federally qualified
 294.8 health centers, inpatient psychiatric facilities, substance use and detoxification facilities, or
 294.9 community-based mental health providers; and

294.10 (ii) other community services, supports, and providers, including schools, child welfare
 294.11 agencies, juvenile and criminal justice agencies, Indian health services clinics, tribally
 294.12 licensed health care and mental health facilities, urban Indian health clinics, Department of
 294.13 Veterans Affairs medical centers, outpatient clinics, drop-in centers, acute care hospitals,
 294.14 and hospital outpatient clinics;

294.15 (8) be certified as mental health clinics under section 245.69, subdivision 2;

294.16 ~~(9) be certified to provide integrated treatment for co-occurring mental illness and~~
 294.17 ~~substance use disorders in adults or children under Minnesota Rules, chapter 9533, effective~~
 294.18 ~~July 1, 2017;~~

294.19 ~~(10)~~ (9) comply with standards relating to mental health services in ~~Minnesota Rules,~~
 294.20 ~~parts 9505.0370 to 9505.0372~~ chapter 245I and section 256B.0671;

294.21 ~~(11)~~ (10) be licensed to provide ~~chemical dependency~~ substance use disorder treatment
 294.22 under chapter 245G;

294.23 ~~(12)~~ (11) be certified to provide children's therapeutic services and supports under section
 294.24 256B.0943;

294.25 ~~(13)~~ (12) be certified to provide adult rehabilitative mental health services under section
 294.26 256B.0623;

294.27 ~~(14)~~ (13) be enrolled to provide mental health crisis response services under ~~section~~
 294.28 sections 256B.0624 and 256B.0944;

294.29 ~~(15)~~ (14) be enrolled to provide mental health targeted case management under section
 294.30 256B.0625, subdivision 20;

294.31 ~~(16)~~ (15) comply with standards relating to mental health case management in Minnesota
 294.32 Rules, parts 9520.0900 to 9520.0926; ~~and~~

295.1 ~~(17)~~ (16) provide services that comply with the evidence-based practices described in
295.2 paragraph (e); and

295.3 (17) comply with standards relating to peer services under sections 256B.0615,
295.4 256B.0616, and 245G.07, subdivision 1, paragraph (a), clause (5), as applicable when peer
295.5 services are provided.

295.6 (b) If an entity is unable to provide one or more of the services listed in paragraph (a),
295.7 clauses (6) to (17), the commissioner may certify the entity as a CCBHC, if the entity has
295.8 a current contract with another entity that has the required authority to provide that service
295.9 and that meets federal CCBHC criteria as a designated collaborating organization, or, to
295.10 the extent allowed by the federal CCBHC criteria, the commissioner may approve a referral
295.11 arrangement. The CCBHC must meet federal requirements regarding the type and scope of
295.12 services to be provided directly by the CCBHC.

295.13 (c) Notwithstanding any other law that requires a county contract or other form of county
295.14 approval for certain services listed in paragraph (a), clause (6), a clinic that otherwise meets
295.15 CCBHC requirements may receive the prospective payment under ~~paragraph (f)~~ section
295.16 256B.0625, subdivision 5m, for those services without a county contract or county approval.
295.17 There is no county share when medical assistance pays the CCBHC prospective payment.
295.18 As part of the certification process in paragraph (a), the commissioner shall require a letter
295.19 of support from the CCBHC's host county confirming that the CCBHC and the county or
295.20 counties it serves have an ongoing relationship to facilitate access and continuity of care,
295.21 especially for individuals who are uninsured or who may go on and off medical assistance.

295.22 (d) When the standards listed in paragraph (a) or other applicable standards conflict or
295.23 address similar issues in duplicative or incompatible ways, the commissioner may grant
295.24 variances to state requirements if the variances do not conflict with federal requirements.
295.25 If standards overlap, the commissioner may substitute all or a part of a licensure or
295.26 certification that is substantially the same as another licensure or certification. The
295.27 commissioner shall consult with stakeholders, as described in subdivision 4, before granting
295.28 variances under this provision. For the CCBHC that is certified but not approved for
295.29 prospective payment under section 256B.0625, subdivision 5m, the commissioner may
295.30 grant a variance under this paragraph if the variance does not increase the state share of
295.31 costs.

295.32 (e) The commissioner shall issue a list of required evidence-based practices to be
295.33 delivered by CCBHCs, and may also provide a list of recommended evidence-based practices.
295.34 The commissioner may update the list to reflect advances in outcomes research and medical

296.1 services for persons living with mental illnesses or substance use disorders. The commissioner
296.2 shall take into consideration the adequacy of evidence to support the efficacy of the practice,
296.3 the quality of workforce available, and the current availability of the practice in the state.
296.4 At least 30 days before issuing the initial list and any revisions, the commissioner shall
296.5 provide stakeholders with an opportunity to comment.

296.6 ~~(f) The commissioner shall establish standards and methodologies for a prospective~~
296.7 ~~payment system for medical assistance payments for services delivered by certified~~
296.8 ~~community behavioral health clinics, in accordance with guidance issued by the Centers~~
296.9 ~~for Medicare and Medicaid Services. During the operation of the demonstration project,~~
296.10 ~~payments shall comply with federal requirements for an enhanced federal medical assistance~~
296.11 ~~percentage. The commissioner may include quality bonus payment in the prospective~~
296.12 ~~payment system based on federal criteria and on a clinic's provision of the evidence-based~~
296.13 ~~practices in paragraph (e). The prospective payment system does not apply to MinnesotaCare.~~
296.14 ~~Implementation of the prospective payment system is effective July 1, 2017, or upon federal~~
296.15 ~~approval, whichever is later.~~

296.16 ~~(g) The commissioner shall seek federal approval to continue federal financial~~
296.17 ~~participation in payment for CCBHC services after the federal demonstration period ends~~
296.18 ~~for clinics that were certified as CCBHCs during the demonstration period and that continue~~
296.19 ~~to meet the CCBHC certification standards in paragraph (a). Payment for CCBHC services~~
296.20 ~~shall cease effective July 1, 2019, if continued federal financial participation for the payment~~
296.21 ~~of CCBHC services cannot be obtained.~~

296.22 ~~(h) The commissioner may certify at least one CCBHC located in an urban area and at~~
296.23 ~~least one CCBHC located in a rural area, as defined by federal criteria. To the extent allowed~~
296.24 ~~by federal law, the commissioner may limit the number of certified clinics so that the~~
296.25 ~~projected claims for certified clinics will not exceed the funds budgeted for this purpose.~~
296.26 ~~The commissioner shall give preference to clinics that:~~

296.27 ~~(1) provide a comprehensive range of services and evidence-based practices for all age~~
296.28 ~~groups, with services being fully coordinated and integrated; and~~

296.29 ~~(2) enhance the state's ability to meet the federal priorities to be selected as a CCBHC~~
296.30 ~~demonstration state.~~

296.31 ~~(i)~~ (f) The commissioner shall recertify CCBHCs at least every three years. The
296.32 commissioner shall establish a process for decertification and shall require corrective action,
296.33 medical assistance repayment, or decertification of a CCBHC that no longer meets the

297.1 requirements in this section or that fails to meet the standards provided by the commissioner
297.2 in the application and certification process.

297.3 **EFFECTIVE DATE.** This section is effective July 1, 2019, or upon federal approval,
297.4 whichever is later. The commissioner of human services shall notify the revisor of statutes
297.5 when federal approval is obtained.

297.6 Sec. 5. Minnesota Statutes 2018, section 245F.05, subdivision 2, is amended to read:

297.7 Subd. 2. **Admission criteria.** For an individual to be admitted to a withdrawal
297.8 management program, the program must make a determination that the program services
297.9 are appropriate to the needs of the individual. A program may only admit individuals who
297.10 meet the admission criteria and who, at the time of admission, meet the criteria for admission
297.11 as determined by current American Society of Addiction Medicine standards for appropriate
297.12 level of withdrawal management.

297.13 ~~(1) are impaired as the result of intoxication;~~

297.14 ~~(2) are experiencing physical, mental, or emotional problems due to intoxication or~~
297.15 ~~withdrawal from alcohol or other drugs;~~

297.16 ~~(3) are being held under apprehend and hold orders under section 253B.07, subdivision~~
297.17 ~~2b;~~

297.18 ~~(4) have been committed under chapter 253B and need temporary placement;~~

297.19 ~~(5) are held under emergency holds or peace and health officer holds under section~~
297.20 ~~253B.05, subdivision 1 or 2; or~~

297.21 ~~(6) need to stay temporarily in a protective environment because of a crisis related to~~
297.22 ~~substance use disorder. Individuals satisfying this clause may be admitted only at the request~~
297.23 ~~of the county of fiscal responsibility, as determined according to section 256G.02, subdivision~~
297.24 ~~4. Individuals admitted according to this clause must not be restricted to the facility.~~

297.25 Sec. 6. Minnesota Statutes 2018, section 254B.02, subdivision 1, is amended to read:

297.26 Subdivision 1. **Chemical dependency treatment allocation.** The chemical dependency
297.27 treatment appropriation shall be placed in a special revenue account. ~~The commissioner~~
297.28 ~~shall annually transfer funds from the chemical dependency fund to pay for operation of~~
297.29 ~~the drug and alcohol abuse normative evaluation system and to pay for all costs incurred~~
297.30 ~~by adding two positions for licensing of chemical dependency treatment and rehabilitation~~
297.31 ~~programs located in hospitals for which funds are not otherwise appropriated. The remainder~~

298.1 of the money in the special revenue account must be used according to the requirements in
298.2 this chapter.

298.3 **EFFECTIVE DATE.** This section is effective July 1, 2019.

298.4 Sec. 7. Minnesota Statutes 2018, section 254B.03, subdivision 2, is amended to read:

298.5 Subd. 2. **Chemical dependency fund payment.** (a) Payment from the chemical
298.6 dependency fund is limited to payments for services other than detoxification licensed under
298.7 Minnesota Rules, parts 9530.6510 to 9530.6590, that, if located outside of federally
298.8 recognized tribal lands, would be required to be licensed by the commissioner as a chemical
298.9 dependency treatment or rehabilitation program under sections 245A.01 to 245A.16, and
298.10 services other than detoxification provided in another state that would be required to be
298.11 licensed as a chemical dependency program if the program were in the state. Out of state
298.12 vendors must also provide the commissioner with assurances that the program complies
298.13 substantially with state licensing requirements and possesses all licenses and certifications
298.14 required by the host state to provide chemical dependency treatment. Vendors receiving
298.15 payments from the chemical dependency fund must not require co-payment from a recipient
298.16 of benefits for services provided under this subdivision. The vendor is prohibited from using
298.17 the client's public benefits to offset the cost of services paid under this section. The vendor
298.18 shall not require the client to use public benefits for room or board costs. This includes but
298.19 is not limited to cash assistance benefits under chapters 119B, 256D, and 256J, or SNAP
298.20 benefits. Retention of SNAP benefits is a right of a client receiving services through the
298.21 consolidated chemical dependency treatment fund or through state contracted managed care
298.22 entities. Payment from the chemical dependency fund shall be made for necessary room
298.23 and board costs provided by vendors ~~certified according to~~ meeting the criteria under section
298.24 254B.05, subdivision 1a, or in a community hospital licensed by the commissioner of health
298.25 according to sections 144.50 to 144.56 to a client who is:

298.26 (1) determined to meet the criteria for placement in a residential chemical dependency
298.27 treatment program according to rules adopted under section 254A.03, subdivision 3; and

298.28 (2) concurrently receiving a chemical dependency treatment service in a program licensed
298.29 by the commissioner and reimbursed by the chemical dependency fund.

298.30 (b) A county may, from its own resources, provide chemical dependency services for
298.31 which state payments are not made. A county may elect to use the same invoice procedures
298.32 and obtain the same state payment services as are used for chemical dependency services
298.33 for which state payments are made under this section if county payments are made to the
298.34 state in advance of state payments to vendors. When a county uses the state system for

299.1 payment, the commissioner shall make monthly billings to the county using the most recent
 299.2 available information to determine the anticipated services for which payments will be made
 299.3 in the coming month. Adjustment of any overestimate or underestimate based on actual
 299.4 expenditures shall be made by the state agency by adjusting the estimate for any succeeding
 299.5 month.

299.6 (c) The commissioner shall coordinate chemical dependency services and determine
 299.7 whether there is a need for any proposed expansion of chemical dependency treatment
 299.8 services. The commissioner shall deny vendor certification to any provider that has not
 299.9 received prior approval from the commissioner for the creation of new programs or the
 299.10 expansion of existing program capacity. The commissioner shall consider the provider's
 299.11 capacity to obtain clients from outside the state based on plans, agreements, and previous
 299.12 utilization history, when determining the need for new treatment services.

299.13 **EFFECTIVE DATE.** This section is effective July 1, 2019.

299.14 Sec. 8. Minnesota Statutes 2018, section 254B.03, subdivision 4, is amended to read:

299.15 Subd. 4. **Division of costs.** (a) Except for services provided by a county under section
 299.16 254B.09, subdivision 1, or services provided under section 256B.69, the county shall, out
 299.17 of local money, pay the state for 22.95 percent of the cost of chemical dependency services,
 299.18 ~~including except for~~ those services provided to persons ~~eligible for~~ enrolled in medical
 299.19 assistance under chapter 256B and room and board services under section 254B.05,
 299.20 subdivision 5, paragraph (b), clause (12). Counties may use the indigent hospitalization
 299.21 levy for treatment and hospital payments made under this section.

299.22 (b) 22.95 percent of any state collections from private or third-party pay, less 15 percent
 299.23 for the cost of payment and collections, must be distributed to the county that paid for a
 299.24 portion of the treatment under this section.

299.25 (c) ~~For fiscal year 2017 only, the 22.95 percentages under paragraphs (a) and (b) are~~
 299.26 ~~equal to 20.2 percent.~~

299.27 **EFFECTIVE DATE.** This section is effective July 1, 2019.

299.28 Sec. 9. Minnesota Statutes 2018, section 254B.04, subdivision 1, is amended to read:

299.29 Subdivision 1. **Eligibility.** (a) Persons eligible for benefits under Code of Federal
 299.30 Regulations, title 25, part 20, ~~and persons eligible for medical assistance benefits under~~
 299.31 ~~sections 256B.055, 256B.056, and 256B.057, subdivisions 1, 5, and 6, or who meet the~~
 299.32 income standards of section 256B.056, subdivision 4, and are not enrolled in medical

300.1 assistance, are entitled to chemical dependency fund services. State money appropriated
300.2 for this paragraph must be placed in a separate account established for this purpose.

300.3 (b) Persons with dependent children who are determined to be in need of chemical
300.4 dependency treatment pursuant to an assessment under section 626.556, subdivision 10, or
300.5 a case plan under section 260C.201, subdivision 6, or 260C.212, shall be assisted by the
300.6 local agency to access needed treatment services. Treatment services must be appropriate
300.7 for the individual or family, which may include long-term care treatment or treatment in a
300.8 facility that allows the dependent children to stay in the treatment facility. The county shall
300.9 pay for out-of-home placement costs, if applicable.

300.10 (c) Notwithstanding paragraph (a), persons enrolled in medical assistance are eligible
300.11 for room and board services under section 254B.05, subdivision 5, paragraph (b), clause
300.12 (12).

300.13 **EFFECTIVE DATE.** This section is effective September 1, 2019.

300.14 Sec. 10. Minnesota Statutes 2018, section 254B.05, subdivision 1a, is amended to read:

300.15 Subd. 1a. **Room and board provider requirements.** (a) Effective January 1, 2000,
300.16 vendors of room and board are eligible for chemical dependency fund payment if the vendor:

300.17 (1) has rules prohibiting residents bringing chemicals into the facility or using chemicals
300.18 while residing in the facility and provide consequences for infractions of those rules;

300.19 (2) is determined to meet applicable health and safety requirements;

300.20 (3) is not a jail or prison;

300.21 (4) is not concurrently receiving funds under chapter 256I for the recipient;

300.22 (5) admits individuals who are 18 years of age or older;

300.23 (6) is registered as a board and lodging or lodging establishment according to section
300.24 157.17;

300.25 (7) has awake staff on site 24 hours per day;

300.26 (8) has staff who are at least 18 years of age and meet the requirements of section
300.27 245G.11, subdivision 1, paragraph (b);

300.28 (9) has emergency behavioral procedures that meet the requirements of section 245G.16;

300.29 (10) meets the requirements of section 245G.08, subdivision 5, if administering
300.30 medications to clients;

301.1 (11) meets the abuse prevention requirements of section 245A.65, including a policy on
301.2 fraternization and the mandatory reporting requirements of section 626.557;

301.3 (12) documents coordination with the treatment provider to ensure compliance with
301.4 section 254B.03, subdivision 2;

301.5 (13) protects client funds and ensures freedom from exploitation by meeting the
301.6 provisions of section 245A.04, subdivision 13;

301.7 (14) has a grievance procedure that meets the requirements of section 245G.15,
301.8 subdivision 2; and

301.9 (15) has sleeping and bathroom facilities for men and women separated by a door that
301.10 is locked, has an alarm, or is supervised by awake staff.

301.11 (b) Programs licensed according to Minnesota Rules, chapter 2960, are exempt from
301.12 paragraph (a), clauses (5) to (15).

301.13 (c) Licensed programs providing intensive residential treatment services or residential
301.14 crisis stabilization services pursuant to section 256B.0622 or 256B.0624 are eligible vendors
301.15 of room and board and are exempt from paragraph (a), clauses (6) to (15).

301.16 **EFFECTIVE DATE.** This section is effective September 1, 2019.

301.17 Sec. 11. Minnesota Statutes 2018, section 254B.06, subdivision 1, is amended to read:

301.18 Subdivision 1. **State collections.** The commissioner is responsible for all collections
301.19 from persons determined to be partially responsible for the cost of care of an eligible person
301.20 receiving services under Laws 1986, chapter 394, sections 8 to 20. The commissioner may
301.21 initiate, or request the attorney general to initiate, necessary civil action to recover the unpaid
301.22 cost of care. The commissioner may collect all third-party payments for chemical dependency
301.23 services provided under Laws 1986, chapter 394, sections 8 to 20, including private insurance
301.24 and federal Medicaid and Medicare financial participation. ~~The commissioner shall deposit~~
301.25 ~~in a dedicated account a percentage of collections to pay for the cost of operating the chemical~~
301.26 ~~dependency consolidated treatment fund invoice processing and vendor payment system,~~
301.27 ~~billing, and collections.~~ The remaining receipts must be deposited in the chemical dependency
301.28 fund.

301.29 **EFFECTIVE DATE.** This section is effective July 1, 2019.

302.1 Sec. 12. Minnesota Statutes 2018, section 254B.06, subdivision 2, is amended to read:

302.2 Subd. 2. **Allocation of collections.** ~~(a) The commissioner shall allocate all federal~~
 302.3 ~~financial participation collections to a special revenue account.~~ The commissioner shall
 302.4 allocate 77.05 percent of patient payments and third-party payments to the special revenue
 302.5 account and 22.95 percent to the county financially responsible for the patient.

302.6 ~~(b) For fiscal year 2017 only, the commissioner's allocation to the special revenue account~~
 302.7 ~~shall be increased from 77.05 percent to 79.8 percent and the county financial responsibility~~
 302.8 ~~shall be reduced from 22.95 percent to 20.2 percent.~~

302.9 **EFFECTIVE DATE.** This section is effective July 1, 2019.

302.10 Sec. 13. Minnesota Statutes 2018, section 256.478, is amended to read:

302.11 **256.478 HOME AND COMMUNITY-BASED SERVICES TRANSITIONS**
 302.12 **GRANTS TRANSITION TO COMMUNITY INITIATIVE.**

302.13 Subdivision 1. Eligibility. (a) An individual is eligible for the transition to community
 302.14 initiative if the individual meets the following criteria:

302.15 (1) without the additional resources available through the transitions to community
 302.16 initiative the individual would otherwise remain at the Anoka-Metro Regional Treatment
 302.17 Center, a state-operated community behavioral health hospital, or the Minnesota Security
 302.18 Hospital;

302.19 (2) the individual's discharge would be significantly delayed without the additional
 302.20 resources available through the transitions to community initiative; and

302.21 (3) the individual met treatment objectives and no longer needs hospital-level care or a
 302.22 secure treatment setting.

302.23 (b) An individual who is in a community hospital and on the waiting list for the
 302.24 Anoka-Metro Regional Treatment Center, but for whom alternative community placement
 302.25 would be appropriate is eligible for the transition to community initiative upon the
 302.26 commissioner's approval.

302.27 Subd. 2. **Transition grants.** The commissioner shall make available ~~home and~~
 302.28 ~~community-based services~~ transition to community grants to serve assist individuals who
 302.29 ~~do not meet eligibility criteria for the medical assistance program under section 256B.056~~
 302.30 ~~or 256B.057, but who otherwise meet the criteria under section 256B.092, subdivision 13,~~
 302.31 ~~or 256B.49, subdivision 24~~ who met the criteria under subdivision 1.

302.32 **EFFECTIVE DATE.** This section is effective July 1, 2019.

303.1 Sec. 14. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision
303.2 to read:

303.3 Subd. 5m. **Certified community behavioral health clinic services.** (a) Medical
303.4 assistance covers certified community behavioral health clinic (CCBHC) services that meet
303.5 the requirements of section 245.735, subdivision 3.

303.6 (b) The commissioner shall establish standards and methodologies for a prospective
303.7 payment system for medical assistance payments for services delivered by a CCBHC, in
303.8 accordance with guidance issued by the Centers for Medicare and Medicaid Services. The
303.9 commissioner shall include a quality bonus payment in the prospective payment system
303.10 based on federal criteria. The prospective payment system does not apply to MinnesotaCare.

303.11 (c) To the extent allowed by federal law, the commissioner may limit the number of
303.12 CCBHCs for the prospective payment system in paragraph (b) to ensure that the projected
303.13 claims do not exceed the money appropriated for this purpose. The commissioner shall
303.14 apply the following priorities, in the order listed, to give preference to clinics that:

303.15 (1) provide a comprehensive range of services and evidence-based practices for all age
303.16 groups, with services being fully coordinated and integrated;

303.17 (2) are certified as CCBHCs during the federal CCBHC demonstration period;

303.18 (3) receive CCBHC grants from the United States Department of Health and Human
303.19 Services; or

303.20 (4) focus on serving individuals in tribal areas and other underserved communities.

303.21 (d) Unless otherwise indicated in applicable federal requirements, the prospective payment
303.22 system must continue to be based on the federal instructions issued for the federal CCBHC
303.23 demonstration, except:

303.24 (1) the commissioner shall rebase CCBHC rates at least every three years;

303.25 (2) the commissioner shall provide for a 60-day appeals process of the rebasing;

303.26 (3) the prohibition against inclusion of new facilities in the demonstration does not apply
303.27 after the demonstration ends;

303.28 (4) the prospective payment rate under this section does not apply to services rendered
303.29 by CCBHCs to individuals who are dually eligible for Medicare and medical assistance
303.30 when Medicare is the primary payer for the service;

303.31 (5) payments for CCBHC services to individuals enrolled in managed care shall be
303.32 coordinated with the state's phase-out of CCBHC wrap payments;

304.1 (6) initial prospective payment rates for CCBHCs certified after July 1, 2019, shall be
304.2 based on rates for comparable CCBHCs. If no comparable provider exists, the commissioner
304.3 shall compute a CCBHC-specific rate based upon the CCBHC's audited costs adjusted for
304.4 changes in the scope of services; and

304.5 (7) the prospective payment rate for each CCBHC shall be adjusted annually by the
304.6 Medicare Economic Index as defined for the CCBHC federal demonstration.

304.7 **EFFECTIVE DATE.** Contingent upon federal approval, this section is effective July
304.8 1, 2019. The commissioner of human services shall notify the revisor of statutes when
304.9 federal approval is obtained or denied.

304.10 Sec. 15. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision
304.11 to read:

304.12 Subd. 20c. **Integrated care model; mental health case management services by**
304.13 **Center for Victims of Torture.** (a) The commissioner of human services, in collaboration
304.14 with the Center for Victims of Torture, shall develop a pilot project to support the continued
304.15 testing of an integrated care model for the delivery of mental health targeted case management
304.16 at three designated service sites. For purposes of this subdivision, "center" means the Center
304.17 for Victims of Torture.

304.18 (b) The commissioner of human services shall contract directly with the center for the
304.19 provision of the services described in paragraph (c). The services shall be paid at \$695 per
304.20 member per month and shall be funded using 100 percent state funding.

304.21 (c) Individuals who are eligible to receive medical assistance under this chapter, who
304.22 are eligible to receive mental health targeted case management as described under section
304.23 245.4711, and who are being served by the center shall be served using the integrated care
304.24 model and must be evaluated using the center's social functioning tool.

304.25 (d) The commissioner of human services, in collaboration with the center, shall also
304.26 evaluate whether the center's social functioning tool can be adapted for use with the general
304.27 medical assistance population. Beginning July 1, 2020, and annually thereafter until the
304.28 evaluation is complete, the commissioner of human services shall report on the results of
304.29 the evaluation to the legislative committees with jurisdiction over human services.

304.30 Sec. 16. Minnesota Statutes 2018, section 256B.0625, subdivision 24, is amended to read:

304.31 Subd. 24. **Other medical or remedial care.** Medical assistance covers any other medical
304.32 or remedial care licensed and recognized under state law unless otherwise prohibited by

305.1 law, ~~except licensed chemical dependency treatment programs or primary treatment or~~
 305.2 ~~extended care treatment units in hospitals that are covered under chapter 254B. The~~
 305.3 ~~commissioner shall include chemical dependency services in the state medical assistance~~
 305.4 ~~plan for federal reporting purposes, but payment must be made under chapter 254B. The~~
 305.5 commissioner shall publish in the State Register a list of elective surgeries that require a
 305.6 second medical opinion before medical assistance reimbursement, and the criteria and
 305.7 standards for deciding whether an elective surgery should require a second medical opinion.
 305.8 The list and criteria and standards are not subject to the requirements of sections 14.01 to
 305.9 14.69.

305.10 **EFFECTIVE DATE.** This section is effective July 1, 2019.

305.11 Sec. 17. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision
 305.12 to read:

305.13 Subd. 24a. **Substance use disorder services.** Medical assistance covers substance use
 305.14 disorder treatment services according to section 254B.05, subdivision 5, except for room
 305.15 and board.

305.16 **EFFECTIVE DATE.** This section is effective July 1, 2019.

305.17 Sec. 18. Minnesota Statutes 2018, section 256B.0625, subdivision 45a, is amended to
 305.18 read:

305.19 Subd. 45a. **Psychiatric residential treatment facility services for persons younger**
 305.20 **than 21 years of age.** (a) Medical assistance covers psychiatric residential treatment facility
 305.21 services, according to section 256B.0941, for persons younger than 21 years of age.
 305.22 Individuals who reach age 21 at the time they are receiving services are eligible to continue
 305.23 receiving services until they no longer require services or until they reach age 22, whichever
 305.24 occurs first.

305.25 (b) For purposes of this subdivision, "psychiatric residential treatment facility" means
 305.26 a facility other than a hospital that provides psychiatric services, as described in Code of
 305.27 Federal Regulations, title 42, sections 441.151 to 441.182, to individuals under age 21 in
 305.28 an inpatient setting.

305.29 (c) The commissioner shall enroll up to 150 certified psychiatric residential treatment
 305.30 facility services beds ~~at up to six sites.~~ The commissioner may enroll an additional 80
 305.31 certified psychiatric residential treatment facility services beds beginning July 1, 2020, and
 305.32 an additional 70 certified psychiatric residential treatment facility services beds beginning

306.1 July 1, 2023. The commissioner shall select psychiatric residential treatment facility services
306.2 providers through a request for proposals process. Providers of state-operated services may
306.3 respond to the request for proposals. The commissioner shall prioritize programs that
306.4 demonstrate the capacity to serve children and youth with aggressive and risky behaviors
306.5 toward themselves or others, multiple diagnoses, neurodevelopmental disorders, or complex
306.6 trauma related issues.

306.7 (d) Notwithstanding the limit on the number of certified psychiatric residential treatment
306.8 facility services beds under paragraph (c), providers of children's residential treatment under
306.9 section 256B.0945, who are enrolled to provide services as of July 1, 2019, may submit a
306.10 letter of intent to develop a psychiatric residential treatment facility program in a format
306.11 developed by the commissioner. Each letter of intent must demonstrate the need for
306.12 psychiatric residential treatment facility services, the proposed bed capacity for the program,
306.13 and the capacity of the organization to develop and deliver psychiatric residential treatment
306.14 facility services. The letter of intent must also include a description of the proposed services
306.15 and physical site as well as specific information about the population that the program plans
306.16 to serve. The commissioner shall respond to the letter of intent within 60 days of receiving
306.17 all requested information with a determination of whether the program is approved, or with
306.18 specific recommended actions required to obtain approval. Programs that receive an approved
306.19 letter of intent must initiate the processes required by the commissioner to enroll as a provider
306.20 of psychiatric residential treatment facility services within 30 days of receiving notice of
306.21 approval. The commissioner shall process letters of intent in the order received. A program
306.22 approved under this paragraph may not increase bed capacity when converting to provide
306.23 psychiatric residential treatment facility services.

306.24 **EFFECTIVE DATE.** This section is effective July 1, 2019.

306.25 Sec. 19. Minnesota Statutes 2018, section 256B.0625, subdivision 57, is amended to read:

306.26 Subd. 57. **Payment for Part B Medicare crossover claims.** (a) Effective for services
306.27 provided on or after January 1, 2012, medical assistance payment for an enrollee's
306.28 cost-sharing associated with Medicare Part B is limited to an amount up to the medical
306.29 assistance total allowed, when the medical assistance rate exceeds the amount paid by
306.30 Medicare.

306.31 (b) Excluded from this limitation are payments for mental health services and payments
306.32 for dialysis services provided to end-stage renal disease patients. The exclusion for mental
306.33 health services does not apply to payments for physician services provided by psychiatrists
306.34 and advanced practice nurses with a specialty in mental health.

307.1 (c) Excluded from this limitation are payments to federally qualified health centers ~~and~~₂
 307.2 rural health clinics, and CCBHCs subject to the prospective payment system under
 307.3 subdivision 5m.

307.4 **EFFECTIVE DATE.** Contingent upon federal approval, this section is effective July
 307.5 1, 2019. The commissioner of human services shall notify the revisor of statutes when
 307.6 federal approval is obtained or denied.

307.7 Sec. 20. Minnesota Statutes 2018, section 256B.0757, subdivision 1, is amended to read:

307.8 Subdivision 1. **Provision of coverage.** (a) The commissioner shall provide medical
 307.9 assistance coverage of health home services for eligible individuals with chronic conditions
 307.10 who select a designated provider as the individual's health home.

307.11 (b) The commissioner shall implement this section in compliance with the requirements
 307.12 of the state option to provide health homes for enrollees with chronic conditions, as provided
 307.13 under the Patient Protection and Affordable Care Act, Public Law 111-148, sections 2703
 307.14 and 3502. Terms used in this section have the meaning provided in that act.

307.15 (c) The commissioner shall establish health homes to serve populations with serious
 307.16 mental illness who meet the eligibility requirements described under subdivision 2, paragraph
 307.17 (b) clause (4) (1). The health home services provided by health homes shall focus on both
 307.18 the behavioral and the physical health of these populations.

307.19 (d) The commissioner shall establish medical respite health homes to serve individuals
 307.20 who are homeless and meet the eligibility requirements described under subdivision 2,
 307.21 paragraph (b), clause (2). The commissioner shall work with stakeholders to develop
 307.22 eligibility requirements, provider qualification requirements, and service delivery
 307.23 requirements.

307.24 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner
 307.25 shall notify the revisor of statutes when federal approval has been obtained.

307.26 Sec. 21. Minnesota Statutes 2018, section 256B.0757, subdivision 2, is amended to read:

307.27 Subd. 2. **Eligible individual.** (a) The commissioner may develop health home models
 307.28 in accordance with United States Code, title 42, section 1396w-4(h)(1).

307.29 (b) An individual is eligible for health home services under this section if the individual
 307.30 is eligible for medical assistance under this chapter and ~~has at least:~~

307.31 ~~(1) two chronic conditions;~~

308.1 ~~(2) one chronic condition and is at risk of having a second chronic condition;~~

308.2 ~~(3) one serious and persistent mental health condition; or~~

308.3 ~~(4) (1) has a condition that meets the definition of serious mental illness as described in~~
 308.4 ~~section 245.462, subdivision 20, paragraph (a), or emotional disturbance as defined in section~~
 308.5 ~~245.4871, subdivision 15, clause (2); and has a current diagnostic assessment as defined in~~
 308.6 ~~Minnesota Rules, part 9505.0372, subpart 1, item B or C, as performed or reviewed by a~~
 308.7 ~~mental health professional employed by or under contract with the behavioral health home~~
 308.8 ~~or~~

308.9 (2) the individual is homeless. For purposes of this clause, an individual is homeless if
 308.10 the individual lacks a fixed, adequate night-time residence.

308.11 The commissioner shall establish criteria for determining continued eligibility.

308.12 **EFFECTIVE DATE.** This section is effective the day following final enactment.

308.13 Sec. 22. Minnesota Statutes 2018, section 256B.0757, is amended by adding a subdivision
 308.14 to read:

308.15 Subd. 2a. **Discharge criteria.** (a) An individual may be discharged from behavioral
 308.16 health home services if:

308.17 (1) the behavioral health home services provider is unable to locate, contact, and engage
 308.18 the individual for a period of greater than three months after persistent efforts by the
 308.19 behavioral health home services provider; or

308.20 (2) the individual is unwilling to participate in behavioral health home services as
 308.21 demonstrated by the individual's refusal to meet with the behavioral health home services
 308.22 provider, or refusal to identify the individual's health and wellness goals or the activities or
 308.23 support necessary to achieve these goals.

308.24 (b) Before discharge from behavioral health home services, the behavioral health home
 308.25 services provider must offer a face-to-face meeting with the individual and the individual's
 308.26 identified supports, to discuss options available to the individual, including maintaining
 308.27 behavioral health home services.

308.28 **EFFECTIVE DATE.** This section is effective the day following final enactment.

308.29 Sec. 23. Minnesota Statutes 2018, section 256B.0757, subdivision 4, is amended to read:

308.30 Subd. 4. **Designated provider.** (a) Health home services are voluntary and an eligible
 308.31 individual may choose any designated provider. The commissioner shall establish designated

309.1 providers to serve as health homes and provide the services described in subdivision 3 to
 309.2 individuals eligible under subdivision 2. The commissioner shall apply for grants as provided
 309.3 under section 3502 of the Patient Protection and Affordable Care Act to establish health
 309.4 homes and provide capitated payments to designated providers. For purposes of this section,
 309.5 "designated provider" means a provider, clinical practice or clinical group practice, rural
 309.6 clinic, community health center, community mental health center, or any other entity that
 309.7 is determined by the commissioner to be qualified to be a health home for eligible individuals.
 309.8 This determination must be based on documentation evidencing that the designated provider
 309.9 has the systems and infrastructure in place to provide health home services and satisfies the
 309.10 qualification standards established by the commissioner in consultation with stakeholders
 309.11 and approved by the Centers for Medicare and Medicaid Services.

309.12 ~~(b) The commissioner shall develop and implement certification standards for designated~~
 309.13 ~~providers under this subdivision.~~

309.14 **EFFECTIVE DATE.** This section is effective the day following final enactment.

309.15 Sec. 24. Minnesota Statutes 2018, section 256B.0757, is amended by adding a subdivision
 309.16 to read:

309.17 **Subd. 4a. Behavioral health home services provider requirements.** A behavioral
 309.18 health home services provider must:

309.19 (1) be an enrolled Minnesota Health Care Programs provider;

309.20 (2) provide a medical assistance covered primary care or behavioral health service;

309.21 (3) utilize an electronic health record;

309.22 (4) utilize an electronic patient registry that contains the data elements required by the
 309.23 commissioner;

309.24 (5) demonstrate the organization's capacity to administer screenings approved by the
 309.25 commissioner for substance use disorder or alcohol and tobacco use;

309.26 (6) demonstrate the organization's capacity to refer an individual to resources appropriate
 309.27 to the individual's screening results;

309.28 (7) have policies and procedures to track referrals to ensure that the referral met the
 309.29 individual's needs;

309.30 (8) conduct a brief needs assessment when an individual begins receiving behavioral
 309.31 health home services. The brief needs assessment must be completed with input from the
 309.32 individual and the individual's identified supports. The brief needs assessment must address

310.1 the individual's immediate safety and transportation needs and potential barriers to
 310.2 participating in behavioral health home services;

310.3 (9) conduct a health wellness assessment within 60 days after intake that contains all
 310.4 required elements identified by the commissioner;

310.5 (10) conduct a health action plan that contains all required elements identified by the
 310.6 commissioner. The plan must be completed within 90 days after intake and must be updated
 310.7 at least once every six months, or more frequently if significant changes to an individual's
 310.8 needs or goals occur;

310.9 (11) agree to cooperate with and participate in the state's monitoring and evaluation of
 310.10 behavioral health home services; and

310.11 (12) obtain the individual's written consent to begin receiving behavioral health home
 310.12 services using a form approved by the commissioner.

310.13 **EFFECTIVE DATE.** This section is effective the day following final enactment.

310.14 Sec. 25. Minnesota Statutes 2018, section 256B.0757, is amended by adding a subdivision
 310.15 to read:

310.16 **Subd. 4b. Behavioral health home provider training and practice transformation**
 310.17 **requirements.** (a) The behavioral health home services provider must ensure that all staff
 310.18 delivering behavioral health home services receive adequate preservice and ongoing training,
 310.19 including:

310.20 (1) training approved by the commissioner that describes the goals and principles of
 310.21 behavioral health home services; and

310.22 (2) training on evidence-based practices to promote an individual's ability to successfully
 310.23 engage with medical, behavioral health, and social services to achieve the individual's health
 310.24 and wellness goals.

310.25 (b) The behavioral health home services provider must ensure that staff are capable of
 310.26 implementing culturally responsive services, as determined by the individual's culture,
 310.27 beliefs, values, and language as identified in the individual's health wellness assessment.

310.28 (c) The behavioral health home services provider must participate in the department's
 310.29 practice transformation activities to support continued skill and competency development
 310.30 in the provision of integrated medical, behavioral health, and social services.

310.31 **EFFECTIVE DATE.** This section is effective the day following final enactment.

311.1 Sec. 26. Minnesota Statutes 2018, section 256B.0757, is amended by adding a subdivision
311.2 to read:

311.3 Subd. 4c. Behavioral health home staff qualifications. (a) A behavioral health home
311.4 services provider must maintain staff with required professional qualifications appropriate
311.5 to the setting.

311.6 (b) If behavioral health home services are offered in a mental health setting, the
311.7 integration specialist must be a registered nurse licensed under the Minnesota Nurse Practice
311.8 Act, sections 148.171 to 148.285.

311.9 (c) If behavioral health home services are offered in a primary care setting, the integration
311.10 specialist must be a mental health professional as defined in section 245.462, subdivision
311.11 18, clauses (1) to (6), or 245.4871, subdivision 27, clauses (1) to (6).

311.12 (d) If behavioral health home services are offered in either a primary care setting or
311.13 mental health setting, the systems navigator must be a mental health practitioner as defined
311.14 in section 245.462, subdivision 17, or a community health worker as defined in section
311.15 256B.0625, subdivision 49.

311.16 (e) If behavioral health home services are offered in either a primary care setting or
311.17 mental health setting, the qualified health home specialist must be one of the following:

311.18 (1) a peer support specialist as defined in section 256B.0615;

311.19 (2) a family peer support specialist as defined in section 256B.0616;

311.20 (3) a case management associate as defined in section 245.462, subdivision 4, paragraph
311.21 (g), or 245.4871, subdivision 4, paragraph (j);

311.22 (4) a mental health rehabilitation worker as defined in section 256B.0623, subdivision
311.23 5, clause (4);

311.24 (5) a community paramedic as defined in section 144E.28, subdivision 9;

311.25 (6) a peer recovery specialist as defined in section 245G.07, subdivision 1, clause (5);

311.26 or

311.27 (7) a community health worker as defined in section 256B.0625, subdivision 49.

311.28 **EFFECTIVE DATE.** This section is effective the day following final enactment.

312.1 Sec. 27. Minnesota Statutes 2018, section 256B.0757, is amended by adding a subdivision
312.2 to read:

312.3 Subd. 4d. Behavioral health home service delivery standards. (a) A behavioral health
312.4 home services provider must meet the following service delivery standards:

312.5 (1) establish and maintain processes to support the coordination of an individual's primary
312.6 care, behavioral health, and dental care;

312.7 (2) maintain a team-based model of care, including regular coordination and
312.8 communication between behavioral health home services team members;

312.9 (3) use evidence-based practices that recognize and are tailored to the medical, social,
312.10 economic, behavioral health, functional impairment, cultural, and environmental factors
312.11 affecting the individual's health and health care choices;

312.12 (4) use person-centered planning practices to ensure the individual's health action plan
312.13 accurately reflects the individual's preferences, goals, resources, and optimal outcomes for
312.14 the individual and the individual's identified supports;

312.15 (5) use the patient registry to identify individuals and population subgroups requiring
312.16 specific levels or types of care and provide or refer the individual to needed treatment,
312.17 intervention, or services;

312.18 (6) utilize the Department of Human Services Partner Portal to identify past and current
312.19 treatment or services and identify potential gaps in care;

312.20 (7) deliver services consistent with the standards for frequency and face-to-face contact
312.21 required by the commissioner;

312.22 (8) ensure that a diagnostic assessment is completed for each individual receiving
312.23 behavioral health home services within six months of the start of behavioral health home
312.24 services;

312.25 (9) deliver services in locations and settings that meet the needs of the individual;

312.26 (10) provide a central point of contact to ensure that individuals and the individual's
312.27 identified supports can successfully navigate the array of services that impact the individual's
312.28 health and well-being;

312.29 (11) have capacity to assess an individual's readiness for change and the individual's
312.30 capacity to integrate new health care or community supports into the individual's life;

313.1 (12) offer or facilitate the provision of wellness and prevention education on
313.2 evidenced-based curriculums specific to the prevention and management of common chronic
313.3 conditions;

313.4 (13) help an individual set up and prepare for medical, behavioral health, social service,
313.5 or community support appointments, including accompanying the individual to appointments
313.6 as appropriate, and providing follow-up with the individual after these appointments;

313.7 (14) offer or facilitate the provision of health coaching related to chronic disease
313.8 management and the navigation of complex systems of care to the individual, the individual's
313.9 family, and identified supports;

313.10 (15) connect the individual, the individual's family, and identified supports to appropriate
313.11 support services that help the individual overcome access or service barriers, increase
313.12 self-sufficiency skills, and improve overall health;

313.13 (16) provide effective referrals and timely access to services; and

313.14 (17) establish a continuous quality improvement process for providing behavioral health
313.15 home services.

313.16 (b) The behavioral health home services provider must also create a plan, in partnership
313.17 with the individual and the individual's identified supports, to support the individual after
313.18 discharge from a hospital, residential treatment program, or other setting. The plan must
313.19 include protocols for:

313.20 (1) maintaining contact between the behavioral health home services team member, the
313.21 individual, and the individual's identified supports during and after discharge;

313.22 (2) linking the individual to new resources as needed;

313.23 (3) reestablishing the individual's existing services and community and social supports;

313.24 and

313.25 (4) following up with appropriate entities to transfer or obtain the individual's service
313.26 records as necessary for continued care.

313.27 (c) If the individual is enrolled in a managed care plan, a behavioral health home services
313.28 provider must:

313.29 (1) notify the behavioral health home services contact designated by the managed care
313.30 plan within 30 days of when the individual begins behavioral health home services; and

313.31 (2) adhere to the managed care plan communication and coordination requirements
313.32 described in the behavioral health home services manual.

314.1 (d) Before terminating behavioral health home services, the behavioral health home
 314.2 services provider must:

314.3 (1) provide a 60-day notice of termination of behavioral health home services to all
 314.4 individuals receiving behavioral health home services, the commissioner, and managed care
 314.5 plans, if applicable; and

314.6 (2) refer individuals receiving behavioral health home services to a new behavioral
 314.7 health home services provider.

314.8 Sec. 28. Minnesota Statutes 2018, section 256B.0757, is amended by adding a subdivision
 314.9 to read:

314.10 Subd. 4e. **Behavioral health home provider variances.** (a) The commissioner may
 314.11 grant a variance to specific requirements under subdivisions 4a, 4b, 4c, or 4d for a behavioral
 314.12 health home services provider according to this subdivision.

314.13 (b) The commissioner may grant a variance if the commissioner finds that:

314.14 (1) failure to grant the variance would result in hardship or injustice to the applicant;

314.15 (2) the variance would be consistent with the public interest; and

314.16 (3) the variance would not reduce the level of services provided to individuals served
 314.17 by the organization.

314.18 (c) The commissioner may grant a variance from one or more requirements to permit
 314.19 an applicant to offer behavioral health home services of a type or in a manner that is
 314.20 innovative, if the commissioner finds that the variance does not impede the achievement of
 314.21 the criteria in subdivisions 4a, 4b, 4c, or 4d and may improve the behavioral health home
 314.22 services provided by the applicant.

314.23 (d) The commissioner's decision to grant or deny a variance request is final and not
 314.24 subject to appeal.

314.25 **EFFECTIVE DATE.** This section is effective the day following final enactment.

314.26 Sec. 29. Minnesota Statutes 2018, section 256B.0757, subdivision 5, is amended to read:

314.27 Subd. 5. **Payments.** (a) The commissioner shall ~~make payments to each designated~~
 314.28 ~~provider for the provision of health home services described in subdivision 3 to each eligible~~
 314.29 ~~individual under subdivision 2 that selects the health home as a provider~~ establish a single,
 314.30 statewide reimbursement rate for behavioral health home services described in subdivisions
 314.31 4a to 4d.

315.1 (b) The commissioner shall establish a single, statewide reimbursement rate for medical
 315.2 respite health home services.

315.3 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner
 315.4 shall notify the revisor of statutes when federal approval has been obtained.

315.5 Sec. 30. Minnesota Statutes 2018, section 256B.0757, subdivision 8, is amended to read:

315.6 Subd. 8. **Evaluation and continued development.** (a) For continued certification under
 315.7 this section, behavioral health homes and medical respite health homes must meet process,
 315.8 outcome, and quality standards developed and specified by the commissioner. The
 315.9 commissioner shall collect data from health homes as necessary to monitor compliance with
 315.10 certification standards.

315.11 (b) The commissioner may contract with a private entity to evaluate patient and family
 315.12 experiences, health care utilization, and costs.

315.13 (c) The commissioner shall utilize findings from the implementation of ~~behavioral~~ health
 315.14 homes to determine populations to serve under subsequent health home models for individuals
 315.15 with chronic conditions.

315.16 **EFFECTIVE DATE.** This section is effective the day following final enactment.

315.17 Sec. 31. **[256B.0759] SUBSTANCE USE DISORDER DEMONSTRATION PROJECT.**

315.18 Subdivision 1. **Establishment.** The commissioner shall develop and implement a medical
 315.19 assistance demonstration project to test reforms of Minnesota's substance use disorder
 315.20 treatment system to ensure individuals with substance use disorders have access to a full
 315.21 continuum of high quality care.

315.22 Subd. 2. **Provider participation.** Substance use disorder treatment providers may elect
 315.23 to participate in the demonstration project and meet the requirements of subdivision 3. To
 315.24 participate, a provider must notify the commissioner of the provider's intent to participate
 315.25 in a format required by the commissioner and enroll as a demonstration project provider.

315.26 Subd. 3. **Provider standards.** (a) The commissioner shall establish requirements for
 315.27 participating providers that are consistent with the federal requirements of the demonstration
 315.28 project.

315.29 (b) A participating residential provider must obtain applicable licensure under chapters
 315.30 245F and 245G or other applicable standards for the services provided and must:

316.1 (1) deliver services in accordance with American Society of Addiction Medicine (ASAM)
 316.2 standards;

316.3 (2) maintain formal patient referral arrangements with providers delivering step-up or
 316.4 step-down levels of care in accordance with ASAM standards; and

316.5 (3) provide or arrange for medication-assisted treatment services if requested by a client
 316.6 for whom an effective medication exists.

316.7 (c) A participating outpatient provider must be licensed and must:

316.8 (1) deliver services in accordance with ASAM standards; and

316.9 (2) maintain formal patient referral arrangements with providers delivering step-up or
 316.10 step-down levels of care in accordance with ASAM standards.

316.11 (d) If the provider standards under chapter 245G or other applicable standards conflict
 316.12 or are duplicative, the commissioner may grant variances to the standards if the variances
 316.13 do not conflict with federal requirements. The commissioner shall publish service
 316.14 components, service standards, and staffing requirements for participating providers that
 316.15 are consistent with ASAM standards and federal requirements.

316.16 Subd. 4. **Provider payment rates.** (a) Payment rates for participating providers must
 316.17 be increased for services provided to medical assistance enrollees.

316.18 (b) For substance use disorder services under section 254B.05, subdivision 5, paragraph
 316.19 (b), clause (8), payment rates must be increased by 15 percent over the rates in effect on
 316.20 January 1, 2020.

316.21 (c) For substance use disorder services under section 254B.05, subdivision 5, paragraph
 316.22 (b), clauses (1), (6), (7), and (10), payment rates must be increased by ten percent over the
 316.23 rates in effect on January 1, 2021.

316.24 Subd. 5. **Federal approval.** The commissioner shall seek federal approval to implement
 316.25 the demonstration project under this section and to receive federal financial participation.

316.26 Sec. 32. Minnesota Statutes 2018, section 256B.0915, subdivision 3b, is amended to read:

316.27 Subd. 3b. **Cost limits for elderly waiver applicants who reside in a nursing facility**
 316.28 **or another eligible facility.** (a) For a person who is a nursing facility resident at the time
 316.29 of requesting a determination of eligibility for elderly waived services, a monthly
 316.30 conversion budget limit for the cost of elderly waived services may be requested. The
 316.31 monthly conversion budget limit for the cost of elderly waiver services shall be the resident
 316.32 class assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, for that resident in

317.1 ~~the nursing facility where the resident currently resides until July 1 of the state fiscal year~~
317.2 ~~in which the resident assessment system as described in section 256B.438 for nursing home~~
317.3 ~~rate determination is implemented. Effective on July 1 of the state fiscal year in which the~~
317.4 ~~resident assessment system as described in section 256B.438 for nursing home rate~~
317.5 ~~determination is implemented, the monthly conversion budget limit for the cost of elderly~~
317.6 ~~waiver services shall be based on the per diem nursing facility rate as determined by the~~
317.7 resident assessment system as described in section ~~256B.438~~ 256R.17 for residents in the
317.8 nursing facility where the elderly waiver applicant currently resides. The monthly conversion
317.9 budget limit shall be calculated by multiplying the per diem by 365, divided by 12, and
317.10 reduced by the recipient's maintenance needs allowance as described in subdivision 1d. The
317.11 initially approved monthly conversion budget limit shall be adjusted annually as described
317.12 in subdivision 3a, paragraph (a). The limit under this ~~subdivision~~ paragraph only applies to
317.13 persons discharged from a nursing facility after a minimum 30-day stay and found eligible
317.14 for waived services on or after July 1, 1997. For conversions from the nursing home to
317.15 the elderly waiver with consumer directed community support services, the nursing facility
317.16 per diem used to calculate the monthly conversion budget limit must be reduced by a
317.17 percentage equal to the percentage difference between the consumer directed services budget
317.18 limit that would be assigned according to the federally approved waiver plan and the
317.19 corresponding community case mix cap, but not to exceed 50 percent.

317.20 (b) A person who meets elderly waiver eligibility criteria and the eligibility criteria under
317.21 section 256.478, subdivision 1, is eligible for a special monthly budget limit for the cost of
317.22 elderly waived services up to \$21,610 per month. The special monthly budget limit must
317.23 be adjusted annually as described in subdivision 3a, paragraphs (a) and (e). For a person
317.24 using a special monthly budget limit under the elderly waiver with consumer-directed
317.25 community support services, the special monthly budget limit must be reduced as described
317.26 in paragraph (a).

317.27 (c) The commissioner may provide an additional payment for documented costs between
317.28 a threshold determined by the commissioner and the special monthly budget limit to a
317.29 managed care plan for elderly waiver services provided to a person who is: (1) eligible for
317.30 a special monthly budget limit under paragraph (b); and (2) enrolled in a managed care plan
317.31 that provides elderly waiver services under section 256B.69.

317.32 (d) For monthly conversion budget limits under paragraph (a) and special monthly budget
317.33 limits under paragraph (b), the service rate limits for adult foster care under subdivision 3d
317.34 and for customized living under subdivision 3e may be exceeded if necessary for the provider
317.35 to meet identified needs and provide services as approved in the coordinated service and

318.1 support plan, if the total cost of all services does not exceed the monthly conversion or
 318.2 special monthly budget limit. Service rates must be established using tools provided by the
 318.3 commissioner.

318.4 (e) The following costs must be included in determining the total monthly costs for the
 318.5 waiver client:

318.6 (1) cost of all waived services, including specialized supplies and equipment and
 318.7 environmental accessibility adaptations; and

318.8 (2) cost of skilled nursing, home health aide, and personal care services reimbursable
 318.9 by medical assistance.

318.10 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner
 318.11 of human services shall notify the revisor of statutes once federal approval is obtained.

318.12 Sec. 33. Minnesota Statutes 2018, section 256B.092, subdivision 13, is amended to read:

318.13 Subd. 13. **Waiver allocations for transition populations.** (a) The commissioner shall
 318.14 make available additional waiver allocations and additional necessary resources ~~to assure~~
 318.15 ~~timely discharges from the Anoka-Metro Regional Treatment Center and the Minnesota~~
 318.16 ~~Security Hospital in St. Peter~~ for individuals who meet the following eligibility criteria:
 318.17 established under section 256.478, subdivision 1.

318.18 ~~(1) are otherwise eligible for the developmental disabilities waiver under this section;~~

318.19 ~~(2) who would otherwise remain at the Anoka-Metro Regional Treatment Center or the~~
 318.20 ~~Minnesota Security Hospital;~~

318.21 ~~(3) whose discharge would be significantly delayed without the available waiver~~
 318.22 ~~allocation; and~~

318.23 ~~(4) who have met treatment objectives and no longer meet hospital level of care.~~

318.24 (b) Additional waiver allocations under this subdivision must meet cost-effectiveness
 318.25 requirements of the federal approved waiver plan.

318.26 (c) Any corporate foster care home developed under this subdivision must be considered
 318.27 an exception under section 245A.03, subdivision 7, paragraph (a).

318.28 **EFFECTIVE DATE.** This section is effective July 1, 2019.

319.1 Sec. 34. Minnesota Statutes 2018, section 256B.0941, subdivision 3, is amended to read:

319.2 Subd. 3. **Per diem rate.** (a) The commissioner shall establish a ~~statewide~~ one per diem
319.3 rate per provider for psychiatric residential treatment facility services for individuals 21
319.4 years of age or younger. The rate for a provider must not exceed the rate charged by that
319.5 provider for the same service to other payers. Payment must not be made to more than one
319.6 entity for each individual for services provided under this section on a given day. The
319.7 commissioner shall set rates prospectively for the annual rate period. The commissioner
319.8 shall require providers to submit annual cost reports on a uniform cost reporting form and
319.9 shall use submitted cost reports to inform the rate-setting process. The cost reporting shall
319.10 be done according to federal requirements for Medicare cost reports.

319.11 (b) The following are included in the rate:

319.12 (1) costs necessary for licensure and accreditation, meeting all staffing standards for
319.13 participation, meeting all service standards for participation, meeting all requirements for
319.14 active treatment, maintaining medical records, conducting utilization review, meeting
319.15 inspection of care, and discharge planning. The direct services costs must be determined
319.16 using the actual cost of salaries, benefits, payroll taxes, and training of direct services staff
319.17 and service-related transportation; and

319.18 (2) payment for room and board provided by facilities meeting all accreditation and
319.19 licensing requirements for participation.

319.20 (c) A facility may submit a claim for payment outside of the per diem for professional
319.21 services arranged by and provided at the facility by an appropriately licensed professional
319.22 who is enrolled as a provider with Minnesota health care programs. Arranged services must
319.23 be billed by the facility on a separate claim, and the facility shall be responsible for payment
319.24 to the provider. These services must be included in the individual plan of care and are subject
319.25 to prior authorization by the state's medical review agent.

319.26 (d) Medicaid shall reimburse for concurrent services as approved by the commissioner
319.27 to support continuity of care and successful discharge from the facility. "Concurrent services"
319.28 means services provided by another entity or provider while the individual is admitted to a
319.29 psychiatric residential treatment facility. Payment for concurrent services may be limited
319.30 and these services are subject to prior authorization by the state's medical review agent.
319.31 Concurrent services may include targeted case management, assertive community treatment,
319.32 clinical care consultation, team consultation, and treatment planning.

319.33 (e) Payment rates under this subdivision shall not include the costs of providing the
319.34 following services:

320.1 (1) educational services;

320.2 (2) acute medical care or specialty services for other medical conditions;

320.3 (3) dental services; and

320.4 (4) pharmacy drug costs.

320.5 (f) For purposes of this section, "actual cost" means costs that are allowable, allocable,
320.6 reasonable, and consistent with federal reimbursement requirements in Code of Federal
320.7 Regulations, title 48, chapter 1, part 31, relating to for-profit entities, and the Office of
320.8 Management and Budget Circular Number A-122, relating to nonprofit entities.

320.9 Sec. 35. Minnesota Statutes 2018, section 256B.49, subdivision 24, is amended to read:

320.10 Subd. 24. **Waiver allocations for transition populations.** (a) The commissioner shall
320.11 make available additional waiver allocations and additional necessary resources to assure
320.12 timely discharges from the Anoka Metro Regional Treatment Center and the Minnesota
320.13 Security Hospital in St. Peter for individuals who meet the following eligibility criteria:
320.14 established under section 256.478, subdivision 1.

320.15 ~~(1) are otherwise eligible for the brain injury, community access for disability inclusion,~~
320.16 ~~or community alternative care waivers under this section;~~

320.17 ~~(2) who would otherwise remain at the Anoka Metro Regional Treatment Center or the~~
320.18 ~~Minnesota Security Hospital;~~

320.19 ~~(3) whose discharge would be significantly delayed without the available waiver~~
320.20 ~~allocation; and~~

320.21 ~~(4) who have met treatment objectives and no longer meet hospital level of care.~~

320.22 (b) Additional waiver allocations under this subdivision must meet cost-effectiveness
320.23 requirements of the federal approved waiver plan.

320.24 (c) Any corporate foster care home developed under this subdivision must be considered
320.25 an exception under section 245A.03, subdivision 7, paragraph (a).

320.26 **EFFECTIVE DATE.** This section is effective July 1, 2019.

320.27 Sec. 36. Minnesota Statutes 2018, section 256I.04, subdivision 1, is amended to read:

320.28 Subdivision 1. **Individual eligibility requirements.** An individual is eligible for and
320.29 entitled to a housing support payment to be made on the individual's behalf if the agency

321.1 has approved the setting where the individual will receive housing support and the individual
321.2 meets the requirements in paragraph (a), (b), or (c).

321.3 (a) The individual is aged, blind, or is over 18 years of age with a disability as determined
321.4 under the criteria used by the title II program of the Social Security Act, and meets the
321.5 resource restrictions and standards of section 256P.02, and the individual's countable income
321.6 after deducting the (1) exclusions and disregards of the SSI program, (2) the medical
321.7 assistance personal needs allowance under section 256B.35, and (3) an amount equal to the
321.8 income actually made available to a community spouse by an elderly waiver participant
321.9 under the provisions of sections 256B.0575, paragraph (a), clause (4), and 256B.058,
321.10 subdivision 2, is less than the monthly rate specified in the agency's agreement with the
321.11 provider of housing support in which the individual resides.

321.12 (b) The individual meets a category of eligibility under section 256D.05, subdivision 1,
321.13 paragraph (a), clauses (1), (3), (4) to (8), and (13), and paragraph (b), if applicable, and the
321.14 individual's resources are less than the standards specified by section 256P.02, and the
321.15 individual's countable income as determined under section 256P.06, less the medical
321.16 assistance personal needs allowance under section 256B.35 is less than the monthly rate
321.17 specified in the agency's agreement with the provider of housing support in which the
321.18 individual resides.

321.19 (c) ~~The individual receives licensed residential crisis stabilization services under section~~
321.20 ~~256B.0624, subdivision 7, and is receiving medical assistance. The individual may receive~~
321.21 ~~concurrent housing support payments if receiving licensed residential crisis stabilization~~
321.22 ~~services under section 256B.0624, subdivision 7. lacks a fixed, adequate, nighttime residence~~
321.23 ~~upon discharge from a residential behavioral health treatment program, as determined by~~
321.24 ~~treatment staff from the residential behavioral health treatment program. An individual is~~
321.25 ~~eligible under this paragraph for up to three months, including a full or partial month from~~
321.26 ~~the individual's move-in date at a setting approved for housing support following discharge~~
321.27 ~~from treatment, plus two full months.~~

321.28 **EFFECTIVE DATE.** This section is effective September 1, 2019.

321.29 Sec. 37. Minnesota Statutes 2018, section 256I.04, subdivision 2f, is amended to read:

321.30 Subd. 2f. **Required services.** (a) In licensed and registered settings under subdivision
321.31 2a, providers shall ensure that participants have at a minimum:

321.32 (1) food preparation and service for three nutritional meals a day on site;

321.33 (2) a bed, clothing storage, linen, bedding, laundering, and laundry supplies or service;

322.1 (3) housekeeping, including cleaning and lavatory supplies or service; and

322.2 (4) maintenance and operation of the building and grounds, including heat, water, garbage
322.3 removal, electricity, telephone for the site, cooling, supplies, and parts and tools to repair
322.4 and maintain equipment and facilities.

322.5 (b) In addition, when providers serve participants described in subdivision 1, paragraph
322.6 (c), the providers are required to assist the participants in applying for continuing housing
322.7 support payments before the end of the eligibility period.

322.8 **EFFECTIVE DATE.** This section is effective September 1, 2019.

322.9 Sec. 38. Minnesota Statutes 2018, section 256I.06, subdivision 8, is amended to read:

322.10 Subd. 8. **Amount of housing support payment.** (a) The amount of a room and board
322.11 payment to be made on behalf of an eligible individual is determined by subtracting the
322.12 individual's countable income under section 256I.04, subdivision 1, for a whole calendar
322.13 month from the room and board rate for that same month. The housing support payment is
322.14 determined by multiplying the housing support rate times the period of time the individual
322.15 was a resident or temporarily absent under section 256I.05, subdivision 1c, paragraph (d).

322.16 (b) For an individual with earned income under paragraph (a), prospective budgeting
322.17 must be used to determine the amount of the individual's payment for the following six-month
322.18 period. An increase in income shall not affect an individual's eligibility or payment amount
322.19 until the month following the reporting month. A decrease in income shall be effective the
322.20 first day of the month after the month in which the decrease is reported.

322.21 (c) For an individual who receives ~~licensed residential crisis stabilization services under~~
322.22 ~~section 256B.0624, subdivision 7,~~ housing support payments under section 256I.04,
322.23 subdivision 1, paragraph (c), the amount of the housing support payment is determined by
322.24 multiplying the housing support rate times the period of time the individual was a resident.

322.25 **EFFECTIVE DATE.** This section is effective September 1, 2019.

322.26 Sec. 39. Laws 2017, First Special Session chapter 6, article 8, section 71, the effective
322.27 date, is amended to read:

322.28 **EFFECTIVE DATE.** This section is effective for services provided on July 1, 2017,
322.29 ~~through April 30, 2019, and expires May 1, 2019~~ and thereafter.

322.30 **EFFECTIVE DATE.** This section is effective April 30, 2019.

323.1 Sec. 40. Laws 2017, First Special Session chapter 6, article 8, section 72, the effective
323.2 date, is amended to read:

323.3 **EFFECTIVE DATE.** This section is effective for services provided on July 1, 2017,
323.4 ~~through April 30, 2019, and expires May 1, 2019~~ and thereafter.

323.5 **EFFECTIVE DATE.** This section is effective April 30, 2019.

323.6 Sec. 41. **COMMUNITY COMPETENCY RESTORATION TASK FORCE.**

323.7 Subdivision 1. **Establishment; purpose.** The Community Competency Restoration Task
323.8 Force is established to evaluate and study community competency restoration programs and
323.9 develop recommendations to address the needs of individuals deemed incompetent to stand
323.10 trial.

323.11 Subd. 2. **Membership.** (a) The Community Competency Restoration Task Force consists
323.12 of the following members, appointed as follows:

323.13 (1) a representative appointed by the governor's office;

323.14 (2) the commissioner of human services or designee;

323.15 (3) the commissioner of corrections or designee;

323.16 (4) a representative from direct care and treatment services with experience in competency
323.17 evaluations, appointed by the commissioner of human services;

323.18 (5) a representative appointed by the designated State Protection and Advocacy system;

323.19 (6) the ombudsman for mental health and developmental disabilities;

323.20 (7) a representative appointed by the Minnesota Hospital Association;

323.21 (8) a representative appointed by the Association of Minnesota Counties;

323.22 (9) two representatives appointed by the Minnesota Association of County Social Service
323.23 Administrators: one from the seven-county metropolitan area, as defined under Minnesota
323.24 Statutes, section 473.121, subdivision 2, and one from outside the seven-county metropolitan
323.25 area;

323.26 (10) a representative appointed by the Board of Public Defense;

323.27 (11) a representative appointed by the Minnesota County Attorney Association;

323.28 (12) a representative appointed by the Chiefs of Police;

323.29 (13) a representative appointed by the Minnesota Psychiatric Society;

- 324.1 (14) a representative appointed by the Minnesota Psychological Association;
- 324.2 (15) a representative appointed by the State Court Administrator;
- 324.3 (16) a representative appointed by the Minnesota Association of Community Mental
- 324.4 Health Programs;
- 324.5 (17) a representative appointed by the Minnesota Sheriff's Association;
- 324.6 (18) a representative appointed by the Sentencing Commission;
- 324.7 (19) a jail administrator appointed by the commissioner of corrections;
- 324.8 (20) a representative from an organization providing reentry services appointed by the
- 324.9 commissioner of corrections;
- 324.10 (21) a representative from a mental health advocacy organization appointed by the
- 324.11 commissioner of human services;
- 324.12 (22) a person with direct experience with competency restoration appointed by the
- 324.13 commissioner of human services;
- 324.14 (23) representatives from organizations representing racial and ethnic groups
- 324.15 overrepresented in the justice system appointed by the commissioner of corrections; and
- 324.16 (24) a crime victim appointed by the commissioner of corrections.
- 324.17 (b) Appointments to the task force must be made no later than July 15, 2019, and members
- 324.18 of the task force may be compensated as provided under Minnesota Statutes, section 15.059,
- 324.19 subdivision 3.
- 324.20 Subd. 3. **Duties.** The task force must:
- 324.21 (1) identify current services and resources available for individuals in the criminal justice
- 324.22 system who have been found incompetent to stand trial;
- 324.23 (2) analyze current trends of competency referrals by county and the impact of any
- 324.24 diversion projects or stepping-up initiatives;
- 324.25 (3) analyze selected case reviews and other data to identify risk levels of those individuals,
- 324.26 service usage, housing status, and health insurance status prior to being jailed;
- 324.27 (4) research how other states address this issue, including funding and structure of
- 324.28 community competency restoration programs, and jail-based programs; and
- 324.29 (5) develop recommendations to address the growing number of individuals deemed
- 324.30 incompetent to stand trial including increasing prevention and diversion efforts, providing

325.1 a timely process for reducing the amount of time individuals remain in the criminal justice
325.2 system, determining how to provide and fund competency restoration services in the
325.3 community, and defining the role of the counties and state in providing competency
325.4 restoration.

325.5 Subd. 4. **Officers; meetings.** (a) The commissioner of human services shall convene
325.6 the first meeting of the task force no later than August 1, 2019.

325.7 (b) The task force must elect a chair and vice-chair from among its members and may
325.8 elect other officers as necessary.

325.9 (c) The task force is subject to the Minnesota Open Meeting Law under Minnesota
325.10 Statutes, chapter 13D.

325.11 Subd. 5. **Staff.** (a) The commissioner of human services must provide staff assistance
325.12 to support the task force's work.

325.13 (b) The task force may utilize the expertise of the Council of State Governments Justice
325.14 Center.

325.15 Subd. 6. **Report required.** (a) By February 1, 2020, the task force shall submit a report
325.16 on its progress and findings to the chairs and ranking minority members of the legislative
325.17 committees with jurisdiction over mental health and corrections.

325.18 (b) By February 1, 2021, the task force must submit a written report including
325.19 recommendations to address the growing number of individuals deemed incompetent to
325.20 stand trial to the chairs and ranking minority members of the legislative committees with
325.21 jurisdiction over mental health and corrections.

325.22 Subd. 7. **Expiration.** The task force expires upon submission of the report in subdivision
325.23 6, paragraph (b), or February 1, 2021, whichever is later.

325.24 **EFFECTIVE DATE.** This section is effective the day following final enactment.

325.25 Sec. 42. **DIRECTION TO COMMISSIONER; IMPROVING SCHOOL-LINKED**
325.26 **MENTAL HEALTH GRANT PROGRAM.**

325.27 (a) The commissioner of human services, in collaboration with the commissioner of
325.28 education, representatives from the education community, mental health providers, and
325.29 advocates, shall assess the school-linked mental health grant program under Minnesota
325.30 Statutes, section 245.4901, and develop recommendations for improvements. The assessment
325.31 must include but is not limited to the following:

325.32 (1) promoting stability among current grantees and school partners;

326.1 (2) assessing the minimum number of full-time equivalents needed per school site to
326.2 effectively carry out the program;

326.3 (3) developing a funding formula that promotes sustainability and consistency across
326.4 grant cycles;

326.5 (4) reviewing current data collection and evaluation; and

326.6 (5) analyzing the impact on outcomes when a school has a school-linked mental health
326.7 program, a multi-tier system of supports, and sufficient school support personnel to meet
326.8 the needs of students.

326.9 (b) The commissioner shall provide a report of the findings of the assessment and
326.10 recommendations, including any necessary statutory changes, to the legislative committees
326.11 with jurisdiction over mental health and education by January 15, 2020.

326.12 **EFFECTIVE DATE.** This section is effective the day following final enactment.

326.13 Sec. 43. **DIRECTION TO COMMISSIONER; CCBHC RATE METHODOLOGY.**

326.14 (a) The commissioner of human services shall develop recommendations for a rate
326.15 methodology that reflects each CCBHC's reasonable cost of providing the services described
326.16 in Minnesota Statutes, section 245.735, subdivision 3, consistent with applicable federal
326.17 requirements. In developing the rate methodology, the commissioner shall consider guidance
326.18 issued by the Centers for Medicare and Medicaid Services for the Section 223 Demonstration
326.19 Program for CCBHC and costs associated with the following:

326.20 (1) a new CCBHC service that is not incorporated in the baseline prospective payment
326.21 system rate, or a deletion of a CCBHC service that is incorporated in the baseline rate;

326.22 (2) a change in service due to amended regulatory requirements or rules;

326.23 (3) a change in types of services due to a change in applicable technology and medical
326.24 practice utilized by the clinic;

326.25 (4) a change in the scope of a project approved by the commissioner; and

326.26 (5) a Minnesota-specific quality incentive program for CCBHCs that achieve target
326.27 performance on select quality measures. The commissioner shall develop the quality incentive
326.28 program, in consultation with stakeholders, with the following requirements:

326.29 (i) the same terms of performance must apply to all CCBHCs;

327.1 (ii) quality payments must be in addition to the prospective payment rate and must not
327.2 exceed an amount equal to five percent of total medical assistance payments for CCBHC
327.3 services provided during the applicable time period; and

327.4 (iii) the quality measures must be consistent with measures used by the commissioner
327.5 for other health care programs.

327.6 (b) By February 15, 2020, the commissioner of human services shall consult with CCBHC
327.7 providers to develop the rate methodology under paragraph (a). The commissioner shall
327.8 report to the chairs and ranking minority members of the legislative committees with
327.9 jurisdiction over mental health services and medical assistance on the recommendations to
327.10 the CCBHC rate methodology including any necessary statutory updates required for federal
327.11 approval.

327.12 (c) An entity that receives a prospective payment system rate that overlaps with the
327.13 CCBHC rate is not eligible for a CCBHC rate. The commissioner shall consult with CCBHCs
327.14 and other providers receiving a prospective payment system rate to study a rate methodology
327.15 that eliminates potential duplication of payment for CCBHC providers who also receive a
327.16 separate prospective payment system rate. By February 15, 2021, the commissioner shall
327.17 report to the chairs and ranking minority members of the legislative committees with
327.18 jurisdiction over mental health services and medical assistance on findings and
327.19 recommendations related to the rate methodology study under this paragraph, including any
327.20 necessary statutory updates to implement recommendations.

327.21 **Sec. 44. DIRECTION TO COMMISSIONER; CONTINUUM OF CARE-BASED**
327.22 **RATE METHODOLOGY.**

327.23 **Subdivision 1. Rate methodology.** (a) The commissioner of human services shall develop
327.24 a comprehensive rate methodology for the consolidated chemical dependency treatment
327.25 fund that reimburses substance use disorder treatment providers for the full continuum of
327.26 care. The continuum of care-based rate methodology must replace the current rates with a
327.27 uniform statewide methodology that accurately reflects provider expenses for providing
327.28 required elements of substance use disorder outpatient and residential services.

327.29 (b) The continuum of care-based rate methodology must include:

327.30 (1) payment methodologies for substance use disorder treatment services provided under
327.31 the consolidated chemical dependency treatment fund: (i) by a state-operated vendor and,
327.32 if the criteria for patient placement is equivalent, by private vendors; or (ii) for persons who

328.1 have been civilly committed to the commissioner, present the most complex and difficult
 328.2 care needs, and are a potential threat to the community;

328.3 (2) compensation to providers who provide culturally competent consultation resources;
 328.4 and

328.5 (3) cost-based reimbursement for substance use disorder providers that use sustainable
 328.6 business models that individualize care and retain individuals in ongoing care at the lowest
 328.7 medically appropriate level.

328.8 (c) The commissioner of human services may contract with a health care policy consultant
 328.9 or other entity to:

328.10 (1) provide stakeholder facilitation and provider outreach services to develop the
 328.11 continuum of care-based rate methodology; and

328.12 (2) provide technical services to develop the continuum of care-based rate methodology.

328.13 (d) The commissioner of human services must develop comprehensive substance use
 328.14 disorder billing guidance for the continuum of care-based rate methodology.

328.15 (e) In developing the continuum of care-based rate methodology, the commissioner of
 328.16 human services must consult with the following stakeholders:

328.17 (1) representatives of at least one provider operating residential treatment services, one
 328.18 provider operating out-patient treatment services, one provider operating an opioid treatment
 328.19 program, and one provider operating both residential and out-patient treatment services;

328.20 (2) representatives of providers who operate in the seven-county metropolitan area and
 328.21 providers who operate in greater Minnesota; and

328.22 (3) representatives of both for-profit and nonprofit providers.

328.23 Subd. 2. **Reports.** (a) By November 1, 2020, the commissioner of human services shall
 328.24 report to the legislature on any modifications to the licensure standards necessary to align
 328.25 provider qualifications with the continuum of care-based rate methodology.

328.26 (b) The commissioner of human services shall propose legislation for the 2021 legislative
 328.27 session necessary to fully implement the continuum of care-based rate methodology.

328.28 Sec. 45. **REQUIREMENTS, STANDARDS, AND QUALIFICATIONS FOR**
 328.29 **MEDICAL RESPITE HEALTH HOMES.**

328.30 The commissioner of human services, in consultation with stakeholders, shall develop
 328.31 requirements, service standards, and qualifications for medical respite health homes.

329.1 **EFFECTIVE DATE.** This section is effective the day following final enactment.

329.2 Sec. 46. **REPEALER.**

329.3 Minnesota Statutes 2018, section 254B.03, subdivision 4a, is repealed.

329.4 **ARTICLE 7**

329.5 **MENTAL HEALTH UNIFORM SERVICE STANDARDS**

329.6 Section 1. Minnesota Statutes 2018, section 62A.152, subdivision 3, is amended to read:

329.7 Subd. 3. **Provider discrimination prohibited.** All group policies and group subscriber
329.8 contracts that provide benefits for mental or nervous disorder treatments in a hospital must
329.9 provide direct reimbursement for those services if performed by a mental health professional;
329.10 ~~as defined in sections 245.462, subdivision 18, clauses (1) to (5); and 245.4871, subdivision~~
329.11 ~~27, clauses (1) to (5);~~ qualified according to section 245I.16, subdivision 2, to the extent
329.12 that the services and treatment are within the scope of mental health professional licensure.

329.13 This subdivision is intended to provide payment of benefits for mental or nervous disorder
329.14 treatments performed by a licensed mental health professional in a hospital and is not
329.15 intended to change or add benefits for those services provided in policies or contracts to
329.16 which this subdivision applies.

329.17 Sec. 2. Minnesota Statutes 2018, section 62A.3094, subdivision 1, is amended to read:

329.18 Subdivision 1. **Definitions.** (a) For purposes of this section, the terms defined in
329.19 paragraphs (b) to (d) have the meanings given.

329.20 (b) "Autism spectrum disorders" means the conditions as determined by criteria set forth
329.21 in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of
329.22 the American Psychiatric Association.

329.23 (c) "Medically necessary care" means health care services appropriate, in terms of type,
329.24 frequency, level, setting, and duration, to the enrollee's condition, and diagnostic testing
329.25 and preventative services. Medically necessary care must be consistent with generally
329.26 accepted practice parameters as determined by physicians and licensed psychologists who
329.27 typically manage patients who have autism spectrum disorders.

329.28 (d) "Mental health professional" means a mental health professional as ~~defined in section~~
329.29 ~~245.4871, subdivision 27~~ described in section 245I.16, subdivision 2, clause (1), (2), (3),
329.30 (4), or (6), who has training and expertise in autism spectrum disorder and child development.

330.1 Sec. 3. Minnesota Statutes 2018, section 148B.5301, subdivision 2, is amended to read:

330.2 Subd. 2. **Supervision.** (a) To qualify as a LPCC, an applicant must have completed
330.3 4,000 hours of post-master's degree supervised professional practice in the delivery of
330.4 clinical services in the diagnosis and treatment of mental illnesses and disorders in both
330.5 children and adults. The supervised practice shall be conducted according to the requirements
330.6 in paragraphs (b) to (e).

330.7 (b) The supervision must have been received under a contract that defines clinical practice
330.8 and supervision from a mental health professional ~~as defined in section 245.462, subdivision~~
330.9 ~~18, clauses (1) to (6), or 245.4871, subdivision 27, clauses (1) to (6),~~ qualified according
330.10 to section 245I.16, subdivision 2, or by a board-approved supervisor, who has at least two
330.11 years of postlicensure experience in the delivery of clinical services in the diagnosis and
330.12 treatment of mental illnesses and disorders. All supervisors must meet the supervisor
330.13 requirements in Minnesota Rules, part 2150.5010.

330.14 (c) The supervision must be obtained at the rate of two hours of supervision per 40 hours
330.15 of professional practice. The supervision must be evenly distributed over the course of the
330.16 supervised professional practice. At least 75 percent of the required supervision hours must
330.17 be received in person. The remaining 25 percent of the required hours may be received by
330.18 telephone or by audio or audiovisual electronic device. At least 50 percent of the required
330.19 hours of supervision must be received on an individual basis. The remaining 50 percent
330.20 may be received in a group setting.

330.21 (d) The supervised practice must include at least 1,800 hours of clinical client contact.

330.22 (e) The supervised practice must be clinical practice. Supervision includes the observation
330.23 by the supervisor of the successful application of professional counseling knowledge, skills,
330.24 and values in the differential diagnosis and treatment of psychosocial function, disability,
330.25 or impairment, including addictions and emotional, mental, and behavioral disorders.

330.26 Sec. 4. Minnesota Statutes 2018, section 148E.0555, subdivision 6, is amended to read:

330.27 Subd. 6. **Qualifications during grandfathering for licensure as LICSW.** (a) To be
330.28 licensed as a licensed independent clinical social worker, an applicant for licensure under
330.29 this section must provide evidence satisfactory to the board that the individual has:

330.30 (1) completed a graduate degree in social work from a program accredited by the Council
330.31 on Social Work Education, the Canadian Association of Schools of Social Work, or a similar
330.32 accrediting body designated by the board; or

331.1 (2) completed a graduate degree and is a mental health professional according to section
331.2 ~~245.462, subdivision 18, clauses (1) to (6)~~ 245I.16, subdivision 2.

331.3 (b) To be licensed as a licensed independent clinical social worker, an applicant for
331.4 licensure under this section must provide evidence satisfactory to the board that the individual
331.5 has:

331.6 (1) practiced clinical social work as defined in section 148E.010, subdivision 6, including
331.7 both diagnosis and treatment, and has met the supervised practice requirements specified
331.8 in sections 148E.100 to 148E.125, excluding the 1,800 hours of direct clinical client contact
331.9 specified in section 148E.115, subdivision 1, except that supervised practice hours obtained
331.10 prior to August 1, 2011, must meet the requirements in Minnesota Statutes 2010, sections
331.11 148D.100 to 148D.125;

331.12 (2) submitted a completed, signed application and the license fee in section 148E.180;

331.13 (3) for applications submitted electronically, provided an attestation as specified by the
331.14 board;

331.15 (4) submitted the criminal background check fee and a form provided by the board
331.16 authorizing a criminal background check;

331.17 (5) paid the license fee in section 148E.180; and

331.18 (6) not engaged in conduct that was or would be in violation of the standards of practice
331.19 specified in Minnesota Statutes 2010, sections 148D.195 to 148D.240, and sections 148E.195
331.20 to 148E.240. If the applicant has engaged in conduct that was or would be in violation of
331.21 the standards of practice, the board may take action according to sections 148E.255 to
331.22 148E.270.

331.23 (c) An application which is not completed, signed, and accompanied by the correct
331.24 license fee must be returned to the applicant, along with any fee submitted, and is void.

331.25 (d) By submitting an application for licensure, an applicant authorizes the board to
331.26 investigate any information provided or requested in the application. The board may request
331.27 that the applicant provide additional information, verification, or documentation.

331.28 (e) Within one year of the time the board receives an application for licensure, the
331.29 applicant must meet all the requirements and provide all of the information requested by
331.30 the board.

332.1 Sec. 5. Minnesota Statutes 2018, section 148E.120, subdivision 2, is amended to read:

332.2 Subd. 2. **Alternate supervisors.** (a) The board may approve an alternate supervisor as
332.3 determined in this subdivision. The board shall approve up to 25 percent of the required
332.4 supervision hours by a licensed mental health professional who is competent and qualified
332.5 to provide supervision according to the mental health professional's respective licensing
332.6 board, as established by section ~~245.462, subdivision 18, clauses (1) to (6), or 245.4871,~~
332.7 ~~subdivision 27, clauses (1) to (6)~~ 245I.16, subdivision 2.

332.8 (b) The board shall approve up to 100 percent of the required supervision hours by an
332.9 alternate supervisor if the board determines that:

332.10 (1) there are five or fewer supervisors in the county where the licensee practices social
332.11 work who meet the applicable licensure requirements in subdivision 1;

332.12 (2) the supervisor is an unlicensed social worker who is employed in, and provides the
332.13 supervision in, a setting exempt from licensure by section 148E.065, and who has
332.14 qualifications equivalent to the applicable requirements specified in sections 148E.100 to
332.15 148E.115;

332.16 (3) the supervisor is a social worker engaged in authorized social work practice in Iowa,
332.17 Manitoba, North Dakota, Ontario, South Dakota, or Wisconsin, and has the qualifications
332.18 equivalent to the applicable requirements in sections 148E.100 to 148E.115; or

332.19 (4) the applicant or licensee is engaged in nonclinical authorized social work practice
332.20 outside of Minnesota and the supervisor meets the qualifications equivalent to the applicable
332.21 requirements in sections 148E.100 to 148E.115, or the supervisor is an equivalent mental
332.22 health professional, as determined by the board, who is credentialed by a state, territorial,
332.23 provincial, or foreign licensing agency; or

332.24 (5) the applicant or licensee is engaged in clinical authorized social work practice outside
332.25 of Minnesota and the supervisor meets qualifications equivalent to the applicable
332.26 requirements in section 148E.115, or the supervisor is an equivalent mental health
332.27 professional as determined by the board, who is credentialed by a state, territorial, provincial,
332.28 or foreign licensing agency.

332.29 (c) In order for the board to consider an alternate supervisor under this section, the
332.30 licensee must:

332.31 (1) request in the supervision plan and verification submitted according to section
332.32 148E.125 that an alternate supervisor conduct the supervision; and

333.1 (2) describe the proposed supervision and the name and qualifications of the proposed
333.2 alternate supervisor. The board may audit the information provided to determine compliance
333.3 with the requirements of this section.

333.4 Sec. 6. Minnesota Statutes 2018, section 148F.11, subdivision 1, is amended to read:

333.5 Subdivision 1. **Other professionals.** (a) Nothing in this chapter prevents members of
333.6 other professions or occupations from performing functions for which they are qualified or
333.7 licensed. This exception includes, but is not limited to: licensed physicians; registered nurses;
333.8 licensed practical nurses; licensed psychologists and licensed psychological practitioners;
333.9 members of the clergy provided such services are provided within the scope of regular
333.10 ministries; American Indian medicine men and women; licensed attorneys; probation officers;
333.11 licensed marriage and family therapists; licensed social workers; social workers employed
333.12 by city, county, or state agencies; licensed professional counselors; licensed professional
333.13 clinical counselors; licensed school counselors; registered occupational therapists or
333.14 occupational therapy assistants; Upper Midwest Indian Council on Addictive Disorders
333.15 (UMICAD) certified counselors when providing services to Native American people; city,
333.16 county, or state employees when providing assessments or case management under Minnesota
333.17 Rules, chapter 9530; and individuals defined in section 256B.0623, subdivision 5, clauses
333.18 (1) ~~and (2)~~ to (4), providing integrated dual diagnosis treatment in adult mental health
333.19 rehabilitative programs certified by the Department of Human Services under section
333.20 256B.0622 or 256B.0623.

333.21 (b) Nothing in this chapter prohibits technicians and resident managers in programs
333.22 licensed by the Department of Human Services from discharging their duties as provided
333.23 in Minnesota Rules, chapter 9530.

333.24 (c) Any person who is exempt from licensure under this section must not use a title
333.25 incorporating the words "alcohol and drug counselor" or "licensed alcohol and drug
333.26 counselor" or otherwise hold himself or herself out to the public by any title or description
333.27 stating or implying that he or she is engaged in the practice of alcohol and drug counseling,
333.28 or that he or she is licensed to engage in the practice of alcohol and drug counseling, unless
333.29 that person is also licensed as an alcohol and drug counselor. Persons engaged in the practice
333.30 of alcohol and drug counseling are not exempt from the board's jurisdiction solely by the
333.31 use of one of the titles in paragraph (a).

334.1 Sec. 7. Minnesota Statutes 2018, section 245.462, subdivision 6, is amended to read:

334.2 Subd. 6. **Community support services program.** "Community support services program"
 334.3 means services, other than inpatient or residential treatment services, provided or coordinated
 334.4 by an identified program and staff under the ~~clinical~~ treatment supervision of a mental health
 334.5 professional designed to help adults with serious and persistent mental illness to function
 334.6 and remain in the community. A community support services program includes:

- 334.7 (1) client outreach,
- 334.8 (2) medication monitoring,
- 334.9 (3) assistance in independent living skills,
- 334.10 (4) development of employability and work-related opportunities,
- 334.11 (5) crisis assistance,
- 334.12 (6) psychosocial rehabilitation,
- 334.13 (7) help in applying for government benefits, and
- 334.14 (8) housing support services.

334.15 The community support services program must be coordinated with the case management
 334.16 services specified in section 245.4711.

334.17 Sec. 8. Minnesota Statutes 2018, section 245.462, subdivision 8, is amended to read:

334.18 Subd. 8. **Day treatment services.** "Day treatment," "day treatment services," or "day
 334.19 treatment program" means ~~a structured program of treatment and care provided to an adult~~
 334.20 ~~in or by: (1) a hospital accredited by the joint commission on accreditation of health~~
 334.21 ~~organizations and licensed under sections 144.50 to 144.55; (2) a community mental health~~
 334.22 ~~center under section 245.62; or (3) an entity that is under contract with the county board to~~
 334.23 ~~operate a program that meets the requirements of section 245.4712, subdivision 2, and~~
 334.24 ~~Minnesota Rules, parts 9505.0170 to 9505.0475. Day treatment consists of group~~
 334.25 ~~psychotherapy and other intensive therapeutic services that are provided at least two days~~
 334.26 ~~a week by a multidisciplinary staff under the clinical supervision of a mental health~~
 334.27 ~~professional. Day treatment may include education and consultation provided to families~~
 334.28 ~~and other individuals as part of the treatment process. The services are aimed at stabilizing~~
 334.29 ~~the adult's mental health status, providing mental health services, and developing and~~
 334.30 ~~improving the adult's independent living and socialization skills. The goal of day treatment~~
 334.31 ~~is to reduce or relieve mental illness and to enable the adult to live in the community. Day~~
 334.32 ~~treatment services are not a part of inpatient or residential treatment services. Day treatment~~

335.1 ~~services are distinguished from day care by their structured therapeutic program of~~
 335.2 ~~psychotherapy services. The commissioner may limit medical assistance reimbursement~~
 335.3 ~~for day treatment to 15 hours per week per person the treatment services described under~~
 335.4 ~~section 256B.0625, subdivision 23.~~

335.5 Sec. 9. Minnesota Statutes 2018, section 245.462, subdivision 9, is amended to read:

335.6 Subd. 9. **Diagnostic assessment.** (a) ~~"Diagnostic assessment" has the meaning given in~~
 335.7 ~~Minnesota Rules, part 9505.0370, subpart 11, and is delivered as provided in Minnesota~~
 335.8 ~~Rules, part 9505.0372, subpart 1, items A, B, C, and E. Diagnostic assessment includes a~~
 335.9 ~~standard, extended, or brief diagnostic assessment, or an adult update means the assessment~~
 335.10 ~~described under section 256B.0671, subdivisions 2 to 4.~~

335.11 ~~(b) A brief diagnostic assessment must include a face-to-face interview with the client~~
 335.12 ~~and a written evaluation of the client by a mental health professional or a clinical trainee,~~
 335.13 ~~as provided in Minnesota Rules, part 9505.0371, subpart 5, item C. The professional or~~
 335.14 ~~clinical trainee must gather initial components of a standard diagnostic assessment, including~~
 335.15 ~~the client's:~~

335.16 ~~(1) age;~~

335.17 ~~(2) description of symptoms, including reason for referral;~~

335.18 ~~(3) history of mental health treatment;~~

335.19 ~~(4) cultural influences and their impact on the client; and~~

335.20 ~~(5) mental status examination.~~

335.21 ~~(c) On the basis of the initial components, the professional or clinical trainee must draw~~
 335.22 ~~a provisional clinical hypothesis. The clinical hypothesis may be used to address the client's~~
 335.23 ~~immediate needs or presenting problem.~~

335.24 ~~(d) Treatment sessions conducted under authorization of a brief assessment may be used~~
 335.25 ~~to gather additional information necessary to complete a standard diagnostic assessment or~~
 335.26 ~~an extended diagnostic assessment.~~

335.27 ~~(e) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1),~~
 335.28 ~~unit (b), prior to completion of a client's initial diagnostic assessment, a client is eligible~~
 335.29 ~~for psychological testing as part of the diagnostic process.~~

335.30 ~~(f) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1),~~
 335.31 ~~unit (c), prior to completion of a client's initial diagnostic assessment, but in conjunction~~
 335.32 ~~with the diagnostic assessment process, a client is eligible for up to three individual or family~~

336.1 ~~psychotherapy sessions or family psychoeducation sessions or a combination of the above~~
 336.2 ~~sessions not to exceed three sessions.~~

336.3 ~~(g) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item B, subitem (3),~~
 336.4 ~~unit (a), a brief diagnostic assessment may be used for a client's family who requires a~~
 336.5 ~~language interpreter to participate in the assessment.~~

336.6 Sec. 10. Minnesota Statutes 2018, section 245.462, subdivision 14, is amended to read:

336.7 Subd. 14. **Individual treatment plan.** "Individual treatment plan" means ~~a written plan~~
 336.8 ~~of intervention, treatment, and services for an adult with mental illness that is developed~~
 336.9 ~~by a service provider under the clinical supervision of a mental health professional on the~~
 336.10 ~~basis of a diagnostic assessment. The plan identifies goals and objectives of treatment,~~
 336.11 ~~treatment strategy, a schedule for accomplishing treatment goals and objectives, and the~~
 336.12 ~~individual responsible for providing treatment to the adult with mental illness~~ the individual
 336.13 treatment plan described under section 256B.0671, subdivisions 5 and 6.

336.14 Sec. 11. Minnesota Statutes 2018, section 245.462, subdivision 17, is amended to read:

336.15 Subd. 17. **Mental health practitioner.** ~~(a) "Mental health practitioner" means a person~~
 336.16 ~~providing services to adults with mental illness or children with emotional disturbance who~~
 336.17 ~~is qualified in at least one of the ways described in paragraphs (b) to (g). A mental health~~
 336.18 ~~practitioner for a child client must have training working with children. A mental health~~
 336.19 ~~practitioner for an adult client must have training working with adults~~ qualified according
 336.20 to section 245I.16, subdivision 4.

336.21 ~~(b) For purposes of this subdivision, a practitioner is qualified through relevant~~
 336.22 ~~coursework if the practitioner completes at least 30 semester hours or 45 quarter hours in~~
 336.23 ~~behavioral sciences or related fields and:~~

336.24 ~~(1) has at least 2,000 hours of supervised experience in the delivery of services to adults~~
 336.25 ~~or children with:~~

336.26 ~~(i) mental illness, substance use disorder, or emotional disturbance; or~~

336.27 ~~(ii) traumatic brain injury or developmental disabilities and completes training on mental~~
 336.28 ~~illness, recovery from mental illness, mental health de-escalation techniques, co-occurring~~
 336.29 ~~mental illness and substance abuse, and psychotropic medications and side effects;~~

336.30 ~~(2) is fluent in the non-English language of the ethnic group to which at least 50 percent~~
 336.31 ~~of the practitioner's clients belong, completes 40 hours of training in the delivery of services~~
 336.32 ~~to adults with mental illness or children with emotional disturbance, and receives clinical~~

337.1 ~~supervision from a mental health professional at least once a week until the requirement of~~
337.2 ~~2,000 hours of supervised experience is met;~~

337.3 ~~(3) is working in a day treatment program under section 245.4712, subdivision 2; or~~

337.4 ~~(4) has completed a practicum or internship that (i) requires direct interaction with adults~~
337.5 ~~or children served, and (ii) is focused on behavioral sciences or related fields.~~

337.6 ~~(e) For purposes of this subdivision, a practitioner is qualified through work experience~~
337.7 ~~if the person:~~

337.8 ~~(1) has at least 4,000 hours of supervised experience in the delivery of services to adults~~
337.9 ~~or children with:~~

337.10 ~~(i) mental illness, substance use disorder, or emotional disturbance; or~~

337.11 ~~(ii) traumatic brain injury or developmental disabilities and completes training on mental~~
337.12 ~~illness, recovery from mental illness, mental health de-escalation techniques, co-occurring~~
337.13 ~~mental illness and substance abuse, and psychotropic medications and side effects; or~~

337.14 ~~(2) has at least 2,000 hours of supervised experience in the delivery of services to adults~~
337.15 ~~or children with:~~

337.16 ~~(i) mental illness, emotional disturbance, or substance use disorder, and receives clinical~~
337.17 ~~supervision as required by applicable statutes and rules from a mental health professional~~
337.18 ~~at least once a week until the requirement of 4,000 hours of supervised experience is met;~~
337.19 ~~or~~

337.20 ~~(ii) traumatic brain injury or developmental disabilities; completes training on mental~~
337.21 ~~illness, recovery from mental illness, mental health de-escalation techniques, co-occurring~~
337.22 ~~mental illness and substance abuse, and psychotropic medications and side effects; and~~
337.23 ~~receives clinical supervision as required by applicable statutes and rules at least once a week~~
337.24 ~~from a mental health professional until the requirement of 4,000 hours of supervised~~
337.25 ~~experience is met.~~

337.26 ~~(d) For purposes of this subdivision, a practitioner is qualified through a graduate student~~
337.27 ~~internship if the practitioner is a graduate student in behavioral sciences or related fields~~
337.28 ~~and is formally assigned by an accredited college or university to an agency or facility for~~
337.29 ~~clinical training.~~

337.30 ~~(e) For purposes of this subdivision, a practitioner is qualified by a bachelor's or master's~~
337.31 ~~degree if the practitioner:~~

337.32 ~~(1) holds a master's or other graduate degree in behavioral sciences or related fields; or~~

338.1 ~~(2) holds a bachelor's degree in behavioral sciences or related fields and completes a~~
338.2 ~~practicum or internship that (i) requires direct interaction with adults or children served,~~
338.3 ~~and (ii) is focused on behavioral sciences or related fields.~~

338.4 ~~(f) For purposes of this subdivision, a practitioner is qualified as a vendor of medical~~
338.5 ~~care if the practitioner meets the definition of vendor of medical care in section 256B.02,~~
338.6 ~~subdivision 7, paragraphs (b) and (c), and is serving a federally recognized tribe.~~

338.7 ~~(g) For purposes of medical assistance coverage of diagnostic assessments, explanations~~
338.8 ~~of findings, and psychotherapy under section 256B.0625, subdivision 65, a mental health~~
338.9 ~~practitioner working as a clinical trainee means that the practitioner's clinical supervision~~
338.10 ~~experience is helping the practitioner gain knowledge and skills necessary to practice~~
338.11 ~~effectively and independently. This may include supervision of direct practice, treatment~~
338.12 ~~team collaboration, continued professional learning, and job management. The practitioner~~
338.13 ~~must also:~~

338.14 ~~(1) comply with requirements for licensure or board certification as a mental health~~
338.15 ~~professional, according to the qualifications under Minnesota Rules, part 9505.0371, subpart~~
338.16 ~~5, item A, including supervised practice in the delivery of mental health services for the~~
338.17 ~~treatment of mental illness; or~~

338.18 ~~(2) be a student in a bona fide field placement or internship under a program leading to~~
338.19 ~~completion of the requirements for licensure as a mental health professional according to~~
338.20 ~~the qualifications under Minnesota Rules, part 9505.0371, subpart 5, item A.~~

338.21 ~~(h) For purposes of this subdivision, "behavioral sciences or related fields" has the~~
338.22 ~~meaning given in section 256B.0623, subdivision 5, paragraph (d).~~

338.23 ~~(i) Notwithstanding the licensing requirements established by a health-related licensing~~
338.24 ~~board, as defined in section 214.01, subdivision 2, this subdivision supersedes any other~~
338.25 ~~statute or rule.~~

338.26 Sec. 12. Minnesota Statutes 2018, section 245.462, subdivision 18, is amended to read:

338.27 Subd. 18. **Mental health professional.** "Mental health professional" means a person
338.28 ~~providing clinical services in the treatment of mental illness who is qualified in at least one~~
338.29 ~~of the following ways: qualified according to section 245I.16, subdivision 2.~~

338.30 ~~(1) in psychiatric nursing: a registered nurse who is licensed under sections 148.171 to~~
338.31 ~~148.285; and:~~

339.1 ~~(i) who is certified as a clinical specialist or as a nurse practitioner in adult or family~~
 339.2 ~~psychiatric and mental health nursing by a national nurse certification organization; or~~

339.3 ~~(ii) who has a master's degree in nursing or one of the behavioral sciences or related~~
 339.4 ~~fields from an accredited college or university or its equivalent, with at least 4,000 hours~~
 339.5 ~~of post-master's supervised experience in the delivery of clinical services in the treatment~~
 339.6 ~~of mental illness;~~

339.7 ~~(2) in clinical social work: a person licensed as an independent clinical social worker~~
 339.8 ~~under chapter 148D, or a person with a master's degree in social work from an accredited~~
 339.9 ~~college or university, with at least 4,000 hours of post-master's supervised experience in~~
 339.10 ~~the delivery of clinical services in the treatment of mental illness;~~

339.11 ~~(3) in psychology: an individual licensed by the Board of Psychology under sections~~
 339.12 ~~148.88 to 148.98 who has stated to the Board of Psychology competencies in the diagnosis~~
 339.13 ~~and treatment of mental illness;~~

339.14 ~~(4) in psychiatry: a physician licensed under chapter 147 and certified by the American~~
 339.15 ~~Board of Psychiatry and Neurology or eligible for board certification in psychiatry, or an~~
 339.16 ~~osteopathic physician licensed under chapter 147 and certified by the American Osteopathic~~
 339.17 ~~Board of Neurology and Psychiatry or eligible for board certification in psychiatry;~~

339.18 ~~(5) in marriage and family therapy: the mental health professional must be a marriage~~
 339.19 ~~and family therapist licensed under sections 148B.29 to 148B.39 with at least two years of~~
 339.20 ~~post-master's supervised experience in the delivery of clinical services in the treatment of~~
 339.21 ~~mental illness;~~

339.22 ~~(6) in licensed professional clinical counseling, the mental health professional shall be~~
 339.23 ~~a licensed professional clinical counselor under section 148B.5301 with at least 4,000 hours~~
 339.24 ~~of post-master's supervised experience in the delivery of clinical services in the treatment~~
 339.25 ~~of mental illness; or~~

339.26 ~~(7) in allied fields: a person with a master's degree from an accredited college or university~~
 339.27 ~~in one of the behavioral sciences or related fields, with at least 4,000 hours of post-master's~~
 339.28 ~~supervised experience in the delivery of clinical services in the treatment of mental illness.~~

339.29 Sec. 13. Minnesota Statutes 2018, section 245.462, subdivision 21, is amended to read:

339.30 Subd. 21. **Outpatient services.** "Outpatient services" means mental health services,
 339.31 excluding day treatment and community support services programs, provided by or under
 339.32 the clinical treatment supervision of a mental health professional to adults with mental
 339.33 illness who live outside a hospital. Outpatient services include clinical activities such as

340.1 individual, group, and family therapy; individual treatment planning; diagnostic assessments;
340.2 medication management; and psychological testing.

340.3 Sec. 14. Minnesota Statutes 2018, section 245.462, subdivision 23, is amended to read:

340.4 Subd. 23. **Residential treatment.** "Residential treatment" means a 24-hour-a-day program
340.5 under the ~~clinical~~ treatment supervision of a mental health professional, in a community
340.6 residential setting other than an acute care hospital or regional treatment center inpatient
340.7 unit, that must be licensed as a residential treatment program for adults with mental illness
340.8 under Minnesota Rules, parts 9520.0500 to 9520.0670₂, or other rules adopted by the
340.9 commissioner.

340.10 Sec. 15. Minnesota Statutes 2018, section 245.462, is amended by adding a subdivision
340.11 to read:

340.12 Subd. 27. **Treatment supervision.** "Treatment supervision" means the treatment
340.13 supervision described under section 245I.18.

340.14 Sec. 16. Minnesota Statutes 2018, section 245.467, subdivision 2, is amended to read:

340.15 Subd. 2. **Diagnostic assessment.** ~~All providers of residential, acute care hospital inpatient,~~
340.16 ~~and regional treatment centers must complete a diagnostic assessment for each of their~~
340.17 ~~clients within five days of admission. Providers of day treatment services must complete a~~
340.18 ~~diagnostic assessment within five days after the adult's second visit or within 30 days after~~
340.19 ~~intake, whichever occurs first. In cases where a diagnostic assessment is available and has~~
340.20 ~~been completed within three years preceding admission, only an adult diagnostic assessment~~
340.21 ~~update is necessary. An "adult diagnostic assessment update" means a written summary by~~
340.22 ~~a mental health professional of the adult's current mental health status and service needs~~
340.23 ~~and includes a face-to-face interview with the adult. If the adult's mental health status has~~
340.24 ~~changed markedly since the adult's most recent diagnostic assessment, a new diagnostic~~
340.25 ~~assessment is required. Compliance with the provisions of this subdivision does not ensure~~
340.26 ~~eligibility for medical assistance reimbursement under chapter 256B. Providers of services~~
340.27 governed by this section shall complete a diagnostic assessment according to the standards
340.28 of section 256B.0671, including for services to a person not eligible for medical assistance.

340.29 Sec. 17. Minnesota Statutes 2018, section 245.467, subdivision 3, is amended to read:

340.30 Subd. 3. **Individual treatment plans.** ~~All providers of outpatient services, day treatment~~
340.31 ~~services, residential treatment, acute care hospital inpatient treatment, and all regional~~

341.1 ~~treatment centers must develop an individual treatment plan for each of their adult clients.~~
 341.2 ~~The individual treatment plan must be based on a diagnostic assessment. To the extent~~
 341.3 ~~possible, the adult client shall be involved in all phases of developing and implementing~~
 341.4 ~~the individual treatment plan. Providers of residential treatment and acute care hospital~~
 341.5 ~~inpatient treatment, and all regional treatment centers must develop the individual treatment~~
 341.6 ~~plan within ten days of client intake and must review the individual treatment plan every~~
 341.7 ~~90 days after intake. Providers of day treatment services must develop the individual~~
 341.8 ~~treatment plan before the completion of five working days in which service is provided or~~
 341.9 ~~within 30 days after the diagnostic assessment is completed or obtained, whichever occurs~~
 341.10 ~~first. Providers of outpatient services must develop the individual treatment plan within 30~~
 341.11 ~~days after the diagnostic assessment is completed or obtained or by the end of the second~~
 341.12 ~~session of an outpatient service, not including the session in which the diagnostic assessment~~
 341.13 ~~was provided, whichever occurs first. Outpatient and day treatment services providers must~~
 341.14 ~~review the individual treatment plan every 90 days after intake. Providers of services~~
 341.15 ~~governed by this section shall complete an individual treatment plan according to the~~
 341.16 ~~standards of section 256B.0671, subdivisions 5 and 6, including for services to a person not~~
 341.17 ~~eligible for medical assistance.~~

341.18 Sec. 18. Minnesota Statutes 2018, section 245.469, subdivision 1, is amended to read:

341.19 Subdivision 1. **Availability of emergency services.** ~~By July 1, 1988,~~ County boards
 341.20 must provide or contract for enough emergency services within the county to meet the needs
 341.21 of adults in the county who are experiencing an emotional crisis or mental illness. Clients
 341.22 may be required to pay a fee according to section 245.481. Emergency service providers
 341.23 shall not delay the timely provision of emergency service because of delays in determining
 341.24 this fee or because of the unwillingness or inability of the client to pay the fee. Emergency
 341.25 services must include assessment, crisis intervention, and appropriate case disposition. A
 341.26 tribal authority that accepts crisis grant funding has the same responsibilities as county
 341.27 boards within the tribal authority's designated service area. Emergency services must:

341.28 (1) promote the safety and emotional stability of adults with mental illness or emotional
 341.29 crises;

341.30 (2) minimize further deterioration of adults with mental illness or emotional crises;

341.31 (3) help adults with mental illness or emotional crises to obtain ongoing care and
 341.32 treatment; ~~and~~

341.33 (4) prevent placement in settings that are more intensive, costly, or restrictive than
 341.34 necessary and appropriate to meet client needs; and

342.1 (5) provide support, psychoeducation, and referrals to family members, friends, service
 342.2 providers, or other third parties on behalf of a recipient in need of emergency services.

342.3 Sec. 19. Minnesota Statutes 2018, section 245.469, subdivision 2, is amended to read:

342.4 Subd. 2. **Specific requirements.** (a) The county board shall require that all service
 342.5 providers of emergency services to adults with mental illness provide immediate direct
 342.6 access to a mental health professional during regular business hours. For evenings, weekends,
 342.7 and holidays, the service may be by direct toll-free telephone access to a mental health
 342.8 professional, a clinical trainee, or a mental health practitioner, ~~or until January 1, 1991, a~~
 342.9 ~~designated person with training in human services who receives clinical supervision from~~
 342.10 ~~a mental health professional.~~

342.11 (b) The commissioner may waive the requirement in paragraph (a) that the evening,
 342.12 weekend, and holiday service be provided by a mental health professional, clinical trainee,
 342.13 ~~or mental health practitioner after January 1, 1991,~~ if the county documents that:

342.14 (1) mental health professionals, clinical trainees, or mental health practitioners are
 342.15 unavailable to provide this service;

342.16 (2) services are provided by a designated person with training in human services who
 342.17 receives ~~clinical~~ treatment supervision from a mental health professional; and

342.18 (3) the service provider is not also the provider of fire and public safety emergency
 342.19 services.

342.20 (c) The commissioner may waive the requirement in paragraph (b), clause (3), that the
 342.21 evening, weekend, and holiday service not be provided by the provider of fire and public
 342.22 safety emergency services if:

342.23 (1) every person who will be providing the first telephone contact has received at least
 342.24 eight hours of training on emergency mental health services reviewed by the state advisory
 342.25 council on mental health and then approved by the commissioner;

342.26 (2) every person who will be providing the first telephone contact will annually receive
 342.27 at least four hours of continued training on emergency mental health services reviewed by
 342.28 the state advisory council on mental health and then approved by the commissioner;

342.29 (3) the local social service agency has provided public education about available
 342.30 emergency mental health services and can assure potential users of emergency services that
 342.31 their calls will be handled appropriately;

343.1 (4) the local social service agency agrees to provide the commissioner with accurate
343.2 data on the number of emergency mental health service calls received;

343.3 (5) the local social service agency agrees to monitor the frequency and quality of
343.4 emergency services; and

343.5 (6) the local social service agency describes how it will comply with paragraph (d).

343.6 (d) Whenever emergency service during nonbusiness hours is provided by anyone other
343.7 than a mental health professional, a mental health professional must be available on call for
343.8 an emergency assessment and crisis intervention services, and must be available for at least
343.9 telephone consultation within 30 minutes.

343.10 Sec. 20. Minnesota Statutes 2018, section 245.470, subdivision 1, is amended to read:

343.11 Subdivision 1. **Availability of outpatient services.** (a) County boards must provide or
343.12 contract for enough outpatient services within the county to meet the needs of adults with
343.13 mental illness residing in the county. Services may be provided directly by the county
343.14 through county-operated mental health centers or mental health clinics approved by the
343.15 commissioner under section 245.69, subdivision 2; by contract with privately operated
343.16 mental health centers or mental health clinics approved by the commissioner under section
343.17 245.69, subdivision 2; by contract with hospital mental health outpatient programs certified
343.18 by the Joint Commission on Accreditation of Hospital Organizations; or by contract with
343.19 a licensed mental health professional as defined in section 245.462, subdivision 18, clauses
343.20 (1) to (6). Clients may be required to pay a fee according to section 245.481. Outpatient
343.21 services include:

343.22 (1) conducting diagnostic assessments;

343.23 (2) conducting psychological testing;

343.24 (3) developing or modifying individual treatment plans;

343.25 (4) making referrals and recommending placements as appropriate;

343.26 (5) treating an adult's mental health needs through therapy;

343.27 (6) prescribing and managing medication and evaluating the effectiveness of prescribed
343.28 medication; and

343.29 (7) preventing placement in settings that are more intensive, costly, or restrictive than
343.30 necessary and appropriate to meet client needs.

344.1 (b) County boards may request a waiver allowing outpatient services to be provided in
344.2 a nearby trade area if it is determined that the client can best be served outside the county.

344.3 Sec. 21. Minnesota Statutes 2018, section 245.4712, subdivision 2, is amended to read:

344.4 Subd. 2. **Day treatment services provided.** (a) Day treatment services must be developed
344.5 as a part of the community support services available to adults with serious and persistent
344.6 mental illness residing in the county. Adults may be required to pay a fee according to
344.7 section 245.481. Day treatment services must be designed to:

344.8 (1) provide a structured environment for treatment;

344.9 (2) provide support for residing in the community;

344.10 (3) prevent placement in settings that are more intensive, costly, or restrictive than
344.11 necessary and appropriate to meet client need;

344.12 (4) coordinate with or be offered in conjunction with a local education agency's special
344.13 education program; and

344.14 (5) operate on a continuous basis throughout the year.

344.15 (b) For purposes of complying with medical assistance requirements, an adult day
344.16 treatment program must comply with the method of ~~clinical~~ clinical treatment supervision specified
344.17 in ~~Minnesota Rules, part 9505.0371, subpart 4~~ section 245I.18. ~~The clinical supervision~~
344.18 ~~must be performed by a qualified supervisor who satisfies the requirements of Minnesota~~
344.19 ~~Rules, part 9505.0371, subpart 5.~~

344.20 A day treatment program must demonstrate compliance with this ~~clinical~~ clinical treatment
344.21 supervision requirement by the commissioner's review and approval of the program according
344.22 to ~~Minnesota Rules, part 9505.0372, subpart 8~~ section 256B.0625, subdivision 23.

344.23 (c) County boards may request a waiver from including day treatment services if they
344.24 can document that:

344.25 (1) an alternative plan of care exists through the county's community support services
344.26 for clients who would otherwise need day treatment services;

344.27 (2) day treatment, if included, would be duplicative of other components of the
344.28 community support services; and

344.29 (3) county demographics and geography make the provision of day treatment services
344.30 cost ineffective and infeasible.

345.1 Sec. 22. Minnesota Statutes 2018, section 245.472, subdivision 2, is amended to read:

345.2 Subd. 2. **Specific requirements.** Providers of residential services must be licensed under
 345.3 applicable rules adopted by the commissioner and must ~~be clinically supervised~~ provide
 345.4 treatment supervision by a mental health professional. ~~Persons employed in facilities licensed~~
 345.5 ~~under Minnesota Rules, parts 9520.0500 to 9520.0670, in the capacity of program director~~
 345.6 ~~as of July 1, 1987, in accordance with Minnesota Rules, parts 9520.0500 to 9520.0670, may~~
 345.7 ~~be allowed to continue providing clinical supervision within a facility, provided they continue~~
 345.8 ~~to be employed as a program director in a facility licensed under Minnesota Rules, parts~~
 345.9 ~~9520.0500 to 9520.0670.~~

345.10 Sec. 23. Minnesota Statutes 2018, section 245.4863, is amended to read:

345.11 **245.4863 INTEGRATED CO-OCCURRING DISORDER TREATMENT.**

345.12 (a) The commissioner shall require individuals who perform chemical dependency
 345.13 assessments to screen clients for co-occurring mental health disorders, and staff who perform
 345.14 mental health diagnostic assessments to screen for co-occurring substance use disorders.
 345.15 Screening tools must be approved by the commissioner. If a client screens positive for a
 345.16 co-occurring mental health or substance use disorder, the individual performing the screening
 345.17 must document what actions will be taken in response to the results and whether further
 345.18 assessments must be performed.

345.19 (b) Notwithstanding paragraph (a), screening is not required when:

345.20 (1) the presence of co-occurring disorders was documented for the client in the past 12
 345.21 months;

345.22 (2) the client is currently receiving co-occurring disorders treatment;

345.23 (3) the client is being referred for co-occurring disorders treatment; or

345.24 (4) a mental health professional, as ~~defined in Minnesota Rules, part 9505.0370, subpart~~
 345.25 ~~18~~ provided by section 245I.16, subdivision 2, who is competent to perform diagnostic
 345.26 assessments of co-occurring disorders is performing a diagnostic assessment that meets the
 345.27 requirements in Minnesota Rules, part 9533.0090, subpart 5, to identify whether the client
 345.28 may have co-occurring mental health and chemical dependency disorders. If an individual
 345.29 is identified to have co-occurring mental health and substance use disorders, the assessing
 345.30 mental health professional must document what actions will be taken to address the client's
 345.31 co-occurring disorders.

346.1 (c) The commissioner shall adopt rules as necessary to implement this section. The
346.2 commissioner shall ensure that the rules are effective on July 1, 2013, thereby establishing
346.3 a certification process for integrated dual disorder treatment providers and a system through
346.4 which individuals receive integrated dual diagnosis treatment if assessed as having both a
346.5 substance use disorder and either a serious mental illness or emotional disturbance.

346.6 (d) The commissioner shall apply for any federal waivers necessary to secure, to the
346.7 extent allowed by law, federal financial participation for the provision of integrated dual
346.8 diagnosis treatment to persons with co-occurring disorders.

346.9 Sec. 24. Minnesota Statutes 2018, section 245.4871, subdivision 9a, is amended to read:

346.10 Subd. 9a. **Crisis ~~assistance~~ planning**. "~~Crisis assistance~~ planning" means ~~assistance to~~
346.11 ~~the child, the child's family, and all providers of services to the child to: recognize factors~~
346.12 ~~precipitating a mental health crisis, identify behaviors related to the crisis, and be informed~~
346.13 ~~of available resources to resolve the crisis. Crisis assistance requires the development of a~~
346.14 ~~plan which addresses prevention and intervention strategies to be used in a potential crisis.~~
346.15 ~~Other interventions include: (1) arranging for admission to acute care hospital inpatient~~
346.16 ~~treatment; (2) crisis placement; (3) community resources for follow-up; and (4) emotional~~
346.17 ~~support to the family during crisis. Crisis assistance does not include services designed to~~
346.18 ~~secure the safety of a child who is at risk of abuse or neglect or necessary emergency services.~~
346.19 the development of a written plan to assist a child's family with a potential crisis and is
346.20 distinct from the immediate provision of mental health mobile crisis intervention services
346.21 as defined in section 256B.0944. The plan must address prevention, de-escalation, and
346.22 intervention strategies to be used in a crisis. The plan identifies factors that might precipitate
346.23 a crisis, behaviors related to the emergence of a crisis, and the resources available to resolve
346.24 a crisis. The plan must include planning for the following potential needs: (1) acute care;
346.25 (2) crisis placement; (3) community resources for follow-up; and (4) emotional support to
346.26 the family during crisis. Crisis planning excludes services designed to secure the safety of
346.27 a child who is at risk of abuse or neglect or necessary emergency services.

346.28 Sec. 25. Minnesota Statutes 2018, section 245.4871, subdivision 10, is amended to read:

346.29 Subd. 10. **Day treatment services**. "Day treatment," "day treatment services," or "day
346.30 treatment program" means a structured program of treatment and care provided to a child
346.31 in:

346.32 (1) an outpatient hospital accredited by the Joint Commission on Accreditation of Health
346.33 Organizations and licensed under sections 144.50 to 144.55;

347.1 (2) a community mental health center under section 245.62;

347.2 (3) an entity that is under contract with the county board to operate a program that meets
347.3 the requirements of section 245.4884, subdivision 2, and Minnesota Rules, parts 9505.0170
347.4 to 9505.0475; ~~or~~

347.5 (4) an entity that operates a program that meets the requirements of section 245.4884,
347.6 subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475, that is under contract
347.7 with an entity that is under contract with a county board; or

347.8 (5) an entity that operates a program certified under section 256B.0943.

347.9 Day treatment consists of group psychotherapy and other intensive therapeutic services
347.10 that are provided for a minimum two-hour time block by a multidisciplinary staff under the
347.11 clinical supervision of a mental health professional. Day treatment may include education
347.12 and consultation provided to families and other individuals as an extension of the treatment
347.13 process. The services are aimed at stabilizing the child's mental health status, and developing
347.14 and improving the child's daily independent living and socialization skills. Day treatment
347.15 services are distinguished from day care by their structured therapeutic program of
347.16 psychotherapy services. Day treatment services are not a part of inpatient hospital or
347.17 residential treatment services.

347.18 A day treatment service must be available to a child up to 15 hours a week throughout
347.19 the year and must be coordinated with, integrated with, or part of an education program
347.20 offered by the child's school.

347.21 Sec. 26. Minnesota Statutes 2018, section 245.4871, subdivision 11a, is amended to read:

347.22 Subd. 11a. **Diagnostic assessment.** ~~(a) "Diagnostic assessment" has the meaning given~~
347.23 ~~in Minnesota Rules, part 9505.0370, subpart 11, and is delivered as provided in Minnesota~~
347.24 ~~Rules, part 9505.0372, subpart 1, items A, B, C, and E. Diagnostic assessment includes a~~
347.25 ~~standard, extended, or brief diagnostic assessment, or an adult update. means the assessment~~
347.26 described under section 256B.0671, subdivisions 2 to 4.

347.27 ~~(b) A brief diagnostic assessment must include a face-to-face interview with the client~~
347.28 ~~and a written evaluation of the client by a mental health professional or a clinical trainee,~~
347.29 ~~as provided in Minnesota Rules, part 9505.0371, subpart 5, item C. The professional or~~
347.30 ~~clinical trainee must gather initial components of a standard diagnostic assessment, including~~
347.31 ~~the client's:~~

347.32 (1) age;

348.1 ~~(2) description of symptoms, including reason for referral;~~

348.2 ~~(3) history of mental health treatment;~~

348.3 ~~(4) cultural influences and their impact on the client; and~~

348.4 ~~(5) mental status examination.~~

348.5 ~~(e) On the basis of the brief components, the professional or clinical trainee must draw~~
 348.6 ~~a provisional clinical hypothesis. The clinical hypothesis may be used to address the client's~~
 348.7 ~~immediate needs or presenting problem.~~

348.8 ~~(d) Treatment sessions conducted under authorization of a brief assessment may be used~~
 348.9 ~~to gather additional information necessary to complete a standard diagnostic assessment or~~
 348.10 ~~an extended diagnostic assessment.~~

348.11 ~~(e) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1),~~
 348.12 ~~unit (b), prior to completion of a client's initial diagnostic assessment, a client is eligible~~
 348.13 ~~for psychological testing as part of the diagnostic process.~~

348.14 ~~(f) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1),~~
 348.15 ~~unit (e), prior to completion of a client's initial diagnostic assessment, but in conjunction~~
 348.16 ~~with the diagnostic assessment process, a client is eligible for up to three individual or family~~
 348.17 ~~psychotherapy sessions or family psychoeducation sessions or a combination of the above~~
 348.18 ~~sessions not to exceed three sessions.~~

348.19 Sec. 27. Minnesota Statutes 2018, section 245.4871, subdivision 17, is amended to read:

348.20 Subd. 17. **Family community support services.** "Family community support services"
 348.21 means services provided under the ~~clinical~~ treatment supervision of a mental health
 348.22 professional and designed to help each child with severe emotional disturbance to function
 348.23 and remain with the child's family in the community. Family community support services
 348.24 do not include acute care hospital inpatient treatment, residential treatment services, or
 348.25 regional treatment center services. Family community support services include:

348.26 (1) client outreach to each child with severe emotional disturbance and the child's family;

348.27 (2) medication monitoring where necessary;

348.28 (3) assistance in developing independent living skills;

348.29 (4) assistance in developing parenting skills necessary to address the needs of the child
 348.30 with severe emotional disturbance;

348.31 (5) assistance with leisure and recreational activities;

- 349.1 (6) crisis assistance, including crisis placement and respite care;
- 349.2 (7) professional home-based family treatment;
- 349.3 (8) foster care with therapeutic supports;
- 349.4 (9) day treatment;
- 349.5 (10) assistance in locating respite care and special needs day care; and
- 349.6 (11) assistance in obtaining potential financial resources, including those benefits listed
- 349.7 in section 245.4884, subdivision 5.

349.8 Sec. 28. Minnesota Statutes 2018, section 245.4871, subdivision 21, is amended to read:

349.9 Subd. 21. **Individual treatment plan.** "Individual treatment plan" means ~~a written plan~~

349.10 ~~of intervention, treatment, and services for a child with an emotional disturbance that is~~

349.11 ~~developed by a service provider under the clinical supervision of a mental health professional~~

349.12 ~~on the basis of a diagnostic assessment. An individual treatment plan for a child must be~~

349.13 ~~developed in conjunction with the family unless clinically inappropriate. The plan identifies~~

349.14 ~~goals and objectives of treatment, treatment strategy, a schedule for accomplishing treatment~~

349.15 ~~goals and objectives, and the individuals responsible for providing treatment to the child~~

349.16 ~~with an emotional disturbance~~ the individual treatment plan described under section

349.17 256B.0671, subdivisions 5 and 6.

349.18 Sec. 29. Minnesota Statutes 2018, section 245.4871, subdivision 26, is amended to read:

349.19 Subd. 26. **Mental health practitioner.** "Mental health practitioner" ~~has the meaning~~

349.20 ~~given in~~ means a person qualified according to section 245.462, subdivision 17 245I.16,

349.21 subdivision 4.

349.22 Sec. 30. Minnesota Statutes 2018, section 245.4871, subdivision 27, is amended to read:

349.23 Subd. 27. **Mental health professional.** "Mental health professional" means a person

349.24 ~~providing clinical services in the diagnosis and treatment of children's emotional disorders.~~

349.25 ~~A mental health professional must have training and experience in working with children~~

349.26 ~~consistent with the age group to which the mental health professional is assigned. A mental~~

349.27 ~~health professional must be qualified in at least one of the following ways: qualified according~~

349.28 to section 245I.16, subdivision 2.

349.29 ~~(1) in psychiatric nursing, the mental health professional must be a registered nurse who~~

349.30 ~~is licensed under sections 148.171 to 148.285 and who is certified as a clinical specialist in~~

349.31 ~~child and adolescent psychiatric or mental health nursing by a national nurse certification~~

350.1 ~~organization or who has a master's degree in nursing or one of the behavioral sciences or~~
 350.2 ~~related fields from an accredited college or university or its equivalent, with at least 4,000~~
 350.3 ~~hours of post-master's supervised experience in the delivery of clinical services in the~~
 350.4 ~~treatment of mental illness;~~

350.5 ~~(2) in clinical social work, the mental health professional must be a person licensed as~~
 350.6 ~~an independent clinical social worker under chapter 148D, or a person with a master's degree~~
 350.7 ~~in social work from an accredited college or university, with at least 4,000 hours of~~
 350.8 ~~post-master's supervised experience in the delivery of clinical services in the treatment of~~
 350.9 ~~mental disorders;~~

350.10 ~~(3) in psychology, the mental health professional must be an individual licensed by the~~
 350.11 ~~board of psychology under sections 148.88 to 148.98 who has stated to the board of~~
 350.12 ~~psychology competencies in the diagnosis and treatment of mental disorders;~~

350.13 ~~(4) in psychiatry, the mental health professional must be a physician licensed under~~
 350.14 ~~chapter 147 and certified by the American Board of Psychiatry and Neurology or eligible~~
 350.15 ~~for board certification in psychiatry or an osteopathic physician licensed under chapter 147~~
 350.16 ~~and certified by the American Osteopathic Board of Neurology and Psychiatry or eligible~~
 350.17 ~~for board certification in psychiatry;~~

350.18 ~~(5) in marriage and family therapy, the mental health professional must be a marriage~~
 350.19 ~~and family therapist licensed under sections 148B.29 to 148B.39 with at least two years of~~
 350.20 ~~post-master's supervised experience in the delivery of clinical services in the treatment of~~
 350.21 ~~mental disorders or emotional disturbances;~~

350.22 ~~(6) in licensed professional clinical counseling, the mental health professional shall be~~
 350.23 ~~a licensed professional clinical counselor under section 148B.5301 with at least 4,000 hours~~
 350.24 ~~of post-master's supervised experience in the delivery of clinical services in the treatment~~
 350.25 ~~of mental disorders or emotional disturbances; or~~

350.26 ~~(7) in allied fields, the mental health professional must be a person with a master's degree~~
 350.27 ~~from an accredited college or university in one of the behavioral sciences or related fields,~~
 350.28 ~~with at least 4,000 hours of post-master's supervised experience in the delivery of clinical~~
 350.29 ~~services in the treatment of emotional disturbances.~~

350.30 Sec. 31. Minnesota Statutes 2018, section 245.4871, subdivision 29, is amended to read:

350.31 Subd. 29. **Outpatient services.** "Outpatient services" means mental health services,
 350.32 excluding day treatment and community support services programs, provided by or under
 350.33 the clinical treatment supervision of a mental health professional to children with emotional

351.1 disturbances who live outside a hospital. Outpatient services include clinical activities such
351.2 as individual, group, and family therapy; individual treatment planning; diagnostic
351.3 assessments; medication management; and psychological testing.

351.4 Sec. 32. Minnesota Statutes 2018, section 245.4871, subdivision 32, is amended to read:

351.5 Subd. 32. **Residential treatment.** "Residential treatment" means a 24-hour-a-day program
351.6 under the ~~clinical~~ treatment supervision of a mental health professional, in a community
351.7 residential setting other than an acute care hospital or regional treatment center inpatient
351.8 unit, that must be licensed as a residential treatment program for children with emotional
351.9 disturbances under Minnesota Rules, parts 2960.0580 to 2960.0700, or other rules adopted
351.10 by the commissioner.

351.11 Sec. 33. Minnesota Statutes 2018, section 245.4871, subdivision 34, is amended to read:

351.12 Subd. 34. **Therapeutic support of foster care.** "Therapeutic support of foster care"
351.13 means the mental health training and mental health support services and ~~clinical~~ treatment
351.14 supervision provided by a mental health professional to foster families caring for children
351.15 with severe emotional disturbance to provide a therapeutic family environment and support
351.16 for the child's improved functioning. Therapeutic support of foster care includes services
351.17 provided under section 256B.0946.

351.18 Sec. 34. Minnesota Statutes 2018, section 245.4876, subdivision 2, is amended to read:

351.19 Subd. 2. **Diagnostic assessment.** ~~All residential treatment facilities and acute care~~
351.20 ~~hospital inpatient treatment facilities that provide mental health services for children must~~
351.21 ~~complete a diagnostic assessment for each of their child clients within five working days~~
351.22 ~~of admission. Providers of day treatment services for children must complete a diagnostic~~
351.23 ~~assessment within five days after the child's second visit or 30 days after intake, whichever~~
351.24 ~~occurs first. In cases where a diagnostic assessment is available and has been completed~~
351.25 ~~within 180 days preceding admission, only updating is necessary. "Updating" means a~~
351.26 ~~written summary by a mental health professional of the child's current mental health status~~
351.27 ~~and service needs. If the child's mental health status has changed markedly since the child's~~
351.28 ~~most recent diagnostic assessment, a new diagnostic assessment is required. Compliance~~
351.29 ~~with the provisions of this subdivision does not ensure eligibility for medical assistance~~
351.30 ~~reimbursement under chapter 256B. Providers of services governed by this section shall~~
351.31 ~~complete a diagnostic assessment according to the standards of section 256B.0671, including~~
351.32 ~~for services to a person not eligible for medical assistance.~~

352.1 Sec. 35. Minnesota Statutes 2018, section 245.4876, subdivision 3, is amended to read:

352.2 Subd. 3. **Individual treatment plans.** ~~All providers of outpatient services, day treatment~~
352.3 ~~services, professional home-based family treatment, residential treatment, and acute care~~
352.4 ~~hospital inpatient treatment, and all regional treatment centers that provide mental health~~
352.5 ~~services for children must develop an individual treatment plan for each child client. The~~
352.6 ~~individual treatment plan must be based on a diagnostic assessment. To the extent appropriate,~~
352.7 ~~the child and the child's family shall be involved in all phases of developing and~~
352.8 ~~implementing the individual treatment plan. Providers of residential treatment, professional~~
352.9 ~~home-based family treatment, and acute care hospital inpatient treatment, and regional~~
352.10 ~~treatment centers must develop the individual treatment plan within ten working days of~~
352.11 ~~client intake or admission and must review the individual treatment plan every 90 days after~~
352.12 ~~intake, except that the administrative review of the treatment plan of a child placed in a~~
352.13 ~~residential facility shall be as specified in sections 260C.203 and 260C.212, subdivision 9.~~
352.14 ~~Providers of day treatment services must develop the individual treatment plan before the~~
352.15 ~~completion of five working days in which service is provided or within 30 days after the~~
352.16 ~~diagnostic assessment is completed or obtained, whichever occurs first. Providers of~~
352.17 ~~outpatient services must develop the individual treatment plan within 30 days after the~~
352.18 ~~diagnostic assessment is completed or obtained or by the end of the second session of an~~
352.19 ~~outpatient service, not including the session in which the diagnostic assessment was provided,~~
352.20 ~~whichever occurs first. Providers of outpatient and day treatment services must review the~~
352.21 ~~individual treatment plan every 90 days after intake. Providers of services governed by this~~
352.22 ~~section shall complete an individual treatment plan according to the standards of section~~
352.23 ~~256B.0671, subdivisions 5 and 6, including for services to a person not eligible for medical~~
352.24 ~~assistance.~~

352.25 Sec. 36. Minnesota Statutes 2018, section 245.4879, subdivision 1, is amended to read:

352.26 Subdivision 1. **Availability of emergency services.** County boards must provide or
352.27 contract for enough mental health emergency services within the county to meet the needs
352.28 of children, and children's families when clinically appropriate, in the county who are
352.29 experiencing an emotional crisis or emotional disturbance. The county board shall ensure
352.30 that parents, providers, and county residents are informed about when and how to access
352.31 emergency mental health services for children. A child or the child's parent may be required
352.32 to pay a fee according to section 245.481. Emergency service providers shall not delay the
352.33 timely provision of emergency service because of delays in determining this fee or because
352.34 of the unwillingness or inability of the parent to pay the fee. Emergency services must
352.35 include assessment, crisis intervention, and appropriate case disposition. A tribal authority

353.1 that accepts crisis grant funding has the same responsibilities as county boards within the
 353.2 tribal authority's designated service area. Emergency services must:

353.3 (1) promote the safety and emotional stability of children with emotional disturbances
 353.4 or emotional crises;

353.5 (2) minimize further deterioration of the child with emotional disturbance or emotional
 353.6 crisis;

353.7 (3) help each child with an emotional disturbance or emotional crisis to obtain ongoing
 353.8 care and treatment; ~~and~~

353.9 (4) prevent placement in settings that are more intensive, costly, or restrictive than
 353.10 necessary and appropriate to meet the child's needs; and

353.11 (5) provide support, psychoeducation, and referrals to family members, service providers,
 353.12 or other third parties on behalf of a client in need of emergency services.

353.13 Sec. 37. Minnesota Statutes 2018, section 245.4879, subdivision 2, is amended to read:

353.14 Subd. 2. **Specific requirements.** (a) The county board shall require that all service
 353.15 providers of emergency services to the child with an emotional disturbance provide immediate
 353.16 direct access to a mental health professional during regular business hours. For evenings,
 353.17 weekends, and holidays, the service may be by direct toll-free telephone access to a mental
 353.18 health professional, a clinical trainee, or a mental health practitioner, ~~or until January 1,~~
 353.19 ~~1991, a designated person with training in human services who receives clinical supervision~~
 353.20 ~~from a mental health professional.~~

353.21 (b) The commissioner may waive the requirement in paragraph (a) that the evening,
 353.22 weekend, and holiday service be provided by a mental health professional, clinical trainee,
 353.23 ~~or mental health practitioner after January 1, 1991,~~ if the county documents that:

353.24 (1) mental health professionals, clinical trainees, or mental health practitioners are
 353.25 unavailable to provide this service;

353.26 (2) services are provided by a designated person with training in human services who
 353.27 receives ~~clinical~~ clinical treatment supervision from a mental health professional; and

353.28 (3) the service provider is not also the provider of fire and public safety emergency
 353.29 services.

353.30 (c) The commissioner may waive the requirement in paragraph (b), clause (3), that the
 353.31 evening, weekend, and holiday service not be provided by the provider of fire and public
 353.32 safety emergency services if:

354.1 (1) every person who will be providing the first telephone contact has received at least
354.2 eight hours of training on emergency mental health services reviewed by the state advisory
354.3 council on mental health and then approved by the commissioner;

354.4 (2) every person who will be providing the first telephone contact will annually receive
354.5 at least four hours of continued training on emergency mental health services reviewed by
354.6 the state advisory council on mental health and then approved by the commissioner;

354.7 (3) the local social service agency has provided public education about available
354.8 emergency mental health services and can assure potential users of emergency services that
354.9 their calls will be handled appropriately;

354.10 (4) the local social service agency agrees to provide the commissioner with accurate
354.11 data on the number of emergency mental health service calls received;

354.12 (5) the local social service agency agrees to monitor the frequency and quality of
354.13 emergency services; and

354.14 (6) the local social service agency describes how it will comply with paragraph (d).

354.15 (d) When emergency service during nonbusiness hours is provided by anyone other than
354.16 a mental health professional, a mental health professional must be available on call for an
354.17 emergency assessment and crisis intervention services, and must be available for at least
354.18 telephone consultation within 30 minutes.

354.19 Sec. 38. Minnesota Statutes 2018, section 245.488, subdivision 1, is amended to read:

354.20 Subdivision 1. **Availability of outpatient services.** (a) County boards must provide or
354.21 contract for enough outpatient services within the county to meet the needs of each child
354.22 with emotional disturbance residing in the county and the child's family. Services may be
354.23 provided directly by the county through county-operated mental health centers or mental
354.24 health clinics approved by the commissioner under section 245.69, subdivision 2; by contract
354.25 with privately operated mental health centers or mental health clinics approved by the
354.26 commissioner under section 245.69, subdivision 2; by contract with hospital mental health
354.27 outpatient programs certified by the Joint Commission on Accreditation of Hospital
354.28 Organizations; or by contract with a licensed mental health professional ~~as defined in section~~
354.29 ~~245.4871, subdivision 27, clauses (1) to (6).~~ A child or a child's parent may be required to
354.30 pay a fee based in accordance with section 245.481. Outpatient services include:

354.31 (1) conducting diagnostic assessments;

354.32 (2) conducting psychological testing;

- 355.1 (3) developing or modifying individual treatment plans;
- 355.2 (4) making referrals and recommending placements as appropriate;
- 355.3 (5) treating the child's mental health needs through therapy; and
- 355.4 (6) prescribing and managing medication and evaluating the effectiveness of prescribed
- 355.5 medication.

355.6 (b) County boards may request a waiver allowing outpatient services to be provided in

355.7 a nearby trade area if it is determined that the child requires necessary and appropriate

355.8 services that are only available outside the county.

355.9 (c) Outpatient services offered by the county board to prevent placement must be at the

355.10 level of treatment appropriate to the child's diagnostic assessment.

355.11 Sec. 39. Minnesota Statutes 2018, section 245.696, is amended by adding a subdivision

355.12 to read:

355.13 Subd. 3. **Certification of mental health peer specialists and mental health family**

355.14 **peer specialists.** The commissioner shall develop a process to certify mental health peer

355.15 specialists and mental health family peer specialists according to federal guidelines and

355.16 section 245I.16, subdivisions 10 to 13, for a provider entity to bill for reimbursable services.

355.17 The training and certification curriculum must teach individuals specific skills relevant to

355.18 providing peer support as appropriate for individual or family peers.

355.19 Sec. 40. **[245I.01] PURPOSE AND CITATION.**

355.20 Subdivision 1. **Citation.** This chapter may be cited as the "Mental Health Uniform

355.21 Service Standards Act."

355.22 Subd. 2. **Purpose.** In accordance with sections 245.461 and 245.487, to create a system

355.23 of mental health care that is unified, accountable, and comprehensive, and to promote the

355.24 recovery of Minnesotans from mental illnesses, the state's public policy is to support quality

355.25 outpatient and residential mental health services reimbursable by public and private health

355.26 insurance programs. Further, the state's public policy is to ensure the safety, rights, and

355.27 well-being of individuals served in these programs.

355.28 Subd. 3. **Variations.** If the conditions in section 245A.04, subdivision 9, are met, the

355.29 commissioner may grant variations to the requirements in this chapter that do not affect a

355.30 client's health or safety.

356.1 Sec. 41. **[245I.02] DEFINITIONS.**

356.2 **Subdivision 1. Scope.** For purposes of this chapter the terms in this section have the
356.3 meanings given them.

356.4 **Subd. 2. Approval.** "Approval" means the documented review of, opportunity to request
356.5 changes to, and agreement with a treatment document by a treatment supervisor or by a
356.6 client. Approval may be demonstrated by written signature, secure electronic signature, or
356.7 documented oral approval.

356.8 **Subd. 3. Behavioral sciences or related fields.** "Behavioral sciences or related fields"
356.9 means an education from an accredited college or university in a field including but not
356.10 limited to social work, psychology, sociology, community counseling, family social science,
356.11 child development, child psychology, community mental health, addiction counseling,
356.12 counseling and guidance, special education, and other similar fields as approved by the
356.13 commissioner.

356.14 **Subd. 4. Certified rehabilitation specialist.** "Certified rehabilitation specialist" means
356.15 a staff person qualified according to section 245I.16, subdivision 8.

356.16 **Subd. 5. Child.** "Child" means a client under 18 years of age, or a client under 21 years
356.17 of age who is eligible for a service otherwise provided to persons under 18 years of age.

356.18 **Subd. 6. Client.** "Client" means a person who is seeking or receiving services regulated
356.19 under this chapter. For the purpose of consent to services, this term includes a parent,
356.20 guardian, or other individual authorized to consent to services by law.

356.21 **Subd. 7. Clinical trainee.** "Clinical trainee" means a staff person qualified according
356.22 to section 245I.16, subdivision 6.

356.23 **Subd. 8. Clinician.** "Clinician" means a mental health professional or clinical trainee
356.24 who is performing diagnostic assessment, testing, or psychotherapy.

356.25 **Subd. 9. Commissioner.** "Commissioner" means the commissioner of human services
356.26 or the commissioner's designee.

356.27 **Subd. 10. Diagnostic assessment.** "Diagnostic assessment" means the evaluation and
356.28 report of a client's potential diagnoses conducted by a clinician. For a client receiving
356.29 publicly funded services, a diagnostic assessment must meet the standards of section
356.30 256B.0671, subdivisions 2 to 4.

356.31 **Subd. 11. Diagnostic formulation.** "Diagnostic formulation" means a written analysis
356.32 and explanation of the information obtained from a clinical assessment to develop a

357.1 hypothesis about the cause and nature of the presenting problems and identify a framework
357.2 for developing the most suitable treatment approach.

357.3 Subd. 12. **Individual treatment plan.** "Individual treatment plan" means the formulation
357.4 of planned services that are responsive to the needs and goals of a client. For a client receiving
357.5 publicly funded services, an individual treatment plan must meet the standards of section
357.6 256B.0671, subdivisions 5 and 6.

357.7 Subd. 13. **Mental health behavioral aide.** "Mental health behavioral aide" means a
357.8 staff person qualified according to section 245I.16, subdivision 16.

357.9 Subd. 14. **Mental health certified family peer specialist.** "Mental health certified
357.10 family peer specialist" means a staff person qualified according to section 245I.16,
357.11 subdivision 12.

357.12 Subd. 15. **Mental health certified peer specialist.** "Mental health certified peer
357.13 specialist" means a staff person qualified according to section 245I.16, subdivision 10.

357.14 Subd. 16. **Mental health practitioner.** "Mental health practitioner" means a staff person
357.15 qualified according to section 245I.16, subdivision 4.

357.16 Subd. 17. **Mental health professional.** "Mental health professional" means a staff person
357.17 qualified according to section 245I.16, subdivision 2.

357.18 Subd. 18. **Mental health rehabilitation worker.** "Mental health rehabilitation worker"
357.19 means a staff person qualified according to section 245I.16, subdivision 14.

357.20 Subd. 19. **Personnel file.** "Personnel file" means the set of records under section 245I.13,
357.21 paragraph (a). Personnel files excludes information related to a person's employment not
357.22 enumerated in section 245I.13.

357.23 Subd. 20. **Provider entity.** "Provider entity" means the organization, governmental unit,
357.24 corporation, or other legal body that is enrolled, certified, licensed, or otherwise authorized
357.25 by the commissioner to provide the services described in this chapter.

357.26 Subd. 21. **Responsivity factors.** "Responsivity factors" means the factors other than the
357.27 diagnostic formulation that may modify an individual's treatment needs. This includes
357.28 learning style, ability, cognitive function, cultural background, and personal circumstance.
357.29 Documentation of responsivity factors includes an analysis of how an individual's strengths
357.30 may be reflected in the planned delivery of services.

357.31 Subd. 22. **Risk factors.** "Risk factors" means factors that predispose a client to engage
357.32 in potentially harmful behaviors to themselves or others.

358.1 Subd. 23. **Strengths.** "Strengths" means inner characteristics, virtues, external
358.2 relationships, activities, and connections to resources that contribute to resilience and core
358.3 competencies and can be built on to support recovery.

358.4 Subd. 24. **Trauma.** "Trauma" means an event, series of events, or set of circumstances
358.5 that is experienced by an individual as physically or emotionally harmful or life threatening
358.6 and has lasting adverse effects on the individual's functioning and mental, physical, social,
358.7 emotional, or spiritual well-being. Trauma includes the cumulative emotional or
358.8 psychological harm of group traumatic experiences, transmitted across generations within
358.9 a community, often associated with racial and ethnic population groups in the country who
358.10 have suffered major intergenerational losses.

358.11 Subd. 25. **Treatment supervision.** "Treatment supervision" means the direction and
358.12 evaluation of individual assessment, treatment planning, and service delivery for each client
358.13 when services are delivered by an individual who is not a licensed mental health professional
358.14 or certified rehabilitation specialist as provided by section 245I.18.

358.15 **Sec. 42. [245I.10] TRAINING REQUIRED.**

358.16 Subdivision 1. **Training plan.** A provider entity must develop a plan to ensure that staff
358.17 persons receive orientation and ongoing training. The plan must include:

358.18 (1) a formal process to evaluate the training needs of each staff person. An annual
358.19 performance evaluation satisfies this requirement;

358.20 (2) a description of how the provider entity conducts annual training, including whether
358.21 annual training is based on a staff person's hire date or a specified annual cycle determined
358.22 by the program; and

358.23 (3) a description of how the provider entity determines when a staff person needs
358.24 additional training, including the timelines in which the additional training is provided.

358.25 Subd. 2. **Documentation of orientation and training.** (a) The provider entity must
358.26 provide training in accordance with the training plan and must document that orientation
358.27 and training was provided. All training programs and materials used by the provider entity
358.28 must be available for review by regulatory agencies. The documentation must include the
358.29 following:

358.30 (1) topic covered in the training;

358.31 (2) identification of the trainee;

358.32 (3) name and credentials of the trainer;

359.1 (4) method of evaluating competency upon completion of training;

359.2 (5) date of training; and

359.3 (6) length of training, in hours.

359.4 (b) Documentation of a continuing education credit accepted by the governing
359.5 health-related licensing board is sufficient for purposes of this subdivision.

359.6 Subd. 3. **Orientation.** (a) Before providing direct contact services, a staff person must
359.7 receive orientation on:

359.8 (1) patient rights as identified in section 144.651;

359.9 (2) vulnerable adult and minor maltreatment requirements in sections 245A.65,
359.10 subdivision 3; 626.556, subdivisions 2, 3, and 7; 626.557; and 626.5572;

359.11 (3) the Minnesota Health Records Act, including confidentiality, family engagement
359.12 according to section 144.294, and client privacy;

359.13 (4) program policies and procedures;

359.14 (5) emergency procedures appropriate to the position, including but not limited to fires,
359.15 inclement weather, missing persons, and medical emergencies;

359.16 (6) professional boundaries;

359.17 (7) behavior management, crisis intervention, and stabilization techniques;

359.18 (8) specific needs of individuals served by the program, including but not limited to
359.19 developmental status, cognitive functioning, and physical and mental abilities; and

359.20 (9) training related to the specific activities and job functions for which the staff person
359.21 is responsible to carry out, including documentation of the delivery of services.

359.22 (b) A staff person must receive orientation on the following topics within 90 calendar
359.23 days of a staff person first providing direct contact services:

359.24 (1) trauma-informed care;

359.25 (2) family- and person-centered individual treatment plans, seeking partnership with
359.26 parents and identified supports, and shared decision making and engagement;

359.27 (3) treatment for co-occurring substance use problems, including the definitions of
359.28 co-occurring disorders, prevalence of co-occurring disorders, common signs and symptoms
359.29 of co-occurring disorders, and the etiology of co-occurring disorders;

359.30 (4) psychotropic medications, side effects, and safe medication management;

360.1 (5) family systems and promoting culturally appropriate support networks;

360.2 (6) culturally responsive treatment practices;

360.3 (7) recovery concepts and principles;

360.4 (8) building resiliency through a strength-based approach;

360.5 (9) person-centered planning and positive support strategies; and

360.6 (10) other training relevant to the staff person's role and responsibilities.

360.7 (c) A provider entity may deem a staff person to have met an orientation requirement

360.8 in paragraph (b) if the staff person has received equivalent postsecondary education in the

360.9 previous four years or training experience in the previous two years. The training plan must

360.10 describe the process and location for verification and documentation of previous training

360.11 experience.

360.12 (d) A provider entity may deem a mental health professional to have met a requirement

360.13 of paragraph (a), clauses (6) to (9), and paragraph (b) after an evaluation of the mental health

360.14 professional's competency, including by interview.

360.15 Subd. 4. **Annual training.** (a) A provider entity shall ensure that staff persons who are

360.16 not licensed mental health professionals receive 15 hours of training each year after the first

360.17 year of employment.

360.18 (b) A licensed mental health professional must follow specific training requirements as

360.19 determined by the professional's governing health-related licensing board.

360.20 (c) All staff persons, including licensed mental health professionals, must receive annual

360.21 training on the topics in subdivision 3, paragraph (a), clauses (2) and (5).

360.22 (d) The selection of additional training topics must be based on program needs and staff

360.23 persons' competency.

360.24 Subd. 5. **Training for services provided to children.** (a) Training and orientation

360.25 required under this section for a staff person working with children must be aligned to the

360.26 developmental characteristics of the children served in the program and address the needs

360.27 of children in the context of the family, support system, and culture. This includes orientation

360.28 under subdivision 3 on the following topics: (1) child development; (2) working with children

360.29 and children's support systems; (3) adverse childhood experiences, cognitive functioning,

360.30 and physical and mental abilities; and (4) understanding family perspective.

360.31 (b) For a mental health behavioral aide, orientation in the first 90 days of service must

360.32 include a parent team training utilizing a curriculum approved by the commissioner.

361.1 Sec. 43. **[245I.13] PERSONNEL FILES.**

361.2 (a) For each staff person, a provider entity shall maintain a personnel file that includes:

361.3 (1) verification of the staff person's qualifications including training, education, and
361.4 licensure;

361.5 (2) documentation related to the staff person's background study;

361.6 (3) the date of hire;

361.7 (4) the effective date of specific duties and responsibilities including the date that the
361.8 staff person begins direct contact with a client;

361.9 (5) documentation of orientation;

361.10 (6) records of training, license renewal, and educational activities completed during the
361.11 staff person's employment;

361.12 (7) annual job performance evaluations; and

361.13 (8) records of clinical supervision, if applicable.

361.14 (b) Personnel files must be made accessible to the commissioner upon request. Personnel
361.15 files must be readily accessible for review but need not be kept in a single location.

361.16 Sec. 44. **[245I.16] PROVIDER QUALIFICATIONS AND SCOPE OF PRACTICE.**

361.17 Subdivision 1. Tribal providers. For purposes of this section, a tribal entity may
361.18 credential an individual under section 256B.02, subdivision 7, paragraphs (b) and (c).

361.19 Subd. 2. Mental health professional qualifications. The following individuals may
361.20 provide services as a mental health professional:

361.21 (1) a registered nurse who is licensed under sections 148.171 to 148.285 and is certified
361.22 as a (i) clinical nurse specialist in child or adolescent, family, or adult psychiatric and mental
361.23 health nursing by a national certification organization, or (ii) nurse practitioner in adult or
361.24 family psychiatric and mental health nursing by a national nurse certification organization;

361.25 (2) a licensed independent clinical social worker as defined in section 148E.050,
361.26 subdivision 5;

361.27 (3) a psychologist licensed by the Board of Psychology under sections 148.88 to 148.98;

361.28 (4) a physician licensed under chapter 147 if the physician is: (i) certified by the American
361.29 Board of Psychiatry and Neurology; (ii) certified by the American Osteopathic Board of
361.30 Neurology and Psychiatry; or (iii) eligible for board certification in psychiatry;

362.1 (5) a marriage and family therapist licensed under sections 148B.29 to 148B.39; or

362.2 (6) a licensed professional clinical counselor licensed under section 148B.5301.

362.3 Subd. 3. **Mental health professional scope of practice.** A mental health professional
362.4 shall maintain a valid license with the mental health professional's governing health-related
362.5 licensing board and shall only provide services within the scope of practice as determined
362.6 by the health-related licensing board.

362.7 Subd. 4. **Mental health practitioner qualifications.** (a) An individual who is qualified
362.8 in at least one of the ways described in paragraphs (b) to (d) may serve as a mental health
362.9 practitioner.

362.10 (b) An individual is qualified through relevant coursework if the individual completes
362.11 at least 30 semester hours or 45 quarter hours in behavioral sciences or related fields and:

362.12 (1) has at least 2,000 hours of supervised experience in the delivery of services to adults
362.13 or children with: (i) mental illness, substance use disorder, or emotional disturbance; or (ii)
362.14 traumatic brain injury or developmental disabilities and completes training on mental illness,
362.15 recovery from mental illness, mental health de-escalation techniques, co-occurring mental
362.16 illness and substance use disorder, and psychotropic medications and side effects;

362.17 (2) is fluent in the non-English language of the ethnic group to which at least 50 percent
362.18 of the individual's clients belong, completes 40 hours of training in the delivery of services
362.19 to adults with mental illness or children with emotional disturbance, and receives treatment
362.20 supervision from a mental health professional at least once per week until the requirement
362.21 of 2,000 hours of supervised experience is met;

362.22 (3) is working in a day treatment program under section 245.4712, subdivision 2; or

362.23 (4) has completed a practicum or internship that (i) requires direct interaction with adults
362.24 or children served, and (ii) is focused on behavioral sciences or related fields.

362.25 (c) An individual is qualified through work experience if the individual:

362.26 (1) has at least 4,000 hours of supervised experience in the delivery of services to adults
362.27 or children with: (i) mental illness, substance use disorder, or emotional disturbance; or (ii)
362.28 traumatic brain injury or developmental disabilities and completes training on mental illness,
362.29 recovery from mental illness, mental health de-escalation techniques, co-occurring mental
362.30 illness and substance use disorder, and psychotropic medications and side effects; or

362.31 (2) has at least 2,000 hours of supervised experience in the delivery of services to adults
362.32 or children with: (i) mental illness, emotional disturbance, or substance use disorder, and

363.1 receives treatment supervision as required by applicable statutes and rules from a mental
363.2 health professional at least once per week until the requirement of 4,000 hours of supervised
363.3 experience is met; or (ii) traumatic brain injury or developmental disabilities, completes
363.4 training on mental illness, recovery from mental illness, mental health de-escalation
363.5 techniques, co-occurring mental illness and substance use disorder, and psychotropic
363.6 medications and side effects, and receives treatment supervision as required by applicable
363.7 statutes and rules at least once per week from a mental health professional until the
363.8 requirement of 4,000 hours of supervised experience is met.

363.9 (d) An individual is qualified by a bachelor's or master's degree if the individual: (1)
363.10 holds a master's or other graduate degree in behavioral sciences or related fields; or (2)
363.11 holds a bachelor's degree in behavioral sciences or related fields and completes a practicum
363.12 or internship that (i) requires direct interaction with adults or children served, and (ii) is
363.13 focused on behavioral sciences or related fields.

363.14 Subd. 5. **Mental health practitioner scope of practice.** (a) A mental health practitioner
363.15 must perform services under the treatment supervision of a mental health professional.

363.16 (b) A mental health practitioner may perform client education, functional assessments
363.17 for adult clients, level of care assessments, rehabilitative interventions, and skills building;
363.18 provide direction to a mental health rehabilitation worker or mental health behavioral aide;
363.19 and propose individual treatment plans.

363.20 (c) A mental health practitioner who provides services according to section 256B.0624
363.21 or 256B.0944 may perform crisis assessment and intervention.

363.22 Subd. 6. **Clinical trainee qualifications.** (a) A clinical trainee is a staff person who is
363.23 enrolled in or has completed an accredited graduate program of study intended to prepare
363.24 the individual for independent licensure as a mental health professional and who: (1)
363.25 participates in a practicum or internship supervised by a mental health professional; or (2)
363.26 is completing postgraduate hours, according to the requirements of a health-related licensing
363.27 board.

363.28 (b) A clinical trainee is responsible for notifying and applying to a health-related licensing
363.29 board to ensure the requirements of the health-related licensing board are met. As permitted
363.30 by a health-related licensing board, treatment supervision under this chapter may be integrated
363.31 into a plan to meet the supervisory requirements of the health-related licensing board but
363.32 does not supersede those requirements.

363.33 Subd. 7. **Clinical trainee scope of practice.** (a) A clinical trainee, under treatment
363.34 supervision of a mental health professional, may perform psychotherapy, diagnostic

364.1 assessments, and services that a mental health practitioner may deliver. A clinical trainee
364.2 shall not provide treatment supervision. A clinical trainee may provide direction to a mental
364.3 health behavioral aide or mental health rehabilitation worker.

364.4 (b) A psychological clinical trainee under the treatment supervision of a psychologist
364.5 may perform psychological testing.

364.6 (c) A clinical trainee shall not deliver services in violation of the practice act of a
364.7 health-related licensing board, including failure to obtain licensure, if required.

364.8 Subd. 8. **Certified rehabilitation specialist qualifications.** A certified rehabilitation
364.9 specialist shall have:

364.10 (1) a master's degree from an accredited college or university in behavioral sciences or
364.11 related fields as defined in section 245I.02, subdivision 3;

364.12 (2) at least 4,000 hours of postmaster's supervised experience in the delivery of mental
364.13 health services; and

364.14 (3) a valid national certification as a certified rehabilitation counselor or certified
364.15 psychosocial rehabilitation practitioner.

364.16 Subd. 9. **Certified rehabilitation specialist scope of practice.** A certified rehabilitation
364.17 specialist shall provide services based on a client's diagnostic assessment. A certified
364.18 rehabilitation specialist may provide supervision for mental health certified peer specialists,
364.19 mental health practitioners, and mental health rehabilitation workers, but is prohibited from
364.20 performing a diagnostic assessment.

364.21 Subd. 10. **Mental health certified peer specialist qualifications.** A mental health
364.22 certified peer specialist shall:

364.23 (1) be 21 years of age or older;

364.24 (2) have been diagnosed with a mental illness;

364.25 (3) be a current or former mental health services client; and

364.26 (4) have a valid certification as a mental health certified peer specialist according to
364.27 section 245.696, subdivision 3.

364.28 Subd. 11. **Mental health certified peer specialist scope of practice.** A mental health
364.29 certified peer specialist shall:

364.30 (1) provide peer support that is individualized to the client;

365.1 (2) promote recovery goals, self-sufficiency, self-advocacy, and the development of
365.2 natural supports; and

365.3 (3) support the maintenance of skills learned in other services.

365.4 Subd. 12. **Mental health certified family peer specialist qualifications.** A mental
365.5 health certified family peer specialist shall:

365.6 (1) be 21 years of age or older;

365.7 (2) have raised or be currently raising a child with a mental illness;

365.8 (3) have experience navigating the children's mental health system; and

365.9 (4) have a valid certification as a mental health certified family peer specialist according
365.10 to section 245.696, subdivision 3.

365.11 Subd. 13. **Mental health certified family peer specialist scope of practice.** A mental
365.12 health certified family peer specialist shall provide services to increase the child's ability to
365.13 function better within the child's home, school, and community. The mental health certified
365.14 family peer specialist shall:

365.15 (1) provide family peer support, to build on strengths of families and help families
365.16 achieve desired outcomes;

365.17 (2) provide nonadversarial advocacy that encourages partnership and promotes positive
365.18 change and growth;

365.19 (3) support families to advocate for culturally appropriate services for a child in each
365.20 treatment setting;

365.21 (4) promote resiliency, self-advocacy, and development of natural supports;

365.22 (5) support the maintenance of skills learned in other services;

365.23 (6) establish and lead parent support groups;

365.24 (7) assist parents to develop coping and problem-solving skills; and

365.25 (8) educate parents on community resources, including resources that connect parents
365.26 with similar experiences.

365.27 Subd. 14. **Mental health rehabilitation worker qualifications.** (a) A mental health
365.28 rehabilitation worker shall (1) be 21 years of age or older; (2) have a high school diploma
365.29 or equivalent; and (3) meet the qualification requirements in paragraph (b).

366.1 (b) In addition to the requirements of paragraph (a), a mental health rehabilitation worker
366.2 shall also:

366.3 (1) be fluent in the non-English language or competent in the culture of the ethnic group
366.4 to which at least 20 percent of the mental health rehabilitation worker's clients belong;

366.5 (2) have an associate of arts degree;

366.6 (3) have two years of full-time postsecondary education or a total of 15 semester hours
366.7 or 23 quarter hours in behavioral sciences or related fields;

366.8 (4) be a registered nurse;

366.9 (5) have within the previous ten years three years of personal life experience with mental
366.10 illness;

366.11 (6) have within the previous ten years three years of life experience as a primary caregiver
366.12 to an adult with a mental illness, traumatic brain injury, substance use disorder, or
366.13 developmental disability; or

366.14 (7) have within the previous ten years 2,000 hours of supervised work experience in
366.15 delivering mental health services to adults with a mental illness, traumatic brain injury,
366.16 substance use disorder, or developmental disability.

366.17 (c) If the mental health rehabilitation worker provides crisis residential services, intensive
366.18 residential treatment services, partial hospitalization, or day treatment services, the mental
366.19 health rehabilitation worker shall: (1) satisfy paragraph (b), clause (1); and (2) have 40 hours
366.20 of additional continuing education on mental health topics during the first year of
366.21 employment.

366.22 Subd. 15. **Mental health rehabilitation worker scope of practice.** (a) A mental health
366.23 rehabilitation worker under supervision of a mental health practitioner or mental health
366.24 professional may provide rehabilitative mental health services identified in the client's
366.25 individual treatment plan and individual behavior plan.

366.26 (b) A mental health rehabilitation worker who solely acts and is scheduled as overnight
366.27 staff is exempt from the additional qualification requirements in subdivision 14, paragraphs
366.28 (a), clause (3), and (b).

366.29 Subd. 16. **Mental health behavioral aide qualifications.** (a) A level 1 mental health
366.30 behavioral aide shall:

366.31 (1) be 18 years of age or older; and

367.1 (2) have a high school diploma or commissioner of education-selected high school
367.2 equivalency certification; or two years of experience as a primary caregiver to a child with
367.3 severe emotional disturbance within the previous ten years.

367.4 (b) A level 2 mental health behavioral aide shall:

367.5 (1) be 18 years of age or older; and

367.6 (2) have an associate or bachelor's degree or be certified by a program under section
367.7 256B.0943, subdivision 8a.

367.8 Subd. 17. **Mental health behavioral aide scope of practice.** The mental health
367.9 behavioral aide under supervision of a mental health professional may provide rehabilitative
367.10 mental health services identified in the client's individual treatment plan and individual
367.11 behavior plan.

367.12 Sec. 45. **[245L.18] TREATMENT SUPERVISION.**

367.13 Subdivision 1. **Generally.** (a) A provider entity shall ensure that a mental health
367.14 professional provides treatment supervision for each staff person who provides services to
367.15 a client and who is not a mental health professional or certified rehabilitation specialist.
367.16 Treatment supervision shall be based on a staff person's written treatment supervision plan.

367.17 (b) Treatment supervision must focus on the client's treatment needs and the ability of
367.18 the staff person receiving treatment supervision to provide services, including:

367.19 (1) review and evaluation of the interventions delivered;

367.20 (2) instruction on alternative strategies if a client is not achieving treatment goals;

367.21 (3) review and evaluation of assessments, treatment plans, and progress notes for accuracy
367.22 and appropriateness;

367.23 (4) approval of diagnostic assessments and individual treatment plans within five business
367.24 days of initial completion by the supervisee;

367.25 (5) instruction on the cultural norms or values of the clients and communities served by
367.26 the provider entity and any impact on treatment;

367.27 (6) evaluation of and feedback on the competencies of direct service staff persons; and

367.28 (7) coaching, teaching, and practicing skills with staff persons.

367.29 (c) A treatment supervisor's responsibility for a supervisee is limited to services provided
367.30 by the associated provider entity. If a supervisee is employed by multiple provider entities,
367.31 each entity is responsible for furnishing the necessary treatment supervision.

368.1 Subd. 2. Permitted modalities. (a) Treatment supervision must be conducted face-to-face,
368.2 including telemedicine, according to the Minnesota Telemedicine Act, sections 62A.67 to
368.3 62A.672.

368.4 (b) Treatment supervision may be conducted using individual, small group, or team
368.5 modalities. "Individual supervision" means one or more mental health professionals and
368.6 one staff person receiving treatment supervision. "Small group supervision" means one or
368.7 more mental health professionals and two to six staff persons receiving treatment supervision.
368.8 "Team supervision" is defined by the service lines for which it may be used.

368.9 Subd. 3. Treatment supervision planning. (a) A written treatment supervision plan
368.10 shall be developed by a mental health professional who is qualified to provide treatment
368.11 supervision and the staff person receiving the treatment supervision. The treatment
368.12 supervision plan must be completed and implemented within 30 days of a new staff person's
368.13 employment. The treatment supervision plan must be reviewed and updated at least annually.

368.14 (b) The treatment supervision plan must include:

368.15 (1) the name and qualifications of the staff person receiving treatment supervision;

368.16 (2) the name of the provider entity under which the staff person is receiving treatment
368.17 supervision;

368.18 (3) the name and licensure of a mental health professional providing treatment
368.19 supervision;

368.20 (4) the number of hours of individual and group supervision the staff person receiving
368.21 treatment supervision must complete and the location of the record if the record is kept
368.22 outside of an individual personnel file;

368.23 (5) procedures that the staff person receiving treatment supervision shall use to respond
368.24 to client emergencies; and

368.25 (6) the authorized scope of practice for the staff person receiving treatment supervision,
368.26 including a description of responsibilities with the provider entity, a description of client
368.27 population, and treatment methods and modalities.

368.28 Subd. 4. Treatment supervision record. (a) A provider entity shall ensure treatment
368.29 supervision is documented in each staff person's treatment supervision record.

368.30 (b) The treatment supervision record must include:

368.31 (1) the date and duration of the supervision;

368.32 (2) identification of the supervision type as individual, small group, or team supervision;

369.1 (3) the name of the mental health professional providing treatment supervision;

369.2 (4) subsequent actions that the staff person receiving treatment supervision shall take;

369.3 and

369.4 (5) the date and signature of the mental health professional providing treatment

369.5 supervision.

369.6 Subd. 5. **Supervision and direct observation of mental health rehabilitation workers**

369.7 and behavioral aides. (a) A mental health practitioner, clinical trainee, or mental health

369.8 professional shall directly observe a mental health behavioral aide or a mental health

369.9 rehabilitation worker while the mental health behavioral aide or mental health rehabilitation

369.10 worker provides services to clients. The amount of direct observation shall be no less than

369.11 twice per month for the first six months and once per month thereafter. The staff performing

369.12 the observation shall approve the progress note for the service observed.

369.13 (b) For a rehabilitation worker qualified under section 245I.16, subdivision 14, paragraph

369.14 (b), clause (1), the treatment supervision in the first 2,000 hours of work shall be no less

369.15 than:

369.16 (1) monthly individual treatment supervision; and

369.17 (2) twice per month direct observation.

369.18 Sec. 46. **[245I.32] CLIENT FILES.**

369.19 Subdivision 1. **Generally.** A provider entity must maintain a file of current and accurate

369.20 client records on the premises where the service is provided or coordinated. Each entry in

369.21 the record must be signed and dated by the staff person making the entry.

369.22 Subd. 2. **Record retention.** A provider entity must retain client records of a discharged

369.23 client for a minimum of seven years from the date of discharge. A provider entity that ceases

369.24 to provide treatment service must retain client records for a minimum of seven years from

369.25 the date the provider entity stopped providing the service and must notify the commissioner

369.26 of the location of the client records and the name of the individual responsible for maintaining

369.27 the client records.

369.28 Subd. 3. **Contents.** Client files must contain the following, as applicable:

369.29 (1) diagnostic assessments;

369.30 (2) functional assessments;

369.31 (3) individual treatment plans;

- 370.1 (4) individual abuse prevention plans;
- 370.2 (5) crisis plans;
- 370.3 (6) documentation of releases of information;
- 370.4 (7) emergency contacts for the client;
- 370.5 (8) documentation of the date of service; signature of the person providing the service;
- 370.6 nature, extent, and units of service; and place of service delivery;
- 370.7 (9) record of all medication prescribed or administered by staff;
- 370.8 (10) documentation of any contact made with the client's other mental health providers,
- 370.9 case manager, family members, primary caregiver, or legal representative or the reason the
- 370.10 provider did not contact the client's family members or primary caregiver;
- 370.11 (11) documentation of any contact made with other persons interested in the client,
- 370.12 including representatives of the courts, corrections systems, or schools;
- 370.13 (12) written information by the client that the client requests be included in the file;
- 370.14 (13) health care directive; and
- 370.15 (14) the date and reason the provider entity's services are discontinued.

370.16 **Sec. 47. [245I.33] DOCUMENTATION STANDARDS.**

370.17 Subdivision 1. **Generally.** As a condition of payment, a provider entity must ensure that

370.18 documentation complies with this section and Minnesota Rules, parts 9505.2175 and

370.19 9505.2197. The department must recover medical assistance payments for a service not

370.20 documented in a client file according to this section.

370.21 Subd. 2. **Documentation standards.** A provider entity must ensure that all documentation

370.22 required under this chapter:

- 370.23 (1) is typed or legible, if handwritten;
- 370.24 (2) identifies the client or staff person on each page, as applicable;
- 370.25 (3) is signed and dated by the staff person who completes the documentation, including
- 370.26 the staff person's credentials; and
- 370.27 (4) is cosigned and dated by the staff person providing treatment supervision as required
- 370.28 under this chapter, including the staff person's credentials.

371.1 Subd. 3. **Progress notes.** A provider entity shall use a progress note to promptly document
 371.2 each occurrence of a mental health service provided to a client. A progress note must include
 371.3 the following:

371.4 (1) the type of service;

371.5 (2) the date of service, including the start and stop time;

371.6 (3) the location of service;

371.7 (4) the scope of service, including: (i) the goal and objective targeted; (ii) the intervention
 371.8 delivered and the methods used; (iii) the client's response or reaction to intervention; (iv)
 371.9 the plan for the next session; and (v) the service modality;

371.10 (5) the signature and the printed name and credentials of the staff person who provided
 371.11 the service;

371.12 (6) the mental health provider travel documentation requirements under section
 371.13 256B.0625, if applicable; and

371.14 (7) other significant observations, including (i) current risk factors the client may be
 371.15 experiencing; (ii) emergency interventions; (iii) consultations with or referrals to other
 371.16 professionals, family, or significant others; (iv) a summary of the effectiveness of treatment,
 371.17 prognosis, or discharge planning; (v) test results and medications; or (vi) changes in mental
 371.18 or physical symptoms.

371.19 Sec. 48. Minnesota Statutes 2018, section 254B.05, subdivision 5, is amended to read:

371.20 **Subd. 5. Rate requirements.** (a) The commissioner shall establish rates for substance
 371.21 use disorder services and service enhancements funded under this chapter.

371.22 (b) Eligible substance use disorder treatment services include:

371.23 (1) outpatient treatment services that are licensed according to sections 245G.01 to
 371.24 245G.17, or applicable tribal license;

371.25 (2) on July 1, 2018, or upon federal approval, whichever is later, comprehensive
 371.26 assessments provided according to sections 245.4863, paragraph (a), and 245G.05, ~~and~~
 371.27 ~~Minnesota Rules, part 9530.6422;~~

371.28 (3) on July 1, 2018, or upon federal approval, whichever is later, care coordination
 371.29 services provided according to section 245G.07, subdivision 1, paragraph (a), clause (6);

371.30 (4) on July 1, 2018, or upon federal approval, whichever is later, peer recovery support
 371.31 services provided according to section 245G.07, subdivision 1, paragraph (a), clause (5);

372.1 (5) on July 1, 2019, or upon federal approval, whichever is later, withdrawal management
372.2 services provided according to chapter 245F;

372.3 (6) medication-assisted therapy services that are licensed according to sections 245G.01
372.4 to 245G.17 and 245G.22, or applicable tribal license;

372.5 (7) medication-assisted therapy plus enhanced treatment services that meet the
372.6 requirements of clause (6) and provide nine hours of clinical services each week;

372.7 (8) high, medium, and low intensity residential treatment services that are licensed
372.8 according to sections 245G.01 to 245G.17 and 245G.21 or applicable tribal license which
372.9 provide, respectively, 30, 15, and five hours of clinical services each week;

372.10 (9) hospital-based treatment services that are licensed according to sections 245G.01 to
372.11 245G.17 or applicable tribal license and licensed as a hospital under sections 144.50 to
372.12 144.56;

372.13 (10) adolescent treatment programs that are licensed as outpatient treatment programs
372.14 according to sections 245G.01 to 245G.18 or as residential treatment programs according
372.15 to Minnesota Rules, parts 2960.0010 to 2960.0220, and 2960.0430 to 2960.0490, or
372.16 applicable tribal license;

372.17 (11) high-intensity residential treatment services that are licensed according to sections
372.18 245G.01 to 245G.17 and 245G.21 or applicable tribal license, which provide 30 hours of
372.19 clinical services each week provided by a state-operated vendor or to clients who have been
372.20 civilly committed to the commissioner, present the most complex and difficult care needs,
372.21 and are a potential threat to the community; and

372.22 (12) room and board facilities that meet the requirements of subdivision 1a.

372.23 (c) The commissioner shall establish higher rates for programs that meet the requirements
372.24 of paragraph (b) and one of the following additional requirements:

372.25 (1) programs that serve parents with their children if the program:

372.26 (i) provides on-site child care during the hours of treatment activity that:

372.27 (A) is licensed under chapter 245A as a child care center under Minnesota Rules, chapter
372.28 9503; or

372.29 (B) meets the licensure exclusion criteria of section 245A.03, subdivision 2, paragraph
372.30 (a), clause (6), and meets the requirements under section 245G.19, subdivision 4; or

372.31 (ii) arranges for off-site child care during hours of treatment activity at a facility that is
372.32 licensed under chapter 245A as:

- 373.1 (A) a child care center under Minnesota Rules, chapter 9503; or
- 373.2 (B) a family child care home under Minnesota Rules, chapter 9502;
- 373.3 (2) culturally specific programs as defined in section 254B.01, subdivision 4a, or
- 373.4 programs or subprograms serving special populations, if the program or subprogram meets
- 373.5 the following requirements:
- 373.6 (i) is designed to address the unique needs of individuals who share a common language,
- 373.7 racial, ethnic, or social background;
- 373.8 (ii) is governed with significant input from individuals of that specific background; and
- 373.9 (iii) employs individuals to provide individual or group therapy, at least 50 percent of
- 373.10 whom are of that specific background, except when the common social background of the
- 373.11 individuals served is a traumatic brain injury or cognitive disability and the program employs
- 373.12 treatment staff who have the necessary professional training, as approved by the
- 373.13 commissioner, to serve clients with the specific disabilities that the program is designed to
- 373.14 serve;
- 373.15 (3) programs that offer medical services delivered by appropriately credentialed health
- 373.16 care staff in an amount equal to two hours per client per week if the medical needs of the
- 373.17 client and the nature and provision of any medical services provided are documented in the
- 373.18 client file; and
- 373.19 (4) programs that offer services to individuals with co-occurring mental health and
- 373.20 chemical dependency problems if:
- 373.21 (i) the program meets the co-occurring requirements in section 245G.20;
- 373.22 (ii) 25 percent of the counseling staff are licensed mental health professionals, ~~as defined~~
- 373.23 ~~in section 245.462, subdivision 18, clauses (1) to (6),~~ qualified according to section 245I.16,
- 373.24 subdivision 2, or are students or licensing candidates under the supervision of a licensed
- 373.25 alcohol and drug counselor supervisor and licensed mental health professional, except that
- 373.26 no more than 50 percent of the mental health staff may be students or licensing candidates
- 373.27 with time documented to be directly related to provisions of co-occurring services;
- 373.28 (iii) clients scoring positive on a standardized mental health screen receive a mental
- 373.29 health diagnostic assessment within ten days of admission;
- 373.30 (iv) the program has standards for multidisciplinary case review that include a monthly
- 373.31 review for each client that, at a minimum, includes a licensed mental health professional
- 373.32 and licensed alcohol and drug counselor, and their involvement in the review is documented;

374.1 (v) family education is offered that addresses mental health and substance abuse disorders
374.2 and the interaction between the two; and

374.3 (vi) co-occurring counseling staff shall receive eight hours of co-occurring disorder
374.4 training annually.

374.5 (d) In order to be eligible for a higher rate under paragraph (c), clause (1), a program
374.6 that provides arrangements for off-site child care must maintain current documentation at
374.7 the chemical dependency facility of the child care provider's current licensure to provide
374.8 child care services. Programs that provide child care according to paragraph (c), clause (1),
374.9 must be deemed in compliance with the licensing requirements in section 245G.19.

374.10 (e) Adolescent residential programs that meet the requirements of Minnesota Rules,
374.11 parts 2960.0430 to 2960.0490 and 2960.0580 to 2960.0690, are exempt from the requirements
374.12 in paragraph (c), clause (4), items (i) to (iv).

374.13 (f) Subject to federal approval, chemical dependency services that are otherwise covered
374.14 as direct face-to-face services may be provided via two-way interactive video. The use of
374.15 two-way interactive video must be medically appropriate to the condition and needs of the
374.16 person being served. Reimbursement shall be at the same rates and under the same conditions
374.17 that would otherwise apply to direct face-to-face services. The interactive video equipment
374.18 and connection must comply with Medicare standards in effect at the time the service is
374.19 provided.

374.20 Sec. 49. Minnesota Statutes 2018, section 256B.0615, subdivision 1, is amended to read:

374.21 Subdivision 1. **Scope.** Medical assistance covers mental health certified peer specialist
374.22 services, ~~as established in subdivision 2, subject to federal approval, if provided to recipients~~
374.23 ~~who are eligible for services under sections 256B.0622, 256B.0623, and 256B.0624 and~~
374.24 ~~are provided by a certified peer specialist who has completed the training under subdivision~~
374.25 ~~5 is qualified according to section 245I.16, subdivision 10.~~

374.26 Sec. 50. Minnesota Statutes 2018, section 256B.0616, subdivision 1, is amended to read:

374.27 Subdivision 1. **Scope.** Medical assistance covers mental health certified family peer
374.28 specialists services, ~~as established in subdivision 2, subject to federal approval, if provided~~
374.29 ~~to recipients who have an emotional disturbance or severe emotional disturbance under~~
374.30 ~~chapter 245, and are provided by a certified family peer specialist who has completed the~~
374.31 ~~training under subdivision 5 is qualified according to section 245I.16, subdivision 12.~~ A
374.32 family peer specialist cannot provide services to the peer specialist's family.

375.1 Sec. 51. Minnesota Statutes 2018, section 256B.0616, subdivision 3, is amended to read:

375.2 Subd. 3. **Eligibility.** Family peer support services may be ~~located in~~ provided to recipients
 375.3 of inpatient hospitalization, partial hospitalization, residential treatment, intensive treatment
 375.4 in foster care, day treatment, children's therapeutic services and supports, or crisis services.

375.5 Sec. 52. Minnesota Statutes 2018, section 256B.0622, subdivision 1, is amended to read:

375.6 Subdivision 1. **Scope.** ~~Subject to federal approval,~~ Medical assistance covers medically
 375.7 necessary, assertive community treatment for clients as defined in subdivision 2a and
 375.8 intensive residential treatment services for clients as defined in subdivision 3, when the
 375.9 services are provided by an entity meeting the standards in this section.

375.10 Sec. 53. Minnesota Statutes 2018, section 256B.0622, subdivision 2, is amended to read:

375.11 Subd. 2. **Definitions.** (a) For purposes of this section, the following terms have the
 375.12 meanings given them.

375.13 (b) "ACT team" means the group of interdisciplinary mental health staff who work as
 375.14 a team to provide assertive community treatment.

375.15 (c) "Assertive community treatment" means intensive nonresidential treatment and
 375.16 rehabilitative mental health services provided according to the assertive community treatment
 375.17 model. Assertive community treatment provides a single, fixed point of responsibility for
 375.18 treatment, rehabilitation, and support needs for clients. Services are offered 24 hours per
 375.19 day, seven days per week, in a community-based setting.

375.20 ~~(d) "Individual treatment plan" means the document that results from a person-centered~~
 375.21 ~~planning process of determining real-life outcomes with clients and developing strategies~~
 375.22 ~~to achieve those outcomes.~~

375.23 ~~(e) "Assertive engagement" means the use of collaborative strategies to engage clients~~
 375.24 ~~to receive services.~~

375.25 ~~(f) "Benefits and finance support" means assisting clients in capably managing financial~~
 375.26 ~~affairs. Services include, but are not limited to, assisting clients in applying for benefits;~~
 375.27 ~~assisting with redetermination of benefits; providing financial crisis management; teaching~~
 375.28 ~~and supporting budgeting skills and asset development; and coordinating with a client's~~
 375.29 ~~representative payee, if applicable.~~

375.30 (d) "Clinical trainee" means a staff person qualified according to section 245I.16,
 375.31 subdivision 6.

376.1 ~~(g)~~ (e) "Co-occurring disorder treatment" means the treatment of co-occurring mental
376.2 illness and substance use disorders and is characterized by assertive outreach, stage-wise
376.3 comprehensive treatment, treatment goal setting, and flexibility to work within each stage
376.4 of treatment. Services include, but are not limited to, assessing and tracking clients' stages
376.5 of change readiness and treatment; applying the appropriate treatment based on stages of
376.6 change, such as outreach and motivational interviewing techniques to work with clients in
376.7 earlier stages of change readiness and cognitive behavioral approaches and relapse prevention
376.8 to work with clients in later stages of change; and facilitating access to community supports.

376.9 ~~(h)~~ (f) "Crisis assessment and intervention" means mental health crisis response services
376.10 as defined in section 256B.0624, subdivision 2, paragraphs (c) to (e).

376.11 ~~(i) "Employment services" means assisting clients to work at jobs of their choosing.
376.12 Services must follow the principles of the individual placement and support (IPS)
376.13 employment model, including focusing on competitive employment; emphasizing individual
376.14 client preferences and strengths; ensuring employment services are integrated with mental
376.15 health services; conducting rapid job searches and systematic job development according
376.16 to client preferences and choices; providing benefits counseling; and offering all services
376.17 in an individualized and time-unlimited manner. Services shall also include educating clients
376.18 about opportunities and benefits of work and school and assisting the client in learning job
376.19 skills, navigating the work place, and managing work relationships.~~

376.20 ~~(j) "Family psychoeducation and support" means services provided to the client's family
376.21 and other natural supports to restore and strengthen the client's unique social and family
376.22 relationships. Services include, but are not limited to, individualized psychoeducation about
376.23 the client's illness and the role of the family and other significant people in the therapeutic
376.24 process; family intervention to restore contact, resolve conflict, and maintain relationships
376.25 with family and other significant people in the client's life; ongoing communication and
376.26 collaboration between the ACT team and the family; introduction and referral to family
376.27 self-help programs and advocacy organizations that promote recovery and family
376.28 engagement, individual supportive counseling, parenting training, and service coordination
376.29 to help clients fulfill parenting responsibilities; coordinating services for the child and
376.30 restoring relationships with children who are not in the client's custody; and coordinating
376.31 with child welfare and family agencies, if applicable. These services must be provided with
376.32 the client's agreement and consent.~~

376.33 ~~(k) "Housing access support" means assisting clients to find, obtain, retain, and move
376.34 to safe and adequate housing of their choice. Housing access support includes, but is not
376.35 limited to, locating housing options with a focus on integrated independent settings; applying~~

377.1 ~~for housing subsidies, programs, or resources; assisting the client in developing relationships~~
 377.2 ~~with local landlords; providing tenancy support and advocacy for the individual's tenancy~~
 377.3 ~~rights at the client's home; and assisting with relocation.~~

377.4 (g) "Individual treatment plan" means a plan described under section 256B.0671,
 377.5 subdivisions 5 and 6.

377.6 ~~(h)~~ (h) "Individual treatment team" means a minimum of three members of the ACT
 377.7 team who are responsible for consistently carrying out most of a client's assertive community
 377.8 treatment services.

377.9 ~~(m)~~ (i) "Intensive residential treatment services treatment team" means all staff who
 377.10 provide intensive residential treatment services under this section to clients. ~~At a minimum,~~
 377.11 ~~this includes the clinical supervisor; mental health professionals as defined in section 245.462,~~
 377.12 ~~subdivision 18, clauses (1) to (6); mental health practitioners as defined in section 245.462,~~
 377.13 ~~subdivision 17; mental health rehabilitation workers under section 256B.0623, subdivision~~
 377.14 ~~5, paragraph (a), clause (4); and mental health certified peer specialists under section~~
 377.15 ~~256B.0615.~~

377.16 ~~(n)~~ (j) "Intensive residential treatment services" means short-term, time-limited services
 377.17 provided in a residential setting to clients who are in need of more restrictive settings and
 377.18 are at risk of significant functional deterioration if they do not receive these services. Services
 377.19 are designed to develop and enhance psychiatric stability, personal and emotional adjustment,
 377.20 self-sufficiency, and skills to live in a more independent setting. Services must be directed
 377.21 toward a targeted discharge date with specified client outcomes.

377.22 ~~(o) "Medication assistance and support" means assisting clients in accessing medication,~~
 377.23 ~~developing the ability to take medications with greater independence, and providing~~
 377.24 ~~medication setup. This includes the prescription, administration, and order of medication~~
 377.25 ~~by appropriate medical staff.~~

377.26 ~~(p) "Medication education" means educating clients on the role and effects of medications~~
 377.27 ~~in treating symptoms of mental illness and the side effects of medications.~~

377.28 (k) "Mental health certified peer specialist" means a staff person qualified according to
 377.29 section 245I.16, subdivision 10.

377.30 (l) "Mental health practitioner" means a staff person qualified according to section
 377.31 245I.16, subdivision 4.

377.32 (m) "Mental health professional" means a staff person qualified according to section
 377.33 245I.16, subdivision 2.

378.1 (n) "Mental health rehabilitation worker" means a staff person qualified according to
378.2 section 245I.16, subdivision 14.

378.3 ~~(q)~~ (o) "Overnight staff" means a member of the intensive residential treatment services
378.4 team who is responsible during hours when clients are typically asleep.

378.5 ~~(r) "Mental health certified peer specialist services" has the meaning given in section~~
378.6 ~~256B.0615.~~

378.7 ~~(s)~~ (p) "Physical health services" means any service or treatment to meet the physical
378.8 health needs of the client to support the client's mental health recovery. Services include,
378.9 but are not limited to, education on primary health issues, including wellness education;
378.10 medication administration and monitoring; providing and coordinating medical screening
378.11 and follow-up; scheduling routine and acute medical and dental care visits; tobacco cessation
378.12 strategies; assisting clients in attending appointments; communicating with other providers;
378.13 and integrating all physical and mental health treatment.

378.14 ~~(t)~~ (q) "Primary team member" means the person who leads and coordinates the activities
378.15 of the individual treatment team and is the individual treatment team member who has
378.16 primary responsibility for establishing and maintaining a therapeutic relationship with the
378.17 client on a continuing basis.

378.18 ~~(u)~~ (r) "Rehabilitative mental health services" means mental health services that are
378.19 rehabilitative and enable the client to develop and enhance psychiatric stability, social
378.20 competencies, personal and emotional adjustment, independent living, parenting skills, and
378.21 community skills, when these abilities are impaired by the symptoms of mental illness.

378.22 ~~(v)~~ (s) "Symptom management" means supporting clients in identifying and targeting
378.23 the symptoms and occurrence patterns of their mental illness and developing strategies to
378.24 reduce the impact of those symptoms.

378.25 ~~(w)~~ (t) "Therapeutic interventions" means empirically supported techniques to address
378.26 specific symptoms and behaviors such as anxiety, psychotic symptoms, emotional
378.27 dysregulation, and trauma symptoms. Interventions include empirically supported
378.28 psychotherapies including, but not limited to, cognitive behavioral therapy, exposure therapy,
378.29 acceptance and commitment therapy, interpersonal therapy, and motivational interviewing.

378.30 ~~(x)~~ (u) "Wellness self-management and prevention" means a combination of approaches
378.31 to working with the client to build and apply skills related to recovery, and to support the
378.32 client in participating in leisure and recreational activities, civic participation, and meaningful
378.33 structure.

379.1 Sec. 54. Minnesota Statutes 2018, section 256B.0622, subdivision 3a, is amended to read:

379.2 Subd. 3a. **Provider certification and contract requirements for assertive community**
379.3 **treatment.** (a) The assertive community treatment provider must:

379.4 (1) have a contract with the host county to provide assertive community treatment
379.5 services; and

379.6 (2) have each ACT team be certified by the state following the certification process and
379.7 procedures developed by the commissioner. The certification process determines whether
379.8 the ACT team meets the standards for assertive community treatment under this section as
379.9 ~~well as, chapter 245I, and~~ minimum program fidelity standards as measured by a nationally
379.10 recognized fidelity tool approved by the commissioner. Recertification must occur at least
379.11 every three years.

379.12 (b) An ACT team certified under this subdivision must meet the following standards:

379.13 (1) have capacity to recruit, hire, manage, and train required ACT team members;

379.14 (2) have adequate administrative ability to ensure availability of services;

379.15 ~~(3) ensure adequate preservice and ongoing training for staff;~~

379.16 ~~(4) ensure that staff is capable of implementing culturally specific services that are~~
379.17 ~~culturally responsive and appropriate as determined by the client's culture, beliefs, values,~~
379.18 ~~and language as identified in the individual treatment plan;~~

379.19 ~~(5)~~ (3) ensure flexibility in service delivery to respond to the changing and intermittent
379.20 care needs of a client as identified by the client and the individual treatment plan;

379.21 ~~(6) develop and maintain client files, individual treatment plans, and contact charting;~~

379.22 ~~(7) develop and maintain staff training and personnel files;~~

379.23 ~~(8)~~ (4) submit information as required by the state;

379.24 ~~(9)~~ (5) keep all necessary records required by law;

379.25 ~~(10) comply with all applicable laws;~~

379.26 ~~(11)~~ (6) be an enrolled Medicaid provider;

379.27 ~~(12)~~ (7) establish and maintain a quality assurance plan to determine specific service
379.28 outcomes and the client's satisfaction with services; and

379.29 ~~(13)~~ (8) develop and maintain written policies and procedures regarding service provision
379.30 and administration of the provider entity.

380.1 (c) The commissioner may intervene at any time and decertify an ACT team with cause.
380.2 The commissioner shall establish a process for decertification of an ACT team and shall
380.3 require corrective action, medical assistance repayment, or decertification of an ACT team
380.4 that no longer meets the requirements in this section or that fails to meet the clinical quality
380.5 standards or administrative standards provided by the commissioner in the application and
380.6 certification process. The decertification is subject to appeal to the state.

380.7 Sec. 55. Minnesota Statutes 2018, section 256B.0622, subdivision 4, is amended to read:

380.8 Subd. 4. **Provider entity licensure and contract requirements for intensive residential**
380.9 **treatment services.** (a) The intensive residential treatment services provider entity must:

380.10 (1) be licensed under Minnesota Rules, parts 9520.0500 to 9520.0670;

380.11 (2) not exceed 16 beds per site; and

380.12 (3) comply with the additional standards in this section and chapter 245I.

380.13 (b) The commissioner shall develop procedures for counties and providers to submit
380.14 other documentation as needed to allow the commissioner to determine whether the standards
380.15 in this section are met.

380.16 (c) A provider entity must specify in the provider entity's application what geographic
380.17 area and populations will be served by the proposed program. A provider entity must
380.18 document that the capacity or program specialties of existing programs are not sufficient
380.19 to meet the service needs of the target population. A provider entity must submit evidence
380.20 of ongoing relationships with other providers and levels of care to facilitate referrals to and
380.21 from the proposed program.

380.22 (d) A provider entity must submit documentation that the provider entity requested a
380.23 statement of need from each county board and tribal authority that serves as a local mental
380.24 health authority in the proposed service area. The statement of need must specify if the local
380.25 mental health authority supports or does not support the need for the proposed program and
380.26 the basis for this determination. If a local mental health authority does not respond within
380.27 60 days of the receipt of the request, the commissioner shall determine the need for the
380.28 program based on the documentation submitted by the provider entity.

380.29 Sec. 56. Minnesota Statutes 2018, section 256B.0622, subdivision 5a, is amended to read:

380.30 Subd. 5a. **Standards for intensive residential rehabilitative mental health services.** (a)

380.31 The standards in this subdivision apply to intensive residential mental health services.

381.1 (b) The provider of intensive residential treatment services must have sufficient staff to
381.2 provide 24-hour-per-day coverage to deliver the rehabilitative services described in the
381.3 treatment plan and to safely supervise and direct the activities of clients, given the client's
381.4 level of behavioral and psychiatric stability, cultural needs, and vulnerability. The provider
381.5 must have the capacity within the facility to provide integrated services for chemical
381.6 dependency, illness management services, and family education, when appropriate.

381.7 (c) At a minimum:

381.8 (1) staff must provide direction and supervision whenever clients are present in the
381.9 facility;

381.10 (2) staff must remain awake during all work hours;

381.11 (3) there must be a staffing ratio of at least one to nine clients for each day and evening
381.12 shift. If more than nine clients are present at the residential site, there must be a minimum
381.13 of two staff during day and evening shifts, one of whom must be a mental health practitioner
381.14 or mental health professional;

381.15 (4) if services are provided to clients who need the services of a medical professional,
381.16 the provider shall ensure that these services are provided either by the provider's own medical
381.17 staff or through referral to a medical professional; and

381.18 (5) the provider must ensure the timely availability of a licensed registered nurse, either
381.19 directly employed or under contract, who is responsible for ensuring the effectiveness and
381.20 safety of medication administration in the facility and assessing clients for medication side
381.21 effects and drug interactions.

381.22 (d) Services must be provided by qualified staff as defined in section 256B.0623,
381.23 subdivision 5, ~~who are trained and supervised according to section 256B.0623, subdivision~~
381.24 ~~6, except that mental health rehabilitation workers acting as overnight staff are not required~~
381.25 ~~to comply with section 256B.0623, subdivision 5, paragraph (a), clause (4), item (iv).~~

381.26 (e) The ~~clinical~~ clinical treatment supervisor must be an active member of the intensive residential
381.27 services treatment team. The team must meet with the ~~clinical~~ clinical treatment supervisor at least
381.28 weekly to discuss clients' progress and make rapid adjustments to meet clients' needs. The
381.29 team meeting shall include client-specific case reviews and general treatment discussions
381.30 among team members. Client-specific case reviews and planning must be documented in
381.31 the client's treatment record.

381.32 (f) Treatment staff must have prompt access in person or by telephone to a mental health
381.33 practitioner or mental health professional. The provider must have the capacity to promptly

382.1 and appropriately respond to emergent needs and make any necessary staffing adjustments
382.2 to ensure the health and safety of clients.

382.3 (g) The initial functional assessment must be completed within ten days of intake and
382.4 updated at least every 30 days, or prior to discharge from the service, whichever comes
382.5 first.

382.6 (h) The initial individual treatment plan must be completed within 24 hours of admission.
382.7 Within ten days of admission, the initial treatment plan must be refined and further developed,
382.8 except for providers certified according to Minnesota Rules, parts 9533.0010 to 9533.0180.
382.9 The individual treatment plan must be reviewed with the client and updated at least monthly.

382.10 Sec. 57. Minnesota Statutes 2018, section 256B.0622, subdivision 7, is amended to read:

382.11 Subd. 7. **Assertive community treatment service standards.** (a) ACT teams must
382.12 offer and have the capacity to directly provide the following services:

382.13 (1) assertive engagement using collaborative strategies to encourage clients to receive
382.14 services;

382.15 (2) benefits and finance support; that assists clients to capably manage financial affairs.
382.16 Services include but are not limited to assisting clients in applying for benefits, assisting
382.17 with redetermination of benefits, providing financial crisis management, teaching and
382.18 supporting budgeting skills and asset development, and coordinating with a client's
382.19 representative payee, if applicable;

382.20 (3) co-occurring disorder treatment;

382.21 (4) crisis assessment and intervention;

382.22 (5) employment services; that assists clients to work at jobs of their choosing. Services
382.23 must follow the principles of the individual placement and support employment model,
382.24 including focusing on competitive employment, emphasizing individual client preferences
382.25 and strengths, ensuring employment services are integrated with mental health services,
382.26 conducting rapid job searches and systematic job development according to client preferences
382.27 and choices, providing benefits counseling, and offering all services in an individualized
382.28 and time-unlimited manner. Services must also include educating clients about opportunities
382.29 and benefits of work and school and assisting the client in learning job skills, navigating
382.30 the workplace, and managing work relationships;

382.31 (6) family psychoeducation and support; provided to the client's family and other natural
382.32 supports to restore and strengthen the client's unique social and family relationships. Services

383.1 include but are not limited to individualized psychoeducation about the client's illness and
383.2 the role of the family and other significant people in the therapeutic process; family
383.3 intervention to restore contact, resolve conflict, and maintain relationships with family and
383.4 other significant people in the client's life; ongoing communication and collaboration between
383.5 the ACT team and the family; introduction and referral to family self-help programs and
383.6 advocacy organizations that promote recovery and family engagement, individual supportive
383.7 counseling, parenting training, and service coordination to help clients fulfill parenting
383.8 responsibilities; coordinating services for the child and restoring relationships with children
383.9 who are not in the client's custody; and coordinating with child welfare and family agencies,
383.10 if applicable. These services must be provided with the client's agreement and consent;

383.11 (7) housing access support; that assists clients to find, obtain, retain, and move to safe
383.12 and adequate housing of their choice. Housing access support includes but is not limited to
383.13 locating housing options with a focus on integrated independent settings; applying for
383.14 housing subsidies, programs, or resources; assisting the client in developing relationships
383.15 with local landlords; providing tenancy support and advocacy for the individual's tenancy
383.16 rights at the client's home; and assisting with relocation;

383.17 (8) medication assistance and support; that assists clients in accessing medication,
383.18 developing the ability to take medications with greater independence, and providing
383.19 medication setup. Medication assistance and support includes assisting the client with the
383.20 prescription, administration, and ordering of medication by appropriate medical staff;

383.21 (9) medication education; that educates clients on the role and effects of medications in
383.22 treating symptoms of mental illness and the side effects of medications;

383.23 (10) mental health certified peer specialists services;

383.24 (11) physical health services;

383.25 (12) rehabilitative mental health services;

383.26 (13) symptom management;

383.27 (14) therapeutic interventions;

383.28 (15) wellness self-management and prevention; and

383.29 (16) other services based on client needs as identified in a client's assertive community
383.30 treatment individual treatment plan.

383.31 (b) ACT teams must ensure the provision of all services necessary to meet a client's
383.32 needs as identified in the client's individual treatment plan.

384.1 Sec. 58. Minnesota Statutes 2018, section 256B.0622, subdivision 7a, is amended to read:

384.2 Subd. 7a. **Assertive community treatment team staff requirements and roles.** (a)

384.3 The required treatment staff qualifications and roles for an ACT team are:

384.4 (1) the team leader:

384.5 (i) shall be a ~~licensed~~ mental health professional ~~who is qualified under Minnesota Rules,~~
384.6 ~~part 9505.0371, subpart 5, item A.~~ Individuals who are not licensed but who are eligible
384.7 for licensure and are otherwise qualified may also fulfill this role but must obtain full
384.8 licensure within 24 months of assuming the role of team leader;

384.9 (ii) must be an active member of the ACT team and provide some direct services to
384.10 clients;

384.11 (iii) must be a single full-time staff member, dedicated to the ACT team, who is
384.12 responsible for overseeing the administrative operations of the team, providing ~~clinical~~
384.13 ~~oversight~~ treatment supervision of services in conjunction with the psychiatrist or psychiatric
384.14 care provider, and supervising team members to ensure delivery of best and ethical practices;
384.15 and

384.16 (iv) must be available to provide overall ~~clinical oversight~~ treatment supervision to the
384.17 ACT team after regular business hours and on weekends and holidays. The team leader may
384.18 delegate this duty to another qualified member of the ACT team;

384.19 (2) the psychiatric care provider:

384.20 (i) must be a ~~licensed psychiatrist certified by the American Board of Psychiatry and~~
384.21 ~~Neurology or eligible for board certification or certified by the American Osteopathic Board~~
384.22 ~~of Neurology and Psychiatry or eligible for board certification, or a psychiatric nurse who~~
384.23 ~~is qualified under Minnesota Rules, part 9505.0371, subpart 5, item A~~ mental health
384.24 professional permitted to prescribe psychiatric medications as part of the professional's
384.25 scope of practice. The psychiatric care provider must have demonstrated clinical experience
384.26 working with individuals with serious and persistent mental illness;

384.27 (ii) shall collaborate with the team leader in sharing overall clinical responsibility for
384.28 screening and admitting clients; monitoring clients' treatment and team member service
384.29 delivery; educating staff on psychiatric and nonpsychiatric medications, their side effects,
384.30 and health-related conditions; actively collaborating with nurses; and helping provide ~~clinical~~
384.31 treatment supervision to the team;

384.32 (iii) shall fulfill the following functions for assertive community treatment clients:
384.33 provide assessment and treatment of clients' symptoms and response to medications, including

385.1 side effects; provide brief therapy to clients; provide diagnostic and medication education
385.2 to clients, with medication decisions based on shared decision making; monitor clients'
385.3 nonpsychiatric medical conditions and nonpsychiatric medications; and conduct home and
385.4 community visits;

385.5 (iv) shall serve as the point of contact for psychiatric treatment if a client is hospitalized
385.6 for mental health treatment and shall communicate directly with the client's inpatient
385.7 psychiatric care providers to ensure continuity of care;

385.8 (v) shall have a minimum full-time equivalency that is prorated at a rate of 16 hours per
385.9 50 clients. Part-time psychiatric care providers shall have designated hours to work on the
385.10 team, with sufficient blocks of time on consistent days to carry out the provider's clinical,
385.11 supervisory, and administrative responsibilities. No more than two psychiatric care providers
385.12 may share this role;

385.13 (vi) may not provide specific roles and responsibilities by telemedicine unless approved
385.14 by the commissioner; and

385.15 (vii) shall provide psychiatric backup to the program after regular business hours and
385.16 on weekends and holidays. The psychiatric care provider may delegate this duty to another
385.17 qualified psychiatric provider;

385.18 (3) the nursing staff:

385.19 (i) shall consist of one to three registered nurses or advanced practice registered nurses,
385.20 of whom at least one has a minimum of one-year experience working with adults with
385.21 serious mental illness and a working knowledge of psychiatric medications. No more than
385.22 two individuals can share a full-time equivalent position;

385.23 (ii) are responsible for managing medication, administering and documenting medication
385.24 treatment, and managing a secure medication room; and

385.25 (iii) shall develop strategies, in collaboration with clients, to maximize taking medications
385.26 as prescribed; screen and monitor clients' mental and physical health conditions and
385.27 medication side effects; engage in health promotion, prevention, and education activities;
385.28 communicate and coordinate services with other medical providers; facilitate the development
385.29 of the individual treatment plan for clients assigned; and educate the ACT team in monitoring
385.30 psychiatric and physical health symptoms and medication side effects;

385.31 (4) the co-occurring disorder specialist:

385.32 (i) shall be a full-time equivalent co-occurring disorder specialist who has received
385.33 specific training on co-occurring disorders that is consistent with national evidence-based

386.1 practices. The training must include practical knowledge of common substances and how
386.2 they affect mental illnesses, the ability to assess substance use disorders and the client's
386.3 stage of treatment, motivational interviewing, and skills necessary to provide counseling to
386.4 clients at all different stages of change and treatment. The co-occurring disorder specialist
386.5 may also be an individual who is a licensed alcohol and drug counselor as described in
386.6 section 148F.01, subdivision 5, or a counselor who otherwise meets the training, experience,
386.7 and other requirements in section 245G.11, subdivision 5. No more than two co-occurring
386.8 disorder specialists may occupy this role; and

386.9 (ii) shall provide or facilitate the provision of co-occurring disorder treatment to clients.
386.10 The co-occurring disorder specialist shall serve as a consultant and educator to fellow ACT
386.11 team members on co-occurring disorders;

386.12 (5) the vocational specialist:

386.13 (i) shall be a full-time vocational specialist who has at least one-year experience providing
386.14 employment services or advanced education that involved field training in vocational services
386.15 to individuals with mental illness. An individual who does not meet these qualifications
386.16 may also serve as the vocational specialist upon completing a training plan approved by the
386.17 commissioner;

386.18 (ii) shall provide or facilitate the provision of vocational services to clients. The vocational
386.19 specialist serves as a consultant and educator to fellow ACT team members on these services;
386.20 and

386.21 (iii) ~~shall~~ shall not refer individuals to receive any type of vocational services or linkage
386.22 by providers outside of the ACT team;

386.23 (6) the mental health certified peer specialist:

386.24 (i) shall be a full-time equivalent ~~mental health certified peer specialist as defined in~~
386.25 ~~section 256B.0615~~. No more than two individuals can share this position. The mental health
386.26 certified peer specialist is a fully integrated team member who provides highly individualized
386.27 services in the community and promotes the self-determination and shared decision-making
386.28 abilities of clients. This requirement may be waived due to workforce shortages upon
386.29 approval of the commissioner;

386.30 (ii) must provide coaching, mentoring, and consultation to the clients to promote recovery,
386.31 self-advocacy, and self-direction, promote wellness management strategies, and assist clients
386.32 in developing advance directives; and

387.1 (iii) must model recovery values, attitudes, beliefs, and personal action to encourage
387.2 wellness and resilience, provide consultation to team members, promote a culture where
387.3 the clients' points of view and preferences are recognized, understood, respected, and
387.4 integrated into treatment, and serve in a manner equivalent to other team members;

387.5 (7) the program administrative assistant shall be a full-time office-based program
387.6 administrative assistant position assigned to solely work with the ACT team, providing a
387.7 range of supports to the team, clients, and families; and

387.8 (8) additional staff:

387.9 (i) shall be based on team size. Additional treatment team staff may include licensed
387.10 mental health professionals as defined in Minnesota Rules, part 9505.0371, subpart 5, item
387.11 A; mental health practitioners as defined in section 245.462, subdivision 17; a mental health
387.12 practitioner working as a clinical trainee according to Minnesota Rules, part 9505.0371,
387.13 subpart 5, item C trainees; or mental health rehabilitation workers as defined in section
387.14 256B.0623, subdivision 5, paragraph (a), clause (4). These individuals shall have the
387.15 knowledge, skills, and abilities required by the population served to carry out rehabilitation
387.16 and support functions; and

387.17 (ii) shall be selected based on specific program needs or the population served.

387.18 (b) Each ACT team must clearly document schedules for all ACT team members.

387.19 (c) Each ACT team member must serve as a primary team member for clients assigned
387.20 by the team leader and are responsible for facilitating the individual treatment plan process
387.21 for those clients. The primary team member for a client is the responsible team member
387.22 knowledgeable about the client's life and circumstances and writes the individual treatment
387.23 plan. The primary team member provides individual supportive therapy or counseling, and
387.24 provides primary support and education to the client's family and support system.

387.25 (d) Members of the ACT team must have strong clinical skills, professional qualifications,
387.26 experience, and competency to provide a full breadth of rehabilitation services. Each staff
387.27 member shall be proficient in their respective discipline and be able to work collaboratively
387.28 as a member of a multidisciplinary team to deliver the majority of the treatment,
387.29 rehabilitation, and support services clients require to fully benefit from receiving assertive
387.30 community treatment.

387.31 (e) Each ACT team member must fulfill training requirements established by the
387.32 commissioner.

388.1 Sec. 59. Minnesota Statutes 2018, section 256B.0622, subdivision 7b, is amended to read:

388.2 Subd. 7b. **Assertive community treatment program size and opportunities.** (a) Each
388.3 ACT team shall maintain an annual average caseload that does not exceed 100 clients.

388.4 Staff-to-client ratios shall be based on team size as follows:

388.5 (1) a small ACT team must:

388.6 (i) employ at least six but no more than seven full-time treatment team staff, excluding
388.7 the program assistant and the psychiatric care provider;

388.8 (ii) serve an annual average maximum of no more than 50 clients;

388.9 (iii) ensure at least one full-time equivalent position for every eight clients served;

388.10 (iv) schedule ACT team staff for at least eight-hour shift coverage on weekdays and
388.11 on-call duty to provide crisis services and deliver services after hours when staff are not
388.12 working;

388.13 (v) provide crisis services during business hours if the small ACT team does not have
388.14 sufficient staff numbers to operate an after-hours on-call system. During all other hours,
388.15 the ACT team may arrange for coverage for crisis assessment and intervention services
388.16 through a reliable crisis-intervention provider as long as there is a mechanism by which the
388.17 ACT team communicates routinely with the crisis-intervention provider and the on-call
388.18 ACT team staff are available to see clients face-to-face when necessary or if requested by
388.19 the crisis-intervention services provider;

388.20 (vi) adjust schedules and provide staff to carry out the needed service activities in the
388.21 evenings or on weekend days or holidays, when necessary;

388.22 (vii) arrange for and provide psychiatric backup during all hours the psychiatric care
388.23 provider is not regularly scheduled to work. If availability of the ACT team's psychiatric
388.24 care provider during all hours is not feasible, alternative psychiatric prescriber backup must
388.25 be arranged and a mechanism of timely communication and coordination established in
388.26 writing; and

388.27 (viii) be composed of, at minimum, one full-time team leader, at least 16 hours each
388.28 week per 50 clients of psychiatric provider time, or equivalent if fewer clients, one full-time
388.29 equivalent nursing, one full-time substance abuse specialist, one full-time equivalent mental
388.30 health certified peer specialist, one full-time vocational specialist, one full-time program
388.31 assistant, and at least one additional full-time ACT team member who has mental health
388.32 professional, clinical trainee, or mental health practitioner status; and

389.1 (2) a midsize ACT team shall:

389.2 (i) be composed of, at minimum, one full-time team leader, at least 16 hours of psychiatry
389.3 time for 51 clients, with an additional two hours for every six clients added to the team, 1.5
389.4 to two full-time equivalent nursing staff, one full-time substance abuse specialist, one
389.5 full-time equivalent mental health certified peer specialist, one full-time vocational specialist,
389.6 one full-time program assistant, and at least 1.5 to two additional full-time equivalent ACT
389.7 members, with at least one dedicated full-time staff member with mental health professional
389.8 status. Remaining team members may have mental health professional, clinical trainee, or
389.9 mental health practitioner status;

389.10 (ii) employ seven or more treatment team full-time equivalents, excluding the program
389.11 assistant and the psychiatric care provider;

389.12 (iii) serve an annual average maximum caseload of 51 to 74 clients;

389.13 (iv) ensure at least one full-time equivalent position for every nine clients served;

389.14 (v) schedule ACT team staff for a minimum of ten-hour shift coverage on weekdays
389.15 and six- to eight-hour shift coverage on weekends and holidays. In addition to these minimum
389.16 specifications, staff are regularly scheduled to provide the necessary services on a
389.17 client-by-client basis in the evenings and on weekends and holidays;

389.18 (vi) schedule ACT team staff on-call duty to provide crisis services and deliver services
389.19 when staff are not working;

389.20 (vii) have the authority to arrange for coverage for crisis assessment and intervention
389.21 services through a reliable crisis-intervention provider as long as there is a mechanism by
389.22 which the ACT team communicates routinely with the crisis-intervention provider and the
389.23 on-call ACT team staff are available to see clients face-to-face when necessary or if requested
389.24 by the crisis-intervention services provider; and

389.25 (viii) arrange for and provide psychiatric backup during all hours the psychiatric care
389.26 provider is not regularly scheduled to work. If availability of the psychiatric care provider
389.27 during all hours is not feasible, alternative psychiatric prescriber backup must be arranged
389.28 and a mechanism of timely communication and coordination established in writing;

389.29 (3) a large ACT team must:

389.30 (i) be composed of, at minimum, one full-time team leader, at least 32 hours each week
389.31 per 100 clients, or equivalent of psychiatry time, three full-time equivalent nursing staff,
389.32 one full-time substance abuse specialist, one full-time equivalent mental health certified
389.33 peer specialist, one full-time vocational specialist, one full-time program assistant, and at

- 390.1 least two additional full-time equivalent ACT team members, with at least one dedicated
 390.2 full-time staff member with mental health professional status. Remaining team members
 390.3 may have mental health professional, clinical trainee, or mental health practitioner status;
- 390.4 (ii) employ nine or more treatment team full-time equivalents, excluding the program
 390.5 assistant and psychiatric care provider;
- 390.6 (iii) serve an annual average maximum caseload of 75 to 100 clients;
- 390.7 (iv) ensure at least one full-time equivalent position for every nine individuals served;
- 390.8 (v) schedule staff to work two eight-hour shifts, with a minimum of two staff on the
 390.9 second shift providing services at least 12 hours per day weekdays. For weekends and
 390.10 holidays, the team must operate and schedule ACT team staff to work one eight-hour shift,
 390.11 with a minimum of two staff each weekend day and every holiday;
- 390.12 (vi) schedule ACT team staff on-call duty to provide crisis services and deliver services
 390.13 when staff are not working; and
- 390.14 (vii) arrange for and provide psychiatric backup during all hours the psychiatric care
 390.15 provider is not regularly scheduled to work. If availability of the ACT team psychiatric care
 390.16 provider during all hours is not feasible, alternative psychiatric backup must be arranged
 390.17 and a mechanism of timely communication and coordination established in writing.
- 390.18 (b) An ACT team of any size may have a staff-to-client ratio that is lower than the
 390.19 requirements described in paragraph (a) upon approval by the commissioner, but may not
 390.20 exceed a one-to-ten staff-to-client ratio.

390.21 Sec. 60. Minnesota Statutes 2018, section 256B.0622, subdivision 7d, is amended to read:

390.22 Subd. 7d. **Assertive community treatment assessment and individual treatment**
 390.23 **plan.** (a) An initial assessment, including a diagnostic assessment that meets the requirements
 390.24 of ~~Minnesota Rules, part 9505.0372, subpart 1,~~ section 256B.0671, subdivisions 2 and 3,
 390.25 and a 30-day treatment plan shall be completed the day of the client's admission to assertive
 390.26 community treatment by the ACT team leader or the psychiatric care provider, with
 390.27 participation by designated ACT team members and the client. The team leader, psychiatric
 390.28 care provider, or other mental health professional designated by the team leader or psychiatric
 390.29 care provider, must update the client's diagnostic assessment at least annually.

390.30 (b) An initial functional assessment must be completed within ten days of intake and
 390.31 updated every six months for assertive community treatment, or prior to discharge from the
 390.32 service, whichever comes first.

391.1 (c) Within 30 days of the client's assertive community treatment admission, the ACT
391.2 team shall complete an in-depth assessment of the domains listed under section 245.462,
391.3 subdivision 11a.

391.4 (d) Each part of the in-depth assessment areas shall be completed by each respective
391.5 team specialist or an ACT team member with skill and knowledge in the area being assessed.
391.6 The assessments are based upon all available information, including that from client interview
391.7 family and identified natural supports, and written summaries from other agencies, including
391.8 police, courts, county social service agencies, outpatient facilities, and inpatient facilities,
391.9 where applicable.

391.10 (e) Between 30 and 45 days after the client's admission to assertive community treatment,
391.11 the entire ACT team must hold a comprehensive case conference, where all team members,
391.12 including the psychiatric provider, present information discovered from the completed
391.13 in-depth assessments and provide treatment recommendations. The conference must serve
391.14 as the basis for the first six-month treatment plan, which must be written by the primary
391.15 team member.

391.16 (f) The client's psychiatric care provider, primary team member, and individual treatment
391.17 team members shall assume responsibility for preparing the written narrative of the results
391.18 from the psychiatric and social functioning history timeline and the comprehensive
391.19 assessment.

391.20 (g) The primary team member and individual treatment team members shall be assigned
391.21 by the team leader in collaboration with the psychiatric care provider by the time of the first
391.22 treatment planning meeting or 30 days after admission, whichever occurs first.

391.23 (h) Individual treatment plans must be developed through the following treatment
391.24 planning process:

391.25 (1) The individual treatment plan shall be developed in collaboration with the client and
391.26 the client's preferred natural supports, and guardian, if applicable and appropriate. The ACT
391.27 team shall evaluate, together with each client, the client's needs, strengths, and preferences
391.28 and develop the individual treatment plan collaboratively. The ACT team shall make every
391.29 effort to ensure that the client and the client's family and natural supports, with the client's
391.30 consent, are in attendance at the treatment planning meeting, are involved in ongoing
391.31 meetings related to treatment, and have the necessary supports to fully participate. The
391.32 client's participation in the development of the individual treatment plan shall be documented.

391.33 (2) The client and the ACT team shall work together to formulate and prioritize the
391.34 issues, set goals, research approaches and interventions, and establish the plan. The plan is

392.1 individually tailored so that the treatment, rehabilitation, and support approaches and
 392.2 interventions achieve optimum symptom reduction, help fulfill the personal needs and
 392.3 aspirations of the client, take into account the cultural beliefs and realities of the individual,
 392.4 and improve all the aspects of psychosocial functioning that are important to the client. The
 392.5 process supports strengths, rehabilitation, and recovery.

392.6 (3) Each client's individual treatment plan shall identify service needs, strengths and
 392.7 capacities, and barriers, and set specific and measurable short- and long-term goals for each
 392.8 service need. The individual treatment plan must clearly specify the approaches and
 392.9 interventions necessary for the client to achieve the individual goals, when the interventions
 392.10 shall happen, and identify which ACT team member shall carry out the approaches and
 392.11 interventions.

392.12 (4) The primary team member and the individual treatment team, together with the client
 392.13 and the client's family and natural supports with the client's consent, are responsible for
 392.14 reviewing and rewriting the treatment goals and individual treatment plan whenever there
 392.15 is a major decision point in the client's course of treatment or at least every six months.

392.16 (5) The primary team member shall prepare a summary that thoroughly describes in
 392.17 writing the client's and the individual treatment team's evaluation of the client's progress
 392.18 and goal attainment, the effectiveness of the interventions, and the satisfaction with services
 392.19 since the last individual treatment plan. The client's most recent diagnostic assessment must
 392.20 be included with the treatment plan summary.

392.21 (6) The individual treatment plan and review must be ~~signed~~ approved or acknowledged
 392.22 by the client, the primary team member, the team leader, the psychiatric care provider, and
 392.23 all individual treatment team members. A copy of the ~~signed~~ individual treatment plan is
 392.24 made available to the client.

392.25 Sec. 61. Minnesota Statutes 2018, section 256B.0623, subdivision 1, is amended to read:

392.26 Subdivision 1. **Scope.** Medical assistance covers adult rehabilitative mental health
 392.27 services as defined in subdivision 2, ~~subject to federal approval~~, if provided to recipients
 392.28 as defined in subdivision 3 and provided by a qualified provider entity meeting the standards
 392.29 in this section and by a qualified individual provider working within the provider's scope
 392.30 of practice and identified in the recipient's individual treatment plan ~~as defined~~ described
 392.31 in section ~~245.462, subdivision 14~~ 256B.0671, subdivisions 5 and 6, and if determined to
 392.32 be medically necessary according to section 62Q.53.

393.1 Sec. 62. Minnesota Statutes 2018, section 256B.0623, subdivision 2, is amended to read:

393.2 Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings
393.3 given them.

393.4 (a) "Adult rehabilitative mental health services" means mental health services which are
393.5 rehabilitative and enable the recipient to develop and enhance psychiatric stability, social
393.6 competencies, personal and emotional adjustment, independent living, parenting skills, and
393.7 community skills, when these abilities are impaired by the symptoms of mental illness.

393.8 ~~Adult rehabilitative mental health services are also appropriate when provided to enable a~~
393.9 ~~recipient to retain stability and functioning, if the recipient would be at risk of significant~~
393.10 ~~functional decompensation or more restrictive service settings without these services.~~

393.11 ~~(1) Adult rehabilitative mental health services instruct, assist, and support the recipient~~
393.12 ~~in areas such as: interpersonal communication skills, community resource utilization and~~
393.13 ~~integration skills, crisis assistance, relapse prevention skills, health care directives, budgeting~~
393.14 ~~and shopping skills, healthy lifestyle skills and practices, cooking and nutrition skills,~~
393.15 ~~transportation skills, medication education and monitoring, mental illness symptom~~
393.16 ~~management skills, household management skills, employment-related skills, parenting~~
393.17 ~~skills, and transition to community living services.~~

393.18 ~~(2) These services shall be provided to the recipient on a one-to-one basis in the recipient's~~
393.19 ~~home or another community setting or in groups.~~

393.20 (b) "Medication education services" means services provided individually or in groups
393.21 which focus on educating the recipient about mental illness and symptoms; the role and
393.22 effects of medications in treating symptoms of mental illness; and the side effects of
393.23 medications. Medication education is coordinated with medication management services
393.24 and does not duplicate it. Medication education services are provided by physicians,
393.25 pharmacists, physician assistants, or registered nurses.

393.26 (c) "Transition to community living services" means services which maintain continuity
393.27 of contact between the rehabilitation services provider and the recipient and which facilitate
393.28 discharge from a hospital, residential treatment program under Minnesota Rules, chapter
393.29 9505, board and lodging facility, or nursing home. Transition to community living services
393.30 are not intended to provide other areas of adult rehabilitative mental health services.

393.31 Sec. 63. Minnesota Statutes 2018, section 256B.0623, subdivision 3, is amended to read:

393.32 Subd. 3. **Eligibility.** An eligible recipient is an individual who:

393.33 (1) is age 18 or older;

394.1 (2) is diagnosed with a medical condition, such as mental illness or traumatic brain
394.2 injury, for which adult rehabilitative mental health services are needed;

394.3 (3) has substantial disability and functional impairment in three or more of the areas
394.4 listed in section 245.462, subdivision 11a, so that self-sufficiency is markedly reduced; and

394.5 (4) has had a recent diagnostic assessment ~~or an adult diagnostic assessment update~~ by
394.6 a qualified professional that documents adult rehabilitative mental health services are
394.7 medically necessary to address identified disability and functional impairments and individual
394.8 recipient goals.

394.9 Sec. 64. Minnesota Statutes 2018, section 256B.0623, subdivision 4, is amended to read:

394.10 Subd. 4. **Provider entity standards.** (a) The provider entity must be certified by the
394.11 state following the certification process and procedures developed by the commissioner.

394.12 (b) The certification process is a determination as to whether the entity meets the standards
394.13 in this subdivision and chapter 245I. The certification must specify which adult rehabilitative
394.14 mental health services the entity is qualified to provide.

394.15 (c) A noncounty provider entity must obtain additional certification from each county
394.16 in which it will provide services. The additional certification must be based on the adequacy
394.17 of the entity's knowledge of that county's local health and human service system, and the
394.18 ability of the entity to coordinate its services with the other services available in that county.
394.19 A county-operated entity must obtain this additional certification from any other county in
394.20 which it will provide services.

394.21 (d) State-level recertification must occur at least every three years.

394.22 (e) The commissioner may intervene at any time and decertify providers with cause.
394.23 The decertification is subject to appeal to the state. A county board may recommend that
394.24 the state decertify a provider for cause.

394.25 (f) The adult rehabilitative mental health services provider entity must meet the following
394.26 standards:

394.27 (1) have capacity to recruit, hire, manage, and train ~~mental health professionals, mental~~
394.28 ~~health practitioners, and mental health rehabilitation workers~~ qualified staff;

394.29 (2) have adequate administrative ability to ensure availability of services;

394.30 ~~(3) ensure adequate preservice and inservice and ongoing training for staff;~~

395.1 ~~(4)~~ (3) ensure that ~~mental health professionals, mental health practitioners, and mental~~
395.2 ~~health rehabilitation workers~~ staff are skilled in the delivery of the specific adult rehabilitative
395.3 mental health services provided to the individual eligible recipient;

395.4 ~~(5) ensure that staff is capable of implementing culturally specific services that are~~
395.5 ~~culturally competent and appropriate as determined by the recipient's culture, beliefs, values,~~
395.6 ~~and language as identified in the individual treatment plan;~~

395.7 ~~(6)~~ (4) ensure enough flexibility in service delivery to respond to the changing and
395.8 intermittent care needs of a recipient as identified by the recipient and the individual treatment
395.9 plan;

395.10 ~~(7) ensure that the mental health professional or mental health practitioner, who is under~~
395.11 ~~the clinical supervision of a mental health professional, involved in a recipient's services~~
395.12 ~~participates in the development of the individual treatment plan;~~

395.13 ~~(8)~~ (5) assist the recipient in arranging needed crisis assessment, intervention, and
395.14 stabilization services;

395.15 ~~(9)~~ (6) ensure that services are coordinated with other recipient mental health services
395.16 providers and the county mental health authority and the federally recognized American
395.17 Indian authority and necessary others after obtaining the consent of the recipient. Services
395.18 must also be coordinated with the recipient's case manager or care coordinator if the recipient
395.19 is receiving case management or care coordination services;

395.20 ~~(10) develop and maintain recipient files, individual treatment plans, and contact charting;~~

395.21 ~~(11) develop and maintain staff training and personnel files;~~

395.22 ~~(12)~~ (7) submit information as required by the state;

395.23 ~~(13) establish and maintain a quality assurance plan to evaluate the outcome of services~~
395.24 ~~provided;~~

395.25 ~~(14)~~ (8) keep all necessary records required by law;

395.26 ~~(15)~~ (9) deliver services as required by section 245.461;

395.27 ~~(16) comply with all applicable laws;~~

395.28 ~~(17)~~ (10) be an enrolled Medicaid provider;

395.29 ~~(18)~~ (11) maintain a quality assurance plan to determine specific service outcomes and
395.30 the recipient's satisfaction with services; and

396.1 ~~(19)~~ (12) develop and maintain written policies and procedures regarding service
 396.2 provision and administration of the provider entity.

396.3 Sec. 65. Minnesota Statutes 2018, section 256B.0623, subdivision 5, is amended to read:

396.4 Subd. 5. **Qualifications of provider staff.** ~~(a)~~ Adult rehabilitative mental health services
 396.5 must be provided by qualified individual provider staff of a certified provider entity.

396.6 Individual provider staff must be qualified ~~under~~ as one of the following ~~criteria~~ providers:

396.7 ~~(1) a mental health professional as defined in section 245.462, subdivision 18, clauses~~
 396.8 ~~(1) to (6). If the recipient has a current diagnostic assessment by a licensed mental health~~
 396.9 ~~professional as defined in section 245.462, subdivision 18, clauses (1) to (6), recommending~~
 396.10 ~~receipt of adult mental health rehabilitative services, the definition of mental health~~
 396.11 ~~professional for purposes of this section includes a person who is qualified under section~~
 396.12 ~~245.462, subdivision 18, clause (7), and who holds a current and valid national certification~~
 396.13 ~~as a certified rehabilitation counselor or certified psychosocial rehabilitation practitioner~~
 396.14 qualified according to section 245I.16, subdivision 2;

396.15 (2) a certified rehabilitation specialist qualified according to section 245I.16, subdivision
 396.16 8;

396.17 (3) a clinical trainee qualified according to section 245I.16, subdivision 6;

396.18 ~~(2)~~ (4) a mental health practitioner as defined in section 245.462, subdivision 17. The
 396.19 mental health practitioner must work under the clinical supervision of a mental health
 396.20 professional qualified according to section 245I.16, subdivision 4;

396.21 ~~(3)~~ (5) a mental health certified peer specialist ~~under section 256B.0615. The certified~~
 396.22 ~~peer specialist must work under the clinical supervision of a mental health professional~~
 396.23 qualified according to section 245I.16, subdivision 10; or

396.24 ~~(4)~~ (6) a mental health rehabilitation worker qualified according to section 245I.16,
 396.25 subdivision 14. A mental health rehabilitation worker means a staff person working under
 396.26 the direction of a mental health practitioner or mental health professional and under the
 396.27 clinical supervision of a mental health professional in the implementation of rehabilitative
 396.28 mental health services as identified in the recipient's individual treatment plan who:

396.29 (i) is at least 21 years of age;

396.30 (ii) has a high school diploma or equivalent;

396.31 ~~(iii) has successfully completed 30 hours of training during the two years immediately~~
 396.32 ~~prior to the date of hire, or before provision of direct services, in all of the following areas:~~

397.1 ~~recovery from mental illness, mental health de-escalation techniques, recipient rights,~~
397.2 ~~recipient-centered individual treatment planning, behavioral terminology, mental illness,~~
397.3 ~~co-occurring mental illness and substance abuse, psychotropic medications and side effects,~~
397.4 ~~functional assessment, local community resources, adult vulnerability, recipient~~
397.5 ~~confidentiality; and~~

397.6 ~~(iv) meets the qualifications in paragraph (b).~~

397.7 ~~(b) In addition to the requirements in paragraph (a), a mental health rehabilitation worker~~
397.8 ~~must also meet the qualifications in clause (1), (2), or (3):~~

397.9 ~~(1) has an associates of arts degree, two years of full-time postsecondary education, or~~
397.10 ~~a total of 15 semester hours or 23 quarter hours in behavioral sciences or related fields; is~~
397.11 ~~a registered nurse; or within the previous ten years has:~~

397.12 ~~(i) three years of personal life experience with serious mental illness;~~

397.13 ~~(ii) three years of life experience as a primary caregiver to an adult with a serious mental~~
397.14 ~~illness, traumatic brain injury, substance use disorder, or developmental disability; or~~

397.15 ~~(iii) 2,000 hours of supervised work experience in the delivery of mental health services~~
397.16 ~~to adults with a serious mental illness, traumatic brain injury, substance use disorder, or~~
397.17 ~~developmental disability;~~

397.18 ~~(2)(i) is fluent in the non-English language or competent in the culture of the ethnic~~
397.19 ~~group to which at least 20 percent of the mental health rehabilitation worker's clients belong;~~

397.20 ~~(ii) receives during the first 2,000 hours of work, monthly documented individual clinical~~
397.21 ~~supervision by a mental health professional;~~

397.22 ~~(iii) has 18 hours of documented field supervision by a mental health professional or~~
397.23 ~~mental health practitioner during the first 160 hours of contact work with recipients, and at~~
397.24 ~~least six hours of field supervision quarterly during the following year;~~

397.25 ~~(iv) has review and cosignature of charting of recipient contacts during field supervision~~
397.26 ~~by a mental health professional or mental health practitioner; and~~

397.27 ~~(v) has 15 hours of additional continuing education on mental health topics during the~~
397.28 ~~first year of employment and 15 hours during every additional year of employment; or~~

397.29 ~~(3) for providers of crisis residential services, intensive residential treatment services,~~
397.30 ~~partial hospitalization, and day treatment services:~~

397.31 ~~(i) satisfies clause (2), items (ii) to (iv); and~~

398.1 ~~(ii) has 40 hours of additional continuing education on mental health topics during the~~
 398.2 ~~first year of employment.~~

398.3 ~~(c) A mental health rehabilitation worker who solely acts and is scheduled as overnight~~
 398.4 ~~staff is not required to comply with paragraph (a), clause (4), item (iv).~~

398.5 ~~(d) For purposes of this subdivision, "behavioral sciences or related fields" means an~~
 398.6 ~~education from an accredited college or university and includes but is not limited to social~~
 398.7 ~~work, psychology, sociology, community counseling, family social science, child~~
 398.8 ~~development, child psychology, community mental health, addiction counseling, counseling~~
 398.9 ~~and guidance, special education, and other fields as approved by the commissioner.~~

398.10 Sec. 66. Minnesota Statutes 2018, section 256B.0623, subdivision 6, is amended to read:

398.11 **Subd. 6. Required training and supervision.** ~~(a) Mental health rehabilitation workers~~
 398.12 ~~must receive ongoing continuing education training of at least 30 hours every two years in~~
 398.13 ~~areas of mental illness and mental health services and other areas specific to the population~~
 398.14 ~~being served. Mental health rehabilitation workers must also be subject to the ongoing~~
 398.15 ~~direction and clinical supervision standards in paragraphs (c) and (d) Staff must receive~~
 398.16 ~~training in accordance with section 245I.10.~~

398.17 ~~(b) Mental health practitioners must receive ongoing continuing education training as~~
 398.18 ~~required by their professional license; or if the practitioner is not licensed, the practitioner~~
 398.19 ~~must receive ongoing continuing education training of at least 30 hours every two years in~~
 398.20 ~~areas of mental illness and mental health services. Mental health practitioners must meet~~
 398.21 ~~the ongoing clinical supervision standards in paragraph (c).~~

398.22 ~~(c) Clinical supervision may be provided by a full- or part-time qualified professional~~
 398.23 ~~employed by or under contract with the provider entity. Clinical supervision may be provided~~
 398.24 ~~by interactive videoconferencing according to procedures developed by the commissioner.~~

398.25 (b) Treatment supervision must be provided according to section 245I.18. A mental health
 398.26 professional providing clinical treatment supervision of staff delivering adult rehabilitative
 398.27 mental health services must provide the following guidance:

398.28 ~~(1) review the information in the recipient's file;~~

398.29 ~~(2) review and approve initial and updates of individual treatment plans;~~

398.30 ~~(3) (1) meet with mental health rehabilitation workers and practitioners, individually or~~
 398.31 ~~in small groups, staff receiving direction at least monthly to discuss treatment topics of~~
 398.32 ~~interest to the workers and practitioners;~~

399.1 ~~(4) meet with mental health rehabilitation workers and practitioners, individually or in~~
 399.2 ~~small groups, at least monthly to~~ (2) discuss treatment plans of recipients, ~~and approve by~~
 399.3 ~~signature and document in the recipient's file any resulting plan updates;~~

399.4 ~~(5) meet at least monthly with the directing mental health practitioner, if there is one,~~
 399.5 ~~to~~ (3) review needs of the adult rehabilitative mental health services program, review staff
 399.6 on-site observations and evaluate mental health rehabilitation workers, plan staff training,
 399.7 and review program evaluation and development, ~~and consult with the directing practitioner;~~
 399.8 ~~and;~~

399.9 ~~(6) be available for urgent consultation as the individual recipient needs or the situation~~
 399.10 ~~necessitates.~~

399.11 ~~(d) An adult rehabilitative mental health services provider entity must have a treatment~~
 399.12 ~~director who is a mental health practitioner or mental health professional. The treatment~~
 399.13 ~~director must ensure the following:~~

399.14 ~~(1) while delivering direct services to recipients, a newly hired mental health rehabilitation~~
 399.15 ~~worker must be directly observed delivering services to recipients by a mental health~~
 399.16 ~~practitioner or mental health professional for at least six hours per 40 hours worked during~~
 399.17 ~~the first 160 hours that the mental health rehabilitation worker works;~~

399.18 ~~(2) the mental health rehabilitation worker must receive ongoing on-site direct service~~
 399.19 ~~observation by a mental health professional or mental health practitioner for at least six~~
 399.20 ~~hours for every six months of employment;~~

399.21 ~~(3)~~ (4) review progress notes ~~are reviewed~~ from on-site service observation prepared by
 399.22 the mental health rehabilitation worker and mental health practitioner for accuracy and
 399.23 consistency with actual recipient contact and the individual treatment plan and goals;

399.24 ~~(4)~~ (5) ensure immediate availability by phone or in person for consultation by a mental
 399.25 health professional or a mental health practitioner to the mental health rehabilitation services
 399.26 worker during service provision; and

399.27 ~~(5) oversee the identification of changes in individual recipient treatment strategies,~~
 399.28 ~~revise the plan, and communicate treatment instructions and methodologies as appropriate~~
 399.29 ~~to ensure that treatment is implemented correctly;~~

399.30 ~~(6) model service practices which: respect the recipient, include the recipient in planning~~
 399.31 ~~and implementation of the individual treatment plan, recognize the recipient's strengths,~~
 399.32 ~~collaborate and coordinate with other involved parties and providers;~~

400.1 ~~(7) (6)~~ ensure that mental health practitioners and mental health rehabilitation workers
 400.2 are able to effectively communicate with the recipients, significant others, and providers;
 400.3 ~~and.~~

400.4 ~~(8) oversee the record of the results of on-site observation and charting evaluation and~~
 400.5 ~~corrective actions taken to modify the work of the mental health practitioners and mental~~
 400.6 ~~health rehabilitation workers.~~

400.7 ~~(e) A mental health practitioner who is providing treatment direction for a provider entity~~
 400.8 ~~must receive supervision at least monthly from a mental health professional to:~~

400.9 ~~(1) identify and plan for general needs of the recipient population served;~~

400.10 ~~(2) identify and plan to address provider entity program needs and effectiveness;~~

400.11 ~~(3) identify and plan provider entity staff training and personnel needs and issues; and~~

400.12 ~~(4) plan, implement, and evaluate provider entity quality improvement programs.~~

400.13 Sec. 67. Minnesota Statutes 2018, section 256B.0623, subdivision 7, is amended to read:

400.14 Subd. 7. **Personnel file.** The adult rehabilitative mental health services provider entity
 400.15 must maintain a personnel file on each staff in accordance with section 245I.13. ~~Each file~~
 400.16 ~~must contain:~~

400.17 ~~(1) an annual performance review;~~

400.18 ~~(2) a summary of on-site service observations and charting review;~~

400.19 ~~(3) a criminal background check of all direct service staff;~~

400.20 ~~(4) evidence of academic degree and qualifications;~~

400.21 ~~(5) a copy of professional license;~~

400.22 ~~(6) any job performance recognition and disciplinary actions;~~

400.23 ~~(7) any individual staff written input into own personnel file;~~

400.24 ~~(8) all clinical supervision provided; and~~

400.25 ~~(9) documentation of compliance with continuing education requirements.~~

400.26 Sec. 68. Minnesota Statutes 2018, section 256B.0623, subdivision 8, is amended to read:

400.27 Subd. 8. **Diagnostic assessment.** Providers of adult rehabilitative mental health services
 400.28 must obtain or complete a diagnostic assessment as defined in according to section 245.462,
 400.29 ~~subdivision 9, within five days after the recipient's second visit or within 30 days after~~

401.1 ~~intake, whichever occurs first. In cases where a diagnostic assessment is available that~~
401.2 ~~reflects the recipient's current status, and has been completed within three years preceding~~
401.3 ~~admission, an adult diagnostic assessment update must be completed. An update shall include~~
401.4 ~~a face-to-face interview with the recipient and a written summary by a mental health~~
401.5 ~~professional of the recipient's current mental health status and service needs. If the recipient's~~
401.6 ~~mental health status has changed significantly since the adult's most recent diagnostic~~
401.7 ~~assessment, a new diagnostic assessment is required 256B.0671, subdivisions 2 and 3.~~

401.8 Sec. 69. Minnesota Statutes 2018, section 256B.0623, subdivision 10, is amended to read:

401.9 Subd. 10. **Individual treatment plan.** All providers of adult rehabilitative mental health
401.10 services must develop and implement an individual treatment plan for each recipient. ~~The~~
401.11 ~~provisions in clauses (1) and (2) apply; according to section 256B.0671, subdivisions 5 and~~
401.12 6.

401.13 ~~(1) Individual treatment plan means a plan of intervention, treatment, and services for~~
401.14 ~~an individual recipient written by a mental health professional or by a mental health~~
401.15 ~~practitioner under the clinical supervision of a mental health professional. The individual~~
401.16 ~~treatment plan must be based on diagnostic and functional assessments. To the extent~~
401.17 ~~possible, the development and implementation of a treatment plan must be a collaborative~~
401.18 ~~process involving the recipient, and with the permission of the recipient, the recipient's~~
401.19 ~~family and others in the recipient's support system. Providers of adult rehabilitative mental~~
401.20 ~~health services must develop the individual treatment plan within 30 calendar days of intake.~~
401.21 The treatment plan must be updated at least every six months thereafter, or more often when
401.22 there is significant change in the recipient's situation or functioning, or in services or service
401.23 methods to be used, or at the request of the recipient or the recipient's legal guardian.

401.24 ~~(2) The individual treatment plan must include:~~

401.25 ~~(i) a list of problems identified in the assessment;~~

401.26 ~~(ii) the recipient's strengths and resources;~~

401.27 ~~(iii) concrete, measurable goals to be achieved, including time frames for achievement;~~

401.28 ~~(iv) specific objectives directed toward the achievement of each one of the goals;~~

401.29 ~~(v) documentation of participants in the treatment planning. The recipient, if possible,~~
401.30 ~~must be a participant. The recipient or the recipient's legal guardian must sign the treatment~~
401.31 ~~plan, or documentation must be provided why this was not possible. A copy of the plan~~
401.32 ~~must be given to the recipient or legal guardian. Referral to formal services must be arranged,~~
401.33 ~~including specific providers where applicable;~~

402.1 ~~(vi) cultural considerations, resources, and needs of the recipient must be included;~~

402.2 ~~(vii) planned frequency and type of services must be initiated; and~~

402.3 ~~(viii) clear progress notes on outcome of goals.~~

402.4 ~~(3) The individual community support plan defined in section 245.462, subdivision 12,~~
 402.5 ~~may serve as the individual treatment plan if there is involvement of a mental health case~~
 402.6 ~~manager, and with the approval of the recipient. The individual community support plan~~
 402.7 ~~must include the criteria in clause (2).~~

402.8 Sec. 70. Minnesota Statutes 2018, section 256B.0623, subdivision 11, is amended to read:

402.9 Subd. 11. **Recipient file.** Providers of adult rehabilitative mental health services must
 402.10 maintain a file for each recipient ~~that contains the following information:~~ according to
 402.11 section 245I.32.

402.12 ~~(1) diagnostic assessment or verification of its location that is current and that was~~
 402.13 ~~reviewed by a mental health professional who is employed by or under contract with the~~
 402.14 ~~provider entity;~~

402.15 ~~(2) functional assessments;~~

402.16 ~~(3) individual treatment plans signed by the recipient and the mental health professional,~~
 402.17 ~~or if the recipient refused to sign the plan, the date and reason stated by the recipient as to~~
 402.18 ~~why the recipient would not sign the plan;~~

402.19 ~~(4) recipient history;~~

402.20 ~~(5) signed release forms;~~

402.21 ~~(6) recipient health information and current medications;~~

402.22 ~~(7) emergency contacts for the recipient;~~

402.23 ~~(8) case records which document the date of service, the place of service delivery,~~
 402.24 ~~signature of the person providing the service, nature, extent and units of service, and place~~
 402.25 ~~of service delivery;~~

402.26 ~~(9) contacts, direct or by telephone, with recipient's family or others, other providers,~~
 402.27 ~~or other resources for service coordination;~~

402.28 ~~(10) summary of recipient case reviews by staff; and~~

402.29 ~~(11) written information by the recipient that the recipient requests be included in the~~
 402.30 ~~file.~~

403.1 Sec. 71. Minnesota Statutes 2018, section 256B.0623, subdivision 12, is amended to read:

403.2 Subd. 12. **Additional requirements.** (a) Providers of adult rehabilitative mental health
403.3 services must comply with the requirements relating to referrals for case management in
403.4 section 245.467, subdivision 4.

403.5 (b) Adult rehabilitative mental health services are provided for most recipients in the
403.6 recipient's home and community. Services may also be provided at the home of a relative
403.7 or significant other, job site, psychosocial clubhouse, drop-in center, social setting, classroom,
403.8 or other places in the community. Except for "transition to community services," the place
403.9 of service does not include a regional treatment center, nursing home, residential treatment
403.10 facility licensed under Minnesota Rules, parts 9520.0500 to 9520.0670 (Rule 36), or an
403.11 acute care hospital.

403.12 (c) Adult rehabilitative mental health services may be provided in group settings if
403.13 appropriate to each participating recipient's needs and treatment plan. A group is defined
403.14 as two to ten clients, at least one of whom is a recipient, who is concurrently receiving a
403.15 service which is identified in this section. The service and group must be specified in the
403.16 recipient's treatment plan. No more than two qualified staff may bill Medicaid for services
403.17 provided to the same group of recipients. If two adult rehabilitative mental health workers
403.18 bill for recipients in the same group session, they must each bill for different recipients.

403.19 (d) Adult rehabilitative mental health services are appropriate if provided to enable a
403.20 recipient to retain stability and functioning, when the recipient is at risk of significant
403.21 functional decompensation or requiring more restrictive service settings without these
403.22 services.

403.23 (e) Adult rehabilitative mental health services instruct, assist, and support the recipient
403.24 in areas including: interpersonal communication skills, community resource utilization and
403.25 integration skills, crisis planning, relapse prevention skills, health care directives, budgeting
403.26 and shopping skills, healthy lifestyle skills and practices, cooking and nutrition skills,
403.27 transportation skills, medication education and monitoring, mental illness symptom
403.28 management skills, household management skills, employment-related skills, parenting
403.29 skills, and transition to community living services.

403.30 (f) Community intervention, including consultation with relatives, guardians, friends,
403.31 employers, treatment providers, and other significant individuals, is appropriate when
403.32 directed exclusively to the treatment of the client.

404.1 Sec. 72. Minnesota Statutes 2018, section 256B.0624, subdivision 2, is amended to read:

404.2 Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings
404.3 given them.

404.4 (a) "Mental health crisis" is an adult behavioral, emotional, or psychiatric situation
404.5 which, but for the provision of crisis response services, would likely result in significantly
404.6 reduced levels of functioning in primary activities of daily living, or in an emergency
404.7 situation, or in the placement of the recipient in a more restrictive setting, including, but
404.8 not limited to, inpatient hospitalization.

404.9 (b) "Mental health emergency" is an adult behavioral, emotional, or psychiatric situation
404.10 which causes an immediate need for mental health services and is consistent with section
404.11 62Q.55.

404.12 A mental health crisis or emergency is determined for medical assistance service
404.13 reimbursement by a physician, a mental health professional, or ~~crisis mental health~~
404.14 ~~practitioner~~ qualified member of a crisis team with input from the recipient whenever
404.15 possible.

404.16 (c) "Mental health crisis assessment" means an immediate face-to-face assessment by
404.17 a physician, a mental health professional, or ~~mental health practitioner under the clinical~~
404.18 ~~supervision of a mental health professional,~~ qualified member of a crisis team following a
404.19 screening that suggests that the adult may be experiencing a mental health crisis or mental
404.20 health emergency situation. It includes, when feasible, assessing whether the person might
404.21 be willing to voluntarily accept treatment, determining whether the person has an advance
404.22 directive, and obtaining information and history from involved family members or caretakers.

404.23 (d) "Mental health mobile crisis intervention services" means face-to-face, short-term
404.24 intensive mental health services initiated during a mental health crisis or mental health
404.25 emergency to help the recipient cope with immediate stressors, identify and utilize available
404.26 resources and strengths, engage in voluntary treatment, and begin to return to the recipient's
404.27 baseline level of functioning. The services, including screening and treatment plan
404.28 recommendations, must be culturally and linguistically appropriate.

404.29 (1) This service is provided on site by a mobile crisis intervention team outside of an
404.30 inpatient hospital setting. Mental health mobile crisis intervention services must be available
404.31 24 hours a day, seven days a week.

404.32 (2) The initial screening must consider other available services to determine which
404.33 service intervention would best address the recipient's needs and circumstances.

405.1 (3) The mobile crisis intervention team must be available to meet promptly face-to-face
405.2 with a person in mental health crisis or emergency in a community setting or hospital
405.3 emergency room.

405.4 (4) The intervention must consist of a mental health crisis assessment and a crisis
405.5 treatment plan.

405.6 (5) The team must be available to individuals who are experiencing a co-occurring
405.7 substance use disorder, who do not need the level of care provided in a detoxification facility.

405.8 (6) The treatment plan must include recommendations for any needed crisis stabilization
405.9 services for the recipient, including engagement in treatment planning and family
405.10 psychoeducation.

405.11 (e) "Mental health crisis stabilization services" means individualized mental health
405.12 services provided to a recipient following crisis intervention services which are designed
405.13 to restore the recipient to the recipient's prior functional level. Mental health crisis
405.14 stabilization services may be provided in the recipient's home, the home of a family member
405.15 or friend of the recipient, another community setting, or a short-term supervised, licensed
405.16 residential program. Mental health crisis stabilization does not include partial hospitalization
405.17 or day treatment. Mental health crisis stabilization services includes family psychoeducation.

405.18 (f) "Clinical trainee" means a person qualified according to section 245I.16, subdivision
405.19 6.

405.20 (g) "Mental health certified family peer specialist" means a person qualified according
405.21 to section 245I.16, subdivision 12.

405.22 (h) "Mental health certified peer specialist" means a person qualified according to section
405.23 245I.16, subdivision 10.

405.24 (i) "Mental health practitioner" means a person qualified according to section 245I.16,
405.25 subdivision 4.

405.26 (j) "Mental health professional" means a person qualified according to section 245I.16,
405.27 subdivision 2.

405.28 (k) "Mental health rehabilitation worker" means a person qualified according to section
405.29 245I.16, subdivision 14.

405.30 Sec. 73. Minnesota Statutes 2018, section 256B.0624, subdivision 4, is amended to read:

405.31 Subd. 4. **Provider entity standards.** (a) A provider entity is an entity that meets the
405.32 standards listed in paragraph (c) and:

406.1 (1) is a county board operated entity; ~~or~~

406.2 (2) is an Indian health service facility or facility owned and operated by a tribe or a tribal
 406.3 organization operating under United States Code, title 25, section 450f; or

406.4 (3) is a provider entity that is under contract with the county board in the county where
 406.5 the potential crisis or emergency is occurring. To provide services under this section, the
 406.6 provider entity must directly provide the services; or if services are subcontracted, the
 406.7 provider entity must maintain responsibility for services and billing.

406.8 (b) A provider entity that provides crisis stabilization services in a residential setting
 406.9 under subdivision 7 is not required to meet the requirements of paragraph (a), clauses (1)
 406.10 ~~and (2)~~ to (3), and paragraph (c), clauses (9), (20), and (21), but must meet all other
 406.11 requirements of this subdivision. Upon approval by the commissioner, a residential crisis
 406.12 services provider meeting relevant standards for supervision and assessment may allow a
 406.13 practitioner to perform a crisis assessment to establish eligibility for admission to the
 406.14 program. A provider performing an assessment under this paragraph shall not bill separately
 406.15 beyond the daily rate for the residential stabilization program.

406.16 (c) The adult mental health crisis response services provider entity must have the capacity
 406.17 to meet and carry out the requirements in chapter 245I and the following standards:

406.18 (1) has the capacity to recruit, hire, and manage and train ~~mental health professionals,~~
 406.19 ~~practitioners, and rehabilitation workers~~ qualified staff;

406.20 (2) has adequate administrative ability to ensure availability of services;

406.21 (3) is able to ensure adequate preservice and in-service training;

406.22 (4) is able to ensure that staff providing these services are skilled in the delivery of
 406.23 mental health crisis response services to recipients;

406.24 (5) is able to ensure that staff are capable of implementing culturally specific treatment
 406.25 identified in the individual treatment plan that is meaningful and appropriate as determined
 406.26 by the recipient's culture, beliefs, values, and language;

406.27 (6) is able to ensure enough flexibility to respond to the changing intervention and care
 406.28 needs of a recipient as identified by the recipient during the service partnership between
 406.29 the recipient and providers;

406.30 (7) is able to ensure that ~~mental health professionals and mental health practitioners~~ staff
 406.31 have the communication tools and procedures to communicate and consult promptly about
 406.32 crisis assessment and interventions as services occur;

407.1 (8) is able to coordinate these services with county emergency services, community
407.2 hospitals, ambulance, transportation services, social services, law enforcement, and mental
407.3 health crisis services through regularly scheduled interagency meetings;

407.4 (9) is able to ensure that mental health crisis assessment and mobile crisis intervention
407.5 services are available 24 hours a day, seven days a week;

407.6 (10) is able to ensure that services are coordinated with other mental health service
407.7 providers, county mental health authorities, or federally recognized American Indian
407.8 authorities and others as necessary, with the consent of the adult. Services must also be
407.9 coordinated with the recipient's case manager if the adult is receiving case management
407.10 services;

407.11 (11) is able to coordinate services with detoxification according to Minnesota Rules,
407.12 parts 9530.6605 to 9530.6655, or withdrawal management according to chapter 245F to
407.13 ensure a recipient receives care that is responsive to the recipient's chemical and mental
407.14 health needs;

407.15 (12) is able to ensure that crisis intervention services are provided in a manner consistent
407.16 with sections 245.461 to 245.486;

407.17 ~~(12)~~ (13) is able to submit information as required by the state;

407.18 ~~(13)~~ (14) maintains staff training and personnel files, including documentation of staff
407.19 completion of required training modules;

407.20 ~~(14)~~ (15) is able to establish and maintain a quality assurance and evaluation plan to
407.21 evaluate the outcomes of services and recipient satisfaction, including notifying recipients
407.22 of the process by which the provider, county, or tribe accepts and responds to concerns;

407.23 ~~(15)~~ (16) is able to keep records as required by applicable laws;

407.24 ~~(16)~~ (17) is able to comply with all applicable laws and statutes;

407.25 ~~(17)~~ (18) is an enrolled medical assistance provider; ~~and~~

407.26 ~~(18)~~ (19) develops and maintains written policies and procedures regarding service
407.27 provision and administration of the provider entity, including safety of staff and recipients
407.28 in high-risk situations;

407.29 (20) is able to respond to a call for crisis services in a designated service area or according
407.30 to a written agreement with the local mental health authority for an adjacent area; and

407.31 (21) documents protocol used when delivering services by telemedicine, according to
407.32 sections 62A.67 to 62A.672, including responsibilities of the originating site, means to

408.1 promote recipient safety, timeliness for connection and response, and steps to take in the
408.2 event of a lost connection.

408.3 Sec. 74. Minnesota Statutes 2018, section 256B.0624, subdivision 5, is amended to read:

408.4 Subd. 5. **Mobile crisis intervention staff qualifications.** ~~For provision of adult mental~~
408.5 ~~health mobile crisis intervention services, a mobile crisis intervention team is comprised of~~
408.6 ~~at least two mental health professionals as defined in section 245.462, subdivision 18, clauses~~
408.7 ~~(1) to (6), or a combination of at least one mental health professional and one mental health~~
408.8 ~~practitioner as defined in section 245.462, subdivision 17, with the required mental health~~
408.9 ~~crisis training and under the clinical supervision of a mental health professional on the team.~~

408.10 (a) Mobile crisis intervention team staff must be qualified to provide services as mental
408.11 health professionals, mental health practitioners, clinical trainees, mental health certified
408.12 family peer specialists, or mental health certified peer specialists.

408.13 (b) A mobile crisis intervention team is comprised of at least two members, one of whom
408.14 must be qualified as a mental health professional. A second member must be qualified as
408.15 a mental health professional, clinical trainee, or mental health practitioner. A provider entity
408.16 must consider the needs of the area served when adding staff.

408.17 (c) Mental health crisis assessment and intervention services must be led by a mental
408.18 health professional, or under the supervision of a mental health professional according to
408.19 subdivision 9, by a clinical trainee or mental health practitioner.

408.20 (d) The team must have at least two people with at least one member providing on-site
408.21 crisis intervention services when needed. Team members must be experienced in mental
408.22 health assessment, crisis intervention techniques, treatment engagement strategies, working
408.23 with families, and clinical decision-making under emergency conditions and have knowledge
408.24 of local services and resources. The team must recommend and coordinate the team's services
408.25 with appropriate local resources such as the county social services agency, mental health
408.26 services, and local law enforcement when necessary.

408.27 Sec. 75. Minnesota Statutes 2018, section 256B.0624, subdivision 6, is amended to read:

408.28 Subd. 6. **Crisis assessment and mobile intervention treatment planning.** (a) Prior to
408.29 initiating mobile crisis intervention services, a screening of the potential crisis situation
408.30 must be conducted. The screening may use the resources of crisis assistance and emergency
408.31 services as defined in sections 245.462, subdivision 6, and 245.469, subdivisions 1 and 2.

409.1 The screening must gather information, determine whether a crisis situation exists, identify
409.2 parties involved, and determine an appropriate response.

409.3 (b) In conducting the screening, a provider shall:

409.4 (1) employ evidence-based practices as identified by the commissioner in collaboration
409.5 with the commissioner of health to reduce the risk of the recipient's suicide and self-injurious
409.6 behavior;

409.7 (2) work with the recipient to establish a plan and time frame for responding to the crisis,
409.8 including immediate needs for support by telephone or text message until a face-to-face
409.9 response arrives;

409.10 (3) document significant factors related to the determination of a crisis, including prior
409.11 calls to the crisis team, recent presentation at an emergency department, known calls to 911
409.12 or law enforcement, or the presence of third parties with knowledge of a potential recipient's
409.13 history or current needs;

409.14 (4) screen for the needs of a third-party caller, including a recipient who primarily
409.15 identifies as a family member or a caregiver but also presents signs of a crisis; and

409.16 (5) provide psychoeducation, including education on the available means for reducing
409.17 self-harm, to relevant third parties, including family members or other persons living in the
409.18 home.

409.19 (c) A provider entity shall consider the following to indicate a positive screening unless
409.20 the provider entity documents specific evidence to show why crisis response was clinically
409.21 inappropriate:

409.22 (1) the recipient presented in an emergency department or urgent care setting, and the
409.23 health care team at that location requested crisis services; or

409.24 (2) a peace officer requested crisis services for a recipient who may be subject to
409.25 transportation under section 253B.05 for a mental health crisis.

409.26 ~~(b)~~ (d) If a crisis exists, a crisis assessment must be completed. A crisis assessment
409.27 evaluates any immediate needs for which emergency services are needed and, as time
409.28 permits, the recipient's current life situation, health information including current medications,
409.29 sources of stress, mental health problems and symptoms, strengths, cultural considerations,
409.30 support network, vulnerabilities, current functioning, and the recipient's preferences as
409.31 communicated directly by the recipient, or as communicated in a health care directive as
409.32 described in chapters 145C and 253B, the treatment plan described under paragraph (d), a
409.33 crisis prevention plan, or a wellness recovery action plan.

410.1 ~~(e)~~ (e) If the crisis assessment determines mobile crisis intervention services are needed,
410.2 the intervention services must be provided promptly. As opportunity presents during the
410.3 intervention, at least two members of the mobile crisis intervention team must confer directly
410.4 or by telephone about the assessment, treatment plan, and actions taken and needed. At least
410.5 one of the team members must be on site providing crisis intervention services. If providing
410.6 on-site crisis intervention services, a mental health practitioner must seek ~~clinical~~ clinical treatment
410.7 supervision as required in subdivision 9.

410.8 (f) Direct contact with the recipient is not required before initiating a crisis assessment
410.9 or intervention service. A crisis team may gather relevant information from a third party at
410.10 the scene to establish the need for services and potential safety factors. A crisis assessment
410.11 is provided face-to-face by a mobile crisis intervention team outside of an inpatient hospital
410.12 setting. A service must be provided promptly and respond to the recipient's location whenever
410.13 possible, including community or clinical settings. As clinically appropriate, a mobile crisis
410.14 intervention team must coordinate a response with other health care providers if a recipient
410.15 requires detoxification, withdrawal management, or medical stabilization services in addition
410.16 to crisis services.

410.17 ~~(d)~~ (g) The mobile crisis intervention team must develop an initial, brief crisis treatment
410.18 plan as soon as appropriate but no later than 24 hours after the initial face-to-face intervention.
410.19 The plan must address the needs and problems noted in the crisis assessment and include
410.20 measurable short-term goals, cultural considerations, and frequency and type of services to
410.21 be provided to achieve the goals and reduce or eliminate the crisis. The treatment plan must
410.22 be updated as needed to reflect current goals and services.

410.23 ~~(e)~~ (h) The team must document which short-term goals have been met and when no
410.24 further crisis intervention services are required. If after an assessment a crisis provider entity
410.25 refers a recipient to an intensive setting, including an emergency department, in-patient
410.26 hospitalization, or crisis residential treatment, one of the crisis team members who performed
410.27 or conferred on the assessment must immediately contact the provider entity and consult
410.28 with the triage nurse or other staff responsible for intake. The crisis team member must
410.29 convey key findings or concerns that led to the referral. The consultation shall occur with
410.30 the recipient's consent, the recipient's legal guardian's consent, or as allowed by section
410.31 144.293, subdivision 5. Any available written documentation, including a crisis treatment
410.32 plan, must be sent no later than the next business day.

410.33 ~~(f)~~ (i) If the recipient's crisis is stabilized, but the recipient needs a referral to other
410.34 services, the team must provide referrals to these services. If the recipient has a case manager,
410.35 planning for other services must be coordinated with the case manager. If the recipient is

411.1 unable to follow up on the referral, the team must link the recipient to the service and follow
411.2 up to ensure the recipient is receiving the service.

411.3 ~~(g)~~ (j) If the recipient's crisis is stabilized and the recipient does not have an advance
411.4 directive, the case manager or crisis team shall offer to work with the recipient to develop
411.5 one.

411.6 (k) If an intervention service is provided without the recipient present, the provider shall
411.7 document the reasons why the service is more effective without the recipient present.

411.8 Sec. 76. Minnesota Statutes 2018, section 256B.0624, subdivision 7, is amended to read:

411.9 **Subd. 7. Crisis stabilization services.** (a) Crisis stabilization services must be provided
411.10 by qualified staff of a crisis stabilization services provider entity and must meet the following
411.11 standards:

411.12 (1) a crisis stabilization treatment plan must be developed which meets the criteria in
411.13 subdivision 11;

411.14 (2) staff must be qualified as defined in subdivision 8; ~~and~~

411.15 (3) services must be delivered according to the treatment plan and include face-to-face
411.16 contact with the recipient by qualified staff for further assessment, help with referrals,
411.17 updating of the crisis stabilization treatment plan, supportive counseling, skills training,
411.18 and collaboration with other service providers in the community; and

411.19 (4) if a stabilization service is provided without the recipient present, the provider shall
411.20 document the reasons why the service is more effective without the recipient present.

411.21 (b) If crisis stabilization services are provided in a supervised, licensed residential setting,
411.22 the recipient must be contacted face-to-face daily by a qualified mental health practitioner
411.23 or mental health professional. The program must have 24-hour-a-day residential staffing
411.24 which may include staff who do not meet the qualifications in subdivision 8. The residential
411.25 staff must have 24-hour-a-day immediate direct or telephone access to a qualified mental
411.26 health professional or practitioner.

411.27 (c) If crisis stabilization services are provided in a supervised, licensed residential setting
411.28 that serves no more than four adult residents, and one or more individuals are present at the
411.29 setting to receive residential crisis stabilization services, the residential staff must include,
411.30 for at least eight hours per day, at least one individual who meets the qualifications in
411.31 subdivision 8, paragraph (a), clause (1) or (2).

412.1 (d) If crisis stabilization services are provided in a supervised, licensed residential setting
 412.2 that serves more than four adult residents, and one or more are recipients of crisis stabilization
 412.3 services, the residential staff must include, for 24 hours a day, at least one individual who
 412.4 meets the qualifications in subdivision 8. When more than four residents are present at the
 412.5 setting during the first 48 hours that a recipient is in the residential program, the residential
 412.6 program must have at least two staff working 24 hours a day. Staffing levels may be adjusted
 412.7 thereafter according to the needs of the recipient as specified in the crisis stabilization
 412.8 treatment plan.

412.9 Sec. 77. Minnesota Statutes 2018, section 256B.0624, subdivision 8, is amended to read:

412.10 Subd. 8. **Adult crisis stabilization staff qualifications.** ~~(a)~~ Adult mental health crisis
 412.11 stabilization services must be provided by qualified individual staff of a qualified provider
 412.12 entity. Individual provider staff must ~~have the following qualifications~~ be:

412.13 (1) ~~be a mental health professional as defined in section 245.462, subdivision 18, clauses~~
 412.14 ~~(1) to (6);~~

412.15 (2) ~~be a mental health practitioner as defined in section 245.462, subdivision 17. The~~
 412.16 ~~mental health practitioner must work under the clinical supervision of a mental health~~
 412.17 ~~professional;~~

412.18 (3) ~~be a mental health certified peer specialist under section 256B.0615. The certified~~
 412.19 ~~peer specialist must work under the clinical supervision of a mental health professional; or~~

412.20 (4) ~~be a mental health rehabilitation worker who meets the criteria in section 256B.0623,~~
 412.21 ~~subdivision 5, paragraph (a), clause (4); works under the direction of a mental health~~
 412.22 ~~practitioner as defined in section 245.462, subdivision 17, or under direction of a mental~~
 412.23 ~~health professional; and works under the clinical supervision of a mental health professional.~~

412.24 ~~(b) Mental health practitioners and mental health rehabilitation workers must have~~
 412.25 ~~completed at least 30 hours of training in crisis intervention and stabilization during the~~
 412.26 ~~past two years.~~

412.27 Sec. 78. Minnesota Statutes 2018, section 256B.0624, subdivision 9, is amended to read:

412.28 Subd. 9. **Supervision.** Mental health practitioners or clinical trainees may provide crisis
 412.29 assessment and mobile crisis intervention services if the following ~~clinical~~ treatment
 412.30 supervision requirements are met:

412.31 (1) the mental health provider entity must accept full responsibility for the services
 412.32 provided;

413.1 (2) the mental health professional of the provider entity, who is an employee or under
 413.2 contract with the provider entity, must be immediately available by phone or in person for
 413.3 clinical supervision;

413.4 (3) the mental health professional is consulted, in person or by phone, during the first
 413.5 three hours when a mental health practitioner or clinical trainee provides on-site service;

413.6 (4) the mental health professional must:

413.7 (i) review and approve of the tentative crisis assessment and crisis treatment plan;

413.8 (ii) document the consultation; and

413.9 (iii) sign the crisis assessment and treatment plan within the next business day; and

413.10 ~~(5) if the mobile crisis intervention services continue into a second calendar day, a mental~~
 413.11 ~~health professional must contact the recipient face-to-face on the second day to provide~~
 413.12 ~~services and update the crisis treatment plan; and~~

413.13 ~~(6)~~ (5) the on-site observation must be documented in the recipient's record and signed
 413.14 by the mental health professional.

413.15 Sec. 79. Minnesota Statutes 2018, section 256B.0624, subdivision 11, is amended to read:

413.16 Subd. 11. **Treatment plan.** The individual crisis stabilization treatment plan must include,
 413.17 at a minimum:

413.18 (1) a list of problems identified in the assessment;

413.19 (2) a list of the recipient's strengths and resources;

413.20 (3) concrete, measurable short-term goals and tasks to be achieved, including time frames
 413.21 for achievement;

413.22 (4) specific objectives directed toward the achievement of each one of the goals;

413.23 (5) documentation of the participants involved in the service planning. The recipient, if
 413.24 possible, must be a participant. The recipient or the recipient's legal guardian must sign the
 413.25 service plan or documentation must be provided why this was not possible. A copy of the
 413.26 plan must be given to the recipient and the recipient's legal guardian. The plan should include
 413.27 services arranged, including specific providers where applicable;

413.28 (6) planned frequency and type of services initiated;

413.29 (7) a crisis response action plan if a crisis should occur;

413.30 (8) clear progress notes on outcome of goals;

414.1 (9) a written plan must be completed within 24 hours of beginning services with the
414.2 recipient; and

414.3 (10) a treatment plan must be developed by a mental health professional, clinical trainee,
414.4 or mental health practitioner ~~under the clinical supervision of a mental health professional.~~
414.5 The mental health professional must approve and sign all treatment plans.

414.6 Sec. 80. Minnesota Statutes 2018, section 256B.0625, subdivision 3b, is amended to read:

414.7 Subd. 3b. **Telemedicine services.** (a) Medical assistance covers medically necessary
414.8 services and consultations delivered by a licensed health care provider via telemedicine in
414.9 the same manner as if the service or consultation was delivered in person. Coverage is
414.10 limited to three telemedicine services per enrollee per calendar week. Telemedicine services
414.11 shall be paid at the full allowable rate.

414.12 (b) The commissioner shall establish criteria that a health care provider must attest to
414.13 in order to demonstrate the safety or efficacy of delivering a particular service via
414.14 telemedicine. The attestation may include that the health care provider:

414.15 (1) has identified the categories or types of services the health care provider will provide
414.16 via telemedicine;

414.17 (2) has written policies and procedures specific to telemedicine services that are regularly
414.18 reviewed and updated;

414.19 (3) has policies and procedures that adequately address patient safety before, during,
414.20 and after the telemedicine service is rendered;

414.21 (4) has established protocols addressing how and when to discontinue telemedicine
414.22 services; and

414.23 (5) has an established quality assurance process related to telemedicine services.

414.24 (c) As a condition of payment, a licensed health care provider must document each
414.25 occurrence of a health service provided by telemedicine to a medical assistance enrollee.
414.26 Health care service records for services provided by telemedicine must meet the requirements
414.27 set forth in Minnesota Rules, part 9505.2175, subparts 1 and 2, and must document:

414.28 (1) the type of service provided by telemedicine;

414.29 (2) the time the service began and the time the service ended, including an a.m. and p.m.
414.30 designation;

415.1 (3) the licensed health care provider's basis for determining that telemedicine is an
415.2 appropriate and effective means for delivering the service to the enrollee;

415.3 (4) the mode of transmission of the telemedicine service and records evidencing that a
415.4 particular mode of transmission was utilized;

415.5 (5) the location of the originating site and the distant site;

415.6 (6) if the claim for payment is based on a physician's telemedicine consultation with
415.7 another physician, the written opinion from the consulting physician providing the
415.8 telemedicine consultation; and

415.9 (7) compliance with the criteria attested to by the health care provider in accordance
415.10 with paragraph (b).

415.11 (d) For purposes of this subdivision, unless otherwise covered under this chapter,
415.12 "telemedicine" is defined as the delivery of health care services or consultations while the
415.13 patient is at an originating site and the licensed health care provider is at a distant site. A
415.14 communication between licensed health care providers, or a licensed health care provider
415.15 and a patient that consists solely of a telephone conversation, e-mail, or facsimile transmission
415.16 does not constitute telemedicine consultations or services. Telemedicine may be provided
415.17 by means of real-time two-way, interactive audio and visual communications, including the
415.18 application of secure video conferencing or store-and-forward technology to provide or
415.19 support health care delivery, which facilitate the assessment, diagnosis, consultation,
415.20 treatment, education, and care management of a patient's health care.

415.21 (e) For purposes of this section, "licensed health care provider" means a licensed health
415.22 care provider under section 62A.671, subdivision 6, a clinical trainee, and a mental health
415.23 practitioner defined under section 245.462, subdivision 17, ~~or 245.4871, subdivision 26~~,
415.24 working under the general supervision of a mental health professional; "health care provider"
415.25 is defined under section 62A.671, subdivision 3; and "originating site" is defined under
415.26 section 62A.671, subdivision 7.

415.27 Sec. 81. Minnesota Statutes 2018, section 256B.0625, subdivision 5, is amended to read:

415.28 Subd. 5. **Community mental health center services.** Medical assistance covers
415.29 community mental health center services provided by a community mental health center
415.30 that meets the requirements in paragraphs (a) to (j).

415.31 (a) The provider is licensed under Minnesota Rules, parts 9520.0750 to 9520.0870, and
415.32 in compliance with requirements under chapter 245I and section 256B.0671.

416.1 (b) The provider provides mental health services under the ~~clinical~~ treatment supervision
416.2 of a mental health professional who is licensed for independent practice at the doctoral level
416.3 or by a board-certified psychiatrist or a psychiatrist who is eligible for board certification.
416.4 ~~Clinical supervision has the meaning given in Minnesota Rules, part 9505.0370, subpart 6.~~
416.5 Treatment supervision means the treatment supervision described under section 245I.18.

416.6 (c) The provider must be a private nonprofit corporation or a governmental agency and
416.7 have a community board of directors as specified by section 245.66.

416.8 (d) The provider must have a sliding fee scale that meets the requirements in section
416.9 245.481, and agree to serve within the limits of its capacity all individuals residing in its
416.10 service delivery area.

416.11 (e) At a minimum, the provider must provide the following outpatient mental health
416.12 services: diagnostic assessment; explanation of findings; and family, group, and individual
416.13 psychotherapy, including crisis intervention psychotherapy services, ~~multiple family group~~
416.14 ~~psychotherapy~~, psychological testing, and medication management. In addition, the provider
416.15 must provide or be capable of providing upon request of the local mental health authority
416.16 day treatment services, multiple family group psychotherapy, and professional home-based
416.17 mental health services. The provider must have the capacity to provide such services to
416.18 specialized populations such as the elderly, families with children, persons who are seriously
416.19 and persistently mentally ill, and children who are seriously emotionally disturbed.

416.20 (f) The provider must be capable of providing the services specified in paragraph (e) to
416.21 individuals who are dually diagnosed with ~~both~~ a mental illness or emotional disturbance,
416.22 ~~and chemical dependency~~ substance use disorder, and to individuals who are dually diagnosed
416.23 with a mental illness or emotional disturbance and developmental disability.

416.24 (g) The provider must provide 24-hour emergency care services or demonstrate the
416.25 capacity to assist recipients in need of such services to access such services on a 24-hour
416.26 basis.

416.27 (h) The provider must have a contract with the local mental health authority to provide
416.28 one or more of the services specified in paragraph (e).

416.29 (i) The provider must agree, upon request of the local mental health authority, to enter
416.30 into a contract with the county to provide mental health services not reimbursable under
416.31 the medical assistance program.

416.32 (j) The provider may not be enrolled with the medical assistance program as both a
416.33 hospital and a community mental health center. The community mental health center's

417.1 administrative, organizational, and financial structure must be separate and distinct from
417.2 that of the hospital.

417.3 Sec. 82. Minnesota Statutes 2018, section 256B.0625, subdivision 51, is amended to read:

417.4 Subd. 51. **Intensive mental health outpatient treatment.** (a) Medical assistance covers
417.5 intensive mental health outpatient treatment for dialectical behavioral therapy for adults.
417.6 The commissioner shall establish:

417.7 (1) certification procedures to ensure that providers of these services are qualified and
417.8 meet the standards in chapter 245I; and

417.9 (2) treatment protocols including required service components and criteria for admission,
417.10 continued treatment, and discharge.

417.11 (b) "Dialectical behavior therapy" means an evidence-based treatment approach provided
417.12 in an intensive outpatient treatment program using a combination of individualized
417.13 rehabilitative and psychotherapeutic interventions. A dialectical behavior therapy program
417.14 involves the following service components: individual dialectical behavior therapy, group
417.15 skills training, telephone coaching, and team consultation meetings.

417.16 (c) To be eligible for dialectical behavior therapy a client must:

417.17 (1) be 18 years of age or older;

417.18 (2) have mental health needs that cannot be met with other available community-based
417.19 services or that must be provided concurrently with other community-based services;

417.20 (3) meet one of the following criteria:

417.21 (i) have a diagnosis of borderline personality disorder; or

417.22 (ii) have multiple mental health diagnoses, exhibit behaviors characterized by impulsivity
417.23 or intentional self-harm, and be at significant risk of death, morbidity, disability, or severe
417.24 dysfunction across multiple life areas;

417.25 (4) understand and be cognitively capable of participating in dialectical behavior therapy
417.26 as an intensive therapy program and be able and willing to follow program policies and
417.27 rules ensuring safety of self and others; and

417.28 (5) be at significant risk of one or more of the following if dialectical behavior therapy
417.29 is not provided:

417.30 (i) having a mental health crisis;

417.31 (ii) requiring a more restrictive setting including hospitalization;

418.1 (iii) decompensation; or

418.2 (iv) engaging in intentional self-harm behavior.

418.3 (d) Individual dialectical behavior therapy combines individualized rehabilitative and
418.4 psychotherapeutic interventions to treat suicidal and other dysfunctional behaviors and
418.5 reinforce the use of adaptive skillful behaviors. Individual dialectical behavior therapy must
418.6 be provided by a mental health professional or a clinical trainee. The mental health
418.7 professional or clinical trainee must:

418.8 (1) identify, prioritize, and sequence behavioral targets;

418.9 (2) treat behavioral targets;

418.10 (3) generalize dialectical behavior therapy skills to the client's natural environment
418.11 through telephone coaching outside of the treatment session;

418.12 (4) measure the client's progress toward dialectical behavior therapy targets;

418.13 (5) help the client manage mental health crises and life-threatening behaviors; and

418.14 (6) help the client learn and apply effective behaviors when working with other treatment
418.15 providers.

418.16 (e) Group skills training combines individualized psychotherapeutic and psychiatric
418.17 rehabilitative interventions conducted in a group setting to reduce the client's suicidal and
418.18 other dysfunctional coping behaviors and restore function. Group skills training must teach
418.19 the client adaptive skills in the following areas:

418.20 (1) mindfulness;

418.21 (2) interpersonal effectiveness;

418.22 (3) emotional regulation; and

418.23 (4) distress tolerance.

418.24 (f) Group skills training must be provided by two mental health professionals, or by a
418.25 mental health professional co-facilitating with a clinical trainee or a mental health practitioner
418.26 as specified in section 245I.16, subdivision 4. Individual skills training must be provided
418.27 by a mental health professional, a clinical trainee, or a mental health practitioner as specified
418.28 in section 245I.16, subdivision 4.

418.29 (g) A program must be certified by the commissioner as a dialectical behavior therapy
418.30 provider. To qualify for certification, a provider must:

419.1 (1) hold current accreditation as a dialectical behavior therapy program from a nationally
 419.2 recognized certification body approved by the commissioner;

419.3 (2) submit to the commissioner's inspection;

419.4 (3) provide evidence that the dialectical behavior therapy program's policies, procedures,
 419.5 and practices continuously meet the requirements of this subdivision;

419.6 (4) be enrolled as a MHCP provider;

419.7 (5) collect and report client outcomes as specified by the commissioner; and

419.8 (6) have a manual that outlines the dialectical behavior therapy program's policies,
 419.9 procedures, and practices that meet the requirements of this subdivision.

419.10 Sec. 83. Minnesota Statutes 2018, section 256B.0625, subdivision 19c, is amended to
 419.11 read:

419.12 Subd. 19c. **Personal care.** Medical assistance covers personal care assistance services
 419.13 provided by an individual who is qualified to provide the services according to subdivision
 419.14 19a and sections 256B.0651 to 256B.0654, provided in accordance with a plan, and
 419.15 supervised by a qualified professional.

419.16 "Qualified professional" means a mental health professional ~~as defined in section 245.462,~~
 419.17 ~~subdivision 18, clauses (1) to (6), or 245.4871, subdivision 27, clauses (1) to (6);~~ a registered
 419.18 nurse as defined in sections 148.171 to 148.285, a licensed social worker as defined in
 419.19 sections 148E.010 and 148E.055, or a qualified designated coordinator under section
 419.20 245D.081, subdivision 2. The qualified professional shall perform the duties required in
 419.21 section 256B.0659.

419.22 Sec. 84. Minnesota Statutes 2018, section 256B.0625, subdivision 23, is amended to read:

419.23 Subd. 23. **Adult day treatment services.** (a) Medical assistance covers adult day
 419.24 treatment services as specified in sections 245.462, subdivision 8, and 245.4871, subdivision
 419.25 10, that are provided under contract with the county board. The commissioner may set
 419.26 authorization thresholds for day treatment for adults according to subdivision 25. Medical
 419.27 assistance covers day treatment services for children as specified under section 256B.0943.
 419.28 Adult day treatment payment is limited to the conditions in paragraphs (b) to (e).

419.29 (b) Adult day treatment is an intensive psychotherapeutic treatment to reduce or relieve
 419.30 the effects of mental illness to enable the client to benefit from a lower level of care and to
 419.31 live and function more independently in the community. Adult day treatment services must

420.1 stabilize the client's mental health status and develop and improve the client's independent
420.2 living and socialization skills. Adult day treatment must consist of at least one hour of group
420.3 psychotherapy and must include group time focused on rehabilitative interventions or other
420.4 therapeutic services that are provided by a multidisciplinary staff person. Adult day treatment
420.5 services are not a part of inpatient or residential treatment services.

420.6 (c) To be eligible for medical assistance payment, an adult day treatment service must:

420.7 (1) be reviewed by and approved by the commissioner;

420.8 (2) be provided to a group of clients by a multidisciplinary staff person under the
420.9 treatment supervision of a mental health professional as described under section 245I.18;

420.10 (3) be available to the client at least two days a week for at least three consecutive hours
420.11 per day. The adult day treatment may be longer than three hours per day, but medical
420.12 assistance must not reimburse a provider for more than 15 hours per week;

420.13 (4) include group psychotherapy by a mental health professional or clinical trainee and
420.14 daily rehabilitative interventions by a mental health professional qualified according to
420.15 section 245I.16, subdivision 2, clinical trainee qualified according to section 245I.16,
420.16 subdivision 6, or mental health practitioner qualified according to section 245I.16, subdivision
420.17 4;

420.18 (5) be included in the client's individual treatment plan as described under section
420.19 256B.0671, subdivisions 5 and 6, as appropriate. The individual treatment plan must include
420.20 attainable, measurable goals related to services and must be completed before the first adult
420.21 day treatment session. The vendor must review the client's progress and update the treatment
420.22 plan at least every 30 days until the client is discharged and include an available discharge
420.23 plan for the client in the treatment plan; and

420.24 (6) document the daily interventions provided and the client's response according to
420.25 section 245I.33.

420.26 (d) To be eligible for adult day treatment, a client must:

420.27 (1) be 18 years of age or older;

420.28 (2) not be residing in a nursing facility, hospital, institute of mental disease, or regional
420.29 treatment center unless the client has an active discharge plan that indicates a move to an
420.30 independent living arrangement within 180 days;

420.31 (3) have a diagnosis of mental illness as determined by a diagnostic assessment;

421.1 (4) have the capacity to engage in the rehabilitative nature, the structured setting, and
 421.2 the therapeutic parts of psychotherapy and skills activities of an adult day treatment program
 421.3 and demonstrate measurable improvements in the client's functioning related to the client's
 421.4 mental illness that would result from participating in the adult day treatment program;

421.5 (5) have at least three areas of functional impairment as determined by a functional
 421.6 assessment with the domains prescribed by section 245.462, subdivision 11a;

421.7 (6) have a level of care determination that supports the need for the level of intensity
 421.8 and duration of an adult day treatment program; and

421.9 (7) be determined to need adult day treatment services by a mental health professional
 421.10 who must deem the adult day treatment services medically necessary.

421.11 (e) The following services are not covered by medical assistance as an adult day treatment
 421.12 service:

421.13 (1) a service that is primarily recreation-oriented or that is provided in a setting that is
 421.14 not medically supervised. This includes sports activities, exercise groups, craft hours, leisure
 421.15 time, social hours, meal or snack time, trips to community activities, and tours;

421.16 (2) a social or educational service that does not have or cannot reasonably be expected
 421.17 to have a therapeutic outcome related to the client's mental illness;

421.18 (3) consultation with other providers or service agency staff persons about the care or
 421.19 progress of a client;

421.20 (4) prevention or education programs provided to the community;

421.21 (5) day treatment for clients with primary diagnoses of alcohol or other drug abuse;

421.22 (6) day treatment provided in the client's home;

421.23 (7) psychotherapy for more than two hours per day; and

421.24 (8) participation in meal preparation and eating that is not part of a clinical treatment
 421.25 plan to address the client's eating disorder.

421.26 Sec. 85. Minnesota Statutes 2018, section 256B.0625, subdivision 42, is amended to read:

421.27 Subd. 42. **Mental health professional.** Notwithstanding Minnesota Rules, part
 421.28 9505.0175, subpart 28, the definition of a mental health professional shall include a person
 421.29 who is qualified as specified in section ~~245.462, subdivision 18, clauses (1) to (6); or~~
 421.30 ~~245.4871, subdivision 27, clauses (1) to (6);~~ 245I.16, subdivision 2, for the purpose of this
 421.31 section and Minnesota Rules, parts 9505.0170 to 9505.0475.

422.1 Sec. 86. Minnesota Statutes 2018, section 256B.0625, subdivision 48, is amended to read:

422.2 Subd. 48. **Psychiatric consultation to primary care practitioners.** Medical assistance
422.3 covers consultation provided by a ~~psychiatrist, a psychologist, an advanced practice registered~~
422.4 ~~nurse certified in psychiatric mental health, a licensed independent clinical social worker,~~
422.5 ~~as defined in section 245.462, subdivision 18, clause (2), or a licensed marriage and family~~
422.6 ~~therapist, as defined in section 245.462, subdivision 18, clause (5),~~ mental health professional
422.7 except one licensed under section 148B.5301 via telephone, e-mail, facsimile, or other
422.8 means of communication to primary care practitioners, including pediatricians. The need
422.9 for consultation and the receipt of the consultation must be documented in the patient record
422.10 maintained by the primary care practitioner. If the patient consents, and subject to federal
422.11 limitations and data privacy provisions, the consultation may be provided without the patient
422.12 present.

422.13 Sec. 87. Minnesota Statutes 2018, section 256B.0625, subdivision 49, is amended to read:

422.14 Subd. 49. **Community health worker.** (a) Medical assistance covers the care
422.15 coordination and patient education services provided by a community health worker if the
422.16 community health worker has: ~~(1) received a certificate from the Minnesota State Colleges~~
422.17 ~~and Universities System approved community health worker curriculum; or,~~

422.18 ~~(2) at least five years of supervised experience with an enrolled physician, registered~~
422.19 ~~nurse, advanced practice registered nurse, mental health professional as defined in section~~
422.20 ~~245.462, subdivision 18, clauses (1) to (6), and section 245.4871, subdivision 27, clauses~~
422.21 ~~(1) to (5), or dentist, or at least five years of supervised experience by a certified public~~
422.22 ~~health nurse operating under the direct authority of an enrolled unit of government.~~

422.23 ~~Community health workers eligible for payment under clause (2) must complete the~~
422.24 ~~certification program by January 1, 2010, to continue to be eligible for payment.~~

422.25 (b) Community health workers must work under the supervision of a medical assistance
422.26 enrolled physician, registered nurse, advanced practice registered nurse, mental health
422.27 professional ~~as defined in section 245.462, subdivision 18, clauses (1) to (6), and section~~
422.28 ~~245.4871, subdivision 27, clauses (1) to (5), or dentist, or work under the supervision of a~~
422.29 ~~certified public health nurse operating under the direct authority of an enrolled unit of~~
422.30 ~~government.~~

422.31 (c) Care coordination and patient education services covered under this subdivision
422.32 include, but are not limited to, services relating to oral health and dental care.

423.1 Sec. 88. Minnesota Statutes 2018, section 256B.0625, subdivision 56a, is amended to
423.2 read:

423.3 Subd. 56a. **Post-arrest community-based service coordination.** (a) Medical assistance
423.4 covers post-arrest community-based service coordination for an individual who:

423.5 (1) has been identified as having a mental illness or substance use disorder using a
423.6 screening tool approved by the commissioner;

423.7 (2) does not require the security of a public detention facility and is not considered an
423.8 inmate of a public institution as defined in Code of Federal Regulations, title 42, section
423.9 435.1010;

423.10 (3) meets the eligibility requirements in section 256B.056; and

423.11 (4) has agreed to participate in post-arrest community-based service coordination through
423.12 a diversion contract in lieu of incarceration.

423.13 (b) Post-arrest community-based service coordination means navigating services to
423.14 address a client's mental health, chemical health, social, economic, and housing needs, or
423.15 any other activity targeted at reducing the incidence of jail utilization and connecting
423.16 individuals with existing covered services available to them, including, but not limited to,
423.17 targeted case management, waiver case management, or care coordination.

423.18 (c) Post-arrest community-based service coordination must be provided by an individual
423.19 who is an employee of a county or is under contract with a county to provide post-arrest
423.20 community-based coordination and is qualified under one of the following criteria:

423.21 (1) a licensed mental health professional ~~as defined in section 245.462, subdivision 18,~~
423.22 ~~clauses (1) to (6);~~

423.23 (2) a mental health practitioner as defined in section 245.462, subdivision 17, working
423.24 under the clinical treatment supervision of a mental health professional; ~~or~~

423.25 (3) a certified peer specialist under section 256B.0615, working under the clinical
423.26 treatment supervision of a mental health professional; or

423.27 (4) a clinical trainee.

423.28 (d) Reimbursement is allowed for up to 60 days following the initial determination of
423.29 eligibility.

423.30 (e) Providers of post-arrest community-based service coordination shall annually report
423.31 to the commissioner on the number of individuals served, and number of the
423.32 community-based services that were accessed by recipients. The commissioner shall ensure

424.1 that services and payments provided under post-arrest community-based service coordination
424.2 do not duplicate services or payments provided under section 256B.0625, subdivision 20,
424.3 256B.0753, 256B.0755, or 256B.0757.

424.4 (f) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of cost for
424.5 post-arrest community-based service coordination services shall be provided by the county
424.6 providing the services, from sources other than federal funds or funds used to match other
424.7 federal funds.

424.8 Sec. 89. Minnesota Statutes 2018, section 256B.0625, subdivision 61, is amended to read:

424.9 Subd. 61. **Family psychoeducation services.** ~~Effective July 1, 2013, or upon federal~~
424.10 ~~approval, whichever is later,~~ Medical assistance covers family psychoeducation services
424.11 provided to a child up to age 21 with a diagnosed mental health condition when identified
424.12 in the child's individual treatment plan and provided by a licensed mental health professional,
424.13 ~~as defined in Minnesota Rules, part 9505.0371, subpart 5, item A,~~ or a clinical trainee, ~~as~~
424.14 ~~defined in Minnesota Rules, part 9505.0371, subpart 5, item C,~~ who has determined it
424.15 medically necessary to involve family members in the child's care. For the purposes of this
424.16 subdivision, "family psychoeducation services" means information or demonstration provided
424.17 to an individual or family as part of an individual, family, multifamily group, or peer group
424.18 session to explain, educate, and support the child and family in understanding a child's
424.19 symptoms of mental illness, the impact on the child's development, and needed components
424.20 of treatment and skill development so that the individual, family, or group can help the child
424.21 to prevent relapse, prevent the acquisition of comorbid disorders, and achieve optimal mental
424.22 health and long-term resilience.

424.23 Sec. 90. Minnesota Statutes 2018, section 256B.0625, subdivision 62, is amended to read:

424.24 Subd. 62. **Mental health clinical care consultation.** ~~Effective July 1, 2013, or upon~~
424.25 ~~federal approval, whichever is later,~~ Medical assistance covers clinical care consultation
424.26 for a person up to age 21 who is diagnosed with a complex mental health condition or a
424.27 mental health condition that co-occurs with other complex and chronic conditions, when
424.28 described in the person's individual treatment plan and provided by a licensed mental health
424.29 professional, ~~as defined in Minnesota Rules, part 9505.0371, subpart 5, item A,~~ or a clinical
424.30 trainee, ~~as defined in Minnesota Rules, part 9505.0371, subpart 5, item C.~~ For the purposes
424.31 of this subdivision, "clinical care consultation" means communication from a treating mental
424.32 health professional to other providers or educators not under the clinical supervision of the
424.33 treating mental health professional who are working with the same client to inform, inquire,

425.1 and instruct regarding the client's symptoms; strategies for effective engagement, care, and
425.2 intervention needs; and treatment expectations across service settings; and to direct and
425.3 coordinate clinical service components provided to the client and family.

425.4 Sec. 91. Minnesota Statutes 2018, section 256B.0625, subdivision 65, is amended to read:

425.5 Subd. 65. **Outpatient mental health services.** For the purposes of this section, "clinical
425.6 trainee" has the meaning given in section 245I.16, subdivision 6. Medical assistance covers
425.7 diagnostic assessment, explanation of findings, and psychotherapy according to Minnesota
425.8 Rules, part 9505.0372, subdivision 69 and section 256B.0671 when the mental health
425.9 services are performed by a mental health practitioner working as a clinical trainee according
425.10 to section 245.462, subdivision 17, paragraph (g).

425.11 Sec. 92. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision
425.12 to read:

425.13 Subd. 66. **Neuropsychological assessment.** (a) "Neuropsychological assessment" means
425.14 a specialized clinical assessment of the client's underlying cognitive abilities related to
425.15 thinking, reasoning, and judgment that is conducted by a qualified neuropsychologist. A
425.16 neuropsychological assessment must include a face-to-face interview with the client,
425.17 interpretation of the test results, and preparation and completion of a report.

425.18 (b) A client is eligible for a neuropsychological assessment if at least one of the following
425.19 criteria is met:

425.20 (1) there is a known or strongly suspected brain disorder based on medical history or
425.21 neurological evaluation, including a history of significant head trauma, brain tumor, stroke,
425.22 seizure disorder, multiple sclerosis, neurodegenerative disorder, significant exposure to
425.23 neurotoxins, central nervous system infection, metabolic or toxic encephalopathy, fetal
425.24 alcohol syndrome, or congenital malformation of the brain; or

425.25 (2) there are cognitive or behavioral symptoms that suggest that the client has an organic
425.26 condition that cannot be readily attributed to functional psychopathology or suspected
425.27 neuropsychological impairment in addition to functional psychopathology. This includes:

425.28 (i) poor memory or impaired problem solving;

425.29 (ii) change in mental status evidenced by lethargy, confusion, or disorientation;

425.30 (iii) deterioration in level of functioning;

425.31 (iv) marked behavioral or personality change;

426.1 (v) in children or adolescents, significant delays in academic skill acquisition or poor
426.2 attention relative to peers;

426.3 (vi) in children or adolescents, significant plateau in expected development of cognitive,
426.4 social, emotional, or physical function relative to peers; and

426.5 (vii) in children or adolescents, significant inability to develop expected knowledge,
426.6 skills, or abilities as required to adapt to new or changing cognitive, social, emotional, or
426.7 physical demands.

426.8 (c) The neuropsychological assessment must be conducted by a neuropsychologist
426.9 competent in the area of neuropsychological assessment who:

426.10 (1) was awarded a diploma by the American Board of Clinical Neuropsychology, the
426.11 American Board of Professional Neuropsychology, or the American Board of Pediatric
426.12 Neuropsychology;

426.13 (2) earned a doctoral degree in psychology from an accredited university training program
426.14 and:

426.15 (i) completed an internship or its equivalent in a clinically relevant area of professional
426.16 psychology;

426.17 (ii) completed the equivalent of two full-time years of experience and specialized training,
426.18 at least one of which is at the postdoctoral level, supervised by a clinical neuropsychologist
426.19 in the study and practice of clinical neuropsychology and related neurosciences; and

426.20 (iii) holds a current license to practice psychology independently according to sections
426.21 144.88 to 144.98;

426.22 (3) is licensed or credentialed by another state's board of psychology examiners in the
426.23 specialty of neuropsychology using requirements equivalent to requirements specified by
426.24 one of the boards named in clause (1); or

426.25 (4) was approved by the commissioner as an eligible provider of neuropsychological
426.26 assessment prior to December 31, 2010.

426.27 Sec. 93. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision
426.28 to read:

426.29 Subd. 67. **Neuropsychological testing.** (a) "Neuropsychological testing" means
426.30 administering standardized tests and measures designed to evaluate the client's ability to
426.31 attend to, process, interpret, comprehend, communicate, learn, and recall information and
426.32 use problem solving and judgment.

- 427.1 (b) Medical assistance covers neuropsychological testing when the client:
- 427.2 (1) has a significant mental status change that is not a result of a metabolic disorder and
- 427.3 that has failed to respond to treatment;
- 427.4 (2) is a child or adolescent with a significant plateau in expected development of
- 427.5 cognitive, social, emotional, or physical function relative to peers;
- 427.6 (3) is a child or adolescent with a significant inability to develop expected knowledge,
- 427.7 skills, or abilities as required to adapt to new or changing cognitive, social, physical, or
- 427.8 emotional demands; or
- 427.9 (4) has a significant behavioral change, memory loss, or suspected neuropsychological
- 427.10 impairment in addition to functional psychopathology, or other organic brain injury or one
- 427.11 of the following:
- 427.12 (i) traumatic brain injury;
- 427.13 (ii) stroke;
- 427.14 (iii) brain tumor;
- 427.15 (iv) substance use disorder;
- 427.16 (v) cerebral anoxic or hypoxic episode;
- 427.17 (vi) central nervous system infection or other infectious disease;
- 427.18 (vii) neoplasms or vascular injury of the central nervous system;
- 427.19 (viii) neurodegenerative disorders;
- 427.20 (ix) demyelinating disease;
- 427.21 (x) extrapyramidal disease;
- 427.22 (xi) exposure to systemic or intrathecal agents or cranial radiation known to be associated
- 427.23 with cerebral dysfunction;
- 427.24 (xii) systemic medical conditions known to be associated with cerebral dysfunction,
- 427.25 including renal disease, hepatic encephalopathy, cardiac anomaly, sickle cell disease, and
- 427.26 related hematologic anomalies, and autoimmune disorders, including lupus, erythematosis,
- 427.27 or celiac disease;
- 427.28 (xiii) congenital genetic or metabolic disorders known to be associated with cerebral
- 427.29 dysfunction, including phenylketonuria, craniofacial syndromes, or congenital hydrocephalus;
- 427.30 (xiv) severe or prolonged nutrition or malabsorption syndromes; or

428.1 (xv) a condition presenting in a manner difficult for a clinician to distinguish between
428.2 the neurocognitive effects of a neurogenic syndrome, including dementia or encephalopathy;
428.3 and a major depressive disorder when adequate treatment for major depressive disorder has
428.4 not resulted in improvement in neurocognitive function; or another disorder, including
428.5 autism, selective mutism, anxiety disorder, or reactive attachment disorder.

428.6 (c) Neuropsychological testing must be administered or clinically supervised by a
428.7 neuropsychologist qualified as defined in subdivision 66, paragraph (c).

428.8 (d) Neuropsychological testing is not covered when performed: (1) primarily for
428.9 educational purposes; (2) primarily for vocational counseling or training; (3) for personnel
428.10 or employment testing; (4) as a routine battery of psychological tests given at inpatient
428.11 admission or during a continued stay; or (5) for legal or forensic purposes.

428.12 Sec. 94. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision
428.13 to read:

428.14 Subd. 68. **Psychological testing.** (a) "Psychological testing" means the use of tests or
428.15 other psychometric instruments to determine the status of the client's mental, intellectual,
428.16 and emotional functioning.

428.17 (b) The psychological testing must:

428.18 (1) be administered or clinically supervised by a licensed psychologist qualified according
428.19 to section 245I.16, subdivision 2, clause (3), competent in the area of psychological testing;
428.20 and

428.21 (2) be validated in a face-to-face interview between the client and a licensed psychologist
428.22 or a clinical psychology trainee qualified according to section 245I.16, subdivision 6, under
428.23 the treatment supervision of a licensed psychologist according to section 245I.18.

428.24 (c) The administration, scoring, and interpretation of the psychological tests must be
428.25 done under the treatment supervision of a licensed psychologist when performed by a clinical
428.26 psychology trainee, technician, psychometrist, or psychological assistant or as part of a
428.27 computer-assisted psychological testing program. The report resulting from the psychological
428.28 testing must be signed by the psychologist conducting the face-to-face interview, placed in
428.29 the client's record, and released to each person authorized by the client.

429.1 Sec. 95. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision
429.2 to read:

429.3 Subd. 69. **Psychotherapy.** (a) "Psychotherapy" means treatment of a client with mental
429.4 illness that applies to the most appropriate psychological, psychiatric, psychosocial, or
429.5 interpersonal method that conforms to prevailing community standards of professional
429.6 practice to meet the mental health needs of the client. Medical assistance covers
429.7 psychotherapy if conducted by a mental health professional qualified according to section
429.8 245I.16, subdivision 2, or a clinical trainee qualified according to section 245I.16, subdivision
429.9 6.

429.10 (b) Individual psychotherapy is psychotherapy designed for one client.

429.11 (c) Family psychotherapy is designed for the client and one or more family members or
429.12 the client's primary caregiver whose participation is necessary to accomplish the client's
429.13 treatment goals. Family members or primary caregivers participating in a therapy session
429.14 do not need to be eligible for medical assistance. For purposes of this paragraph, "primary
429.15 caregiver whose participation is necessary to accomplish the client's treatment goals" excludes
429.16 shift or facility staff persons at the client's residence. Medical assistance payment for family
429.17 psychotherapy is limited to face-to-face sessions at which the client is present throughout
429.18 the family psychotherapy session unless the mental health professional believes the client's
429.19 absence from the family psychotherapy session is necessary to carry out the client's individual
429.20 treatment plan. If the client is excluded, the mental health professional must document the
429.21 reason for and the length of time of the exclusion. The mental health professional must also
429.22 document any reason a member of the client's family is excluded.

429.23 (d) Group psychotherapy is appropriate for a client who, because of the nature of the
429.24 client's emotional, behavioral, or social dysfunctions, can derive mutual benefit from
429.25 treatment in a group setting. For a group of three to eight persons, one mental health
429.26 professional or clinical trainee is required to conduct the group. For a group of nine to 12
429.27 persons, a team of at least two mental health professionals or two clinical trainees or one
429.28 mental health professional and one clinical trainee is required to co-conduct the group.
429.29 Medical assistance payment is limited to a group of no more than 12 persons.

429.30 (e) A multiple-family group psychotherapy session is eligible for medical assistance
429.31 payment if the psychotherapy session is designed for at least two but not more than five
429.32 families. Multiple-family group psychotherapy is clearly directed toward meeting the
429.33 identified treatment needs of each client as indicated in each client's treatment plan. If the
429.34 client is excluded, the mental health professional or clinical trainee must document the

430.1 reason for and the length of time of the exclusion. The mental health professional or clinical
 430.2 trainee must document any reason a member of the client's family is excluded.

430.3 Sec. 96. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision
 430.4 to read:

430.5 Subd. 70. **Partial hospitalization.** "Partial hospitalization" means a provider's
 430.6 time-limited, structured program of psychotherapy and other therapeutic services, as defined
 430.7 in United States Code, title 42, chapter 7, subchapter XVIII, part E, section 1395x(ff), that
 430.8 is provided in an outpatient hospital facility or community mental health center that meets
 430.9 Medicare requirements to provide partial hospitalization services. Partial hospitalization is
 430.10 a covered service when it is an appropriate alternative to inpatient hospitalization for a client
 430.11 who is experiencing an acute episode of mental illness that meets the criteria for an inpatient
 430.12 hospital admission under Minnesota Rules, part 9505.0520, subpart 1, and who has the
 430.13 family and community resources necessary and appropriate to support the client's residence
 430.14 in the community. Partial hospitalization consists of multiple intensive short-term therapeutic
 430.15 services provided by a multidisciplinary staff person to treat the client's mental illness.

430.16 Sec. 97. **[256B.0671] CLIENT ELIGIBILITY FOR MENTAL HEALTH SERVICES.**

430.17 Subdivision 1. **Definitions.** For the purposes of this section, the definitions in section
 430.18 245I.02 apply.

430.19 Subd. 1a. **Generally.** (a) The provider must use a diagnostic assessment or crisis
 430.20 assessment to determine a client's eligibility for mental health services, except as provided
 430.21 in this section.

430.22 (b) Prior to completion of a client's initial diagnostic assessment, a client is eligible for:

430.23 (1) one explanation of findings;

430.24 (2) one psychological testing;

430.25 (3) any combination of individual psychotherapy sessions, family psychotherapy sessions,
 430.26 group psychotherapy sessions, and individual or family psychoeducation sessions not to
 430.27 exceed three sessions; and

430.28 (4) crisis assessment and intervention services provided according to section 256B.0624
 430.29 or 256B.0944.

430.30 (c) Based on the needs identified in a crisis assessment as specified in section 256B.0624
 430.31 or 256B.0944, a client may receive: (1) crisis stabilization services; and (2) any combination

431.1 of individual psychotherapy sessions, family psychotherapy sessions, or family
431.2 psychoeducation sessions not to exceed ten sessions within a 12-month period without prior
431.3 authorization.

431.4 (d) Based on the needs identified in a brief diagnostic assessment, a client may receive
431.5 a combination of individual psychotherapy sessions, family psychotherapy sessions, or
431.6 family psychoeducation sessions not to exceed ten sessions within a 12-month period without
431.7 prior authorization for any new client or for an existing client who is projected to need fewer
431.8 than ten sessions in the next 12 months.

431.9 (e) If the amount of services or intensity required by the client exceeds the coverage
431.10 limits in this section, a provider shall complete a standard diagnostic assessment.

431.11 (f) A new standard diagnostic assessment must be completed:

431.12 (1) when the client requires services of a greater number or intensity than those permitted
431.13 by paragraphs (b) to (d);

431.14 (2) at least annually following the initial diagnostic assessment if additional services are
431.15 needed and the client does not meet the criteria for brief assessment.

431.16 (3) when the client's mental health condition has changed markedly since the client's
431.17 most recent diagnostic assessment; or

431.18 (4) when the client's current mental health condition does not meet the criteria of the
431.19 client's current diagnosis.

431.20 (g) For an existing client, a new standard diagnostic assessment shall include a written
431.21 update of the parts where significant new or changed information exists, and documentation
431.22 where there has not been significant change, including discussion with the client about
431.23 changes in the client's life situation, functioning, presenting problems, and progress on
431.24 treatment goals since the last diagnostic assessment was completed.

431.25 Subd. 1b. **Continuity of services.** (a) For any client served with a diagnostic assessment
431.26 completed under Minnesota Rules, parts 9505.0370 to 9505.0372, before the effective date,
431.27 the diagnostic assessment is valid for purposes of authorizing treatment and billing for one
431.28 calendar year after completion.

431.29 (b) For any client served with an individual treatment plan completed under section
431.30 256B.0622, 256B.0623, 256B.0943, 256B.0946, or 256B.0947 or Minnesota Rules, parts
431.31 9505.0370 to 9505.0372, the individual treatment plan is valid for purposes of authorizing
431.32 treatment and billing until its expiration date.

432.1 (c) This subdivision expires July 1, 2021.

432.2 Subd. 2. **Diagnostic assessment.** To be eligible for medical assistance payment, a
432.3 diagnostic assessment must (1) identify at least one mental health diagnosis and recommend
432.4 mental health services to develop the client's mental health services and treatment plan, or
432.5 (2) include a finding that the client does not meet the criteria for a mental health disorder.

432.6 Subd. 3. **Standard diagnostic assessment requirements.** (a) A standard diagnostic
432.7 assessment must include a face-to-face interview with the client and contain a written
432.8 evaluation of a client by a mental health professional or clinical trainee. The standard
432.9 diagnostic assessment must be completed within the cultural context of the client.

432.10 (b) The clinician shall gather and document information related to the client's current
432.11 life situation and the client's:

432.12 (1) age;

432.13 (2) current living situation, including household membership and housing status;

432.14 (3) basic needs status;

432.15 (4) education level and employment status;

432.16 (5) family and other significant personal relationships, including the client's evaluation
432.17 of relationship quality;

432.18 (6) strengths and resources, including the extent and quality of social networks;

432.19 (7) belief systems;

432.20 (8) current medications; and

432.21 (9) immediate risks to health and safety.

432.22 (c) The clinician shall gather and document information related to the elements of the
432.23 assessment, including the client's:

432.24 (1) perceptions of the client's condition;

432.25 (2) description of symptoms, including reason for referral;

432.26 (3) history of mental health treatment; and

432.27 (4) cultural influences and the impact on the client.

432.28 (d) A clinician completing a diagnostic assessment shall use professional judgment in
432.29 making inquiries under this paragraph. If information cannot be obtained without
432.30 retraumatizing the client or harming the client's willingness to engage in treatment, the

433.1 clinician shall document which topics require further attention in the course of treatment.

433.2 A clinician must, as clinically appropriate, include the following information related to a
 433.3 client in a diagnostic assessment:

433.4 (1) important developmental incidents;

433.5 (2) maltreatment, trauma, potential brain injuries, or abuse issues;

433.6 (3) history of alcohol and drug usage and treatment; and

433.7 (4) health history and family health history, including physical, chemical, and mental
 433.8 health history.

433.9 (e) The clinician must perform and document the following components of the
 433.10 assessment:

433.11 (1) the client's mental status examination;

433.12 (2) information gathered concerning the client's baseline measurements; symptoms;

433.13 behavior; skills; abilities; resources; vulnerabilities; safety needs, including client data

433.14 adequate to support findings based on the current edition of the Diagnostic and Statistical

433.15 Manual of Mental Disorders, published by the American Psychiatric Association; and any

433.16 differential diagnosis;

433.17 (3) for a child younger than 6 years of age, a clinician may use the current edition of the

433.18 DC: 0-5 Diagnostic Classification of Mental Health and Development Disorders of Infancy

433.19 and Early Childhood instead of the Diagnostic and Statistical Manual of Mental Disorders;

433.20 (4) the screenings used to determine the client's substance use, abuse, or dependency

433.21 and other standardized screening instruments determined by the commissioner;

433.22 (5) use of standardized outcome measurements by the provider as determined and

433.23 periodically updated by the commissioner; and

433.24 (6) a case conceptualization that explains: (i) the diagnostic formulation made based on

433.25 the information gathered through the interview, assessment, available psychological testing,

433.26 and collateral information; (ii) the needs of the client; (iii) risk factors; (iv) strengths; and

433.27 (v) responsivity factors.

433.28 (f) The diagnostic assessment must include recommendations, client and family

433.29 participation in assessment and service preferences, and referrals to services required by

433.30 law.

433.31 Subd. 4. **Brief diagnostic assessment requirements.** (a) A brief diagnostic assessment

433.32 must include a face-to-face interview with the client and a written evaluation of the client

434.1 by a mental health professional or a clinical trainee. The mental health professional or
434.2 clinical trainee must gather initial components of a standard diagnostic assessment, including
434.3 the client's:

434.4 (1) age;

434.5 (2) description of symptoms, including reason for referral;

434.6 (3) history of mental health treatment;

434.7 (4) cultural influences and their impact on the client; and

434.8 (5) mental status examination.

434.9 (b) On the basis of the initial components, the mental health professional or clinical
434.10 trainee must draw a provisional diagnostic formulation. The diagnostic formulation may be
434.11 used to address the client's immediate needs or presenting problem.

434.12 (c) Treatment sessions conducted under authorization of a brief diagnostic assessment
434.13 may be used to gather additional information necessary to complete a standard diagnostic
434.14 assessment if coverage limits in subdivision 1 will be exceeded.

434.15 Subd. 5. **Individual treatment plan.** Medical assistance payment is available only for
434.16 mental health services provided in accordance with the client's written individual treatment
434.17 plan, with the following exceptions: (1) services that do not require a standard diagnostic
434.18 assessment prior to service delivery; (2) service plan development; and (3) re-engagement
434.19 of a client as described in subdivision 6, clause (6).

434.20 Subd. 6. **Individual treatment plan; required elements.** An individual treatment plan
434.21 must:

434.22 (1) be based on the information in the client's diagnostic assessment and baselines;

434.23 (2) identify goals and objectives of treatment, the treatment strategy, the schedule for
434.24 accomplishing treatment goals and measurable objectives, and the individuals responsible
434.25 for providing treatment services and supports;

434.26 (3) be developed after completion of the client's diagnostic assessment, within three
434.27 visits unless otherwise specified by a service line;

434.28 (4) for a child client, be developed through a child-centered, family-driven, culturally
434.29 appropriate planning process, including allowing parents and guardians to observe or
434.30 participate in individual and family treatment services, assessment, and treatment planning.

434.31 For an adult client, the individual treatment plan must be developed through a

435.1 person-centered, culturally appropriate planning process, including allowing identified
 435.2 supports to observe or participate in treatment services, assessment, and treatment planning;

435.3 (5) be reviewed at least every 90 days unless otherwise specified by the requirements
 435.4 of a service line and revised to document treatment progress on each treatment objective
 435.5 and next goals or, if progress is not documented, to document changes in treatment; and

435.6 (6) be approved by the client, the client's parent, or other person authorized by law to
 435.7 consent to mental health services for the client. If approval cannot be obtained, a mental
 435.8 health professional shall make efforts to obtain approval from an authorized person for a
 435.9 period of 30 days following the date the previous individual treatment plan expired. A client
 435.10 shall not be denied service in this time period solely on the basis of an unapproved individual
 435.11 treatment plan. A provider entity may continue to bill for otherwise eligible services during
 435.12 a period of re-engagement.

435.13 Sec. 98. Minnesota Statutes 2018, section 256B.0757, subdivision 2, is amended to read:

435.14 Subd. 2. **Eligible individual.** An individual is eligible for health home services under
 435.15 this section if the individual is eligible for medical assistance under this chapter and has at
 435.16 least:

435.17 (1) two chronic conditions;

435.18 (2) one chronic condition and is at risk of having a second chronic condition;

435.19 (3) one serious and persistent mental health condition; or

435.20 (4) a condition that meets the definition in section 245.462, subdivision 20, paragraph
 435.21 (a), or 245.4871, subdivision 15, clause (2); and has a current diagnostic assessment as
 435.22 ~~defined in Minnesota Rules, part 9505.0372, subpart 1, item B or C~~ that meets the
 435.23 requirements of section 256B.0671, subdivisions 2 and 3, as performed or reviewed by a
 435.24 mental health professional employed by or under contract with the behavioral health home.
 435.25 The commissioner shall establish criteria for determining continued eligibility.

435.26 Sec. 99. Minnesota Statutes 2018, section 256B.0941, subdivision 1, is amended to read:

435.27 Subdivision 1. **Eligibility.** (a) An individual who is eligible for mental health treatment
 435.28 services in a psychiatric residential treatment facility must meet all of the following criteria:

435.29 (1) before admission, services are determined to be medically necessary by the state's
 435.30 medical review agent according to Code of Federal Regulations, title 42, section 441.152;

436.1 (2) is younger than 21 years of age at the time of admission. Services may continue until
 436.2 the individual meets criteria for discharge or reaches 22 years of age, whichever occurs
 436.3 first;

436.4 (3) has a mental health diagnosis as defined in the most recent edition of the Diagnostic
 436.5 and Statistical Manual for Mental Disorders, as well as clinical evidence of severe aggression,
 436.6 or a finding that the individual is a risk to self or others;

436.7 (4) has functional impairment and a history of difficulty in functioning safely and
 436.8 successfully in the community, school, home, or job; an inability to adequately care for
 436.9 one's physical needs; or caregivers, guardians, or family members are unable to safely fulfill
 436.10 the individual's needs;

436.11 (5) requires psychiatric residential treatment under the direction of a physician to improve
 436.12 the individual's condition or prevent further regression so that services will no longer be
 436.13 needed;

436.14 (6) utilized and exhausted other community-based mental health services, or clinical
 436.15 evidence indicates that such services cannot provide the level of care needed; and

436.16 (7) was referred for treatment in a psychiatric residential treatment facility by a qualified
 436.17 mental health professional licensed as defined in section 245.4871, subdivision 27, clauses
 436.18 ~~(1) to (6)~~ qualified according to section 245I.16, subdivision 2.

436.19 (b) A mental health professional making a referral shall submit documentation to the
 436.20 state's medical review agent containing all information necessary to determine medical
 436.21 necessity, including a standard diagnostic assessment completed within 180 days of the
 436.22 individual's admission. Documentation shall include evidence of family participation in the
 436.23 individual's treatment planning and signed consent for services.

436.24 Sec. 100. Minnesota Statutes 2018, section 256B.0943, subdivision 1, is amended to read:

436.25 Subdivision 1. **Definitions.** For purposes of this section, the following terms have the
 436.26 meanings given them.

436.27 (a) "Children's therapeutic services and supports" means the flexible package of mental
 436.28 health services for children who require varying therapeutic and rehabilitative levels of
 436.29 intervention to treat a diagnosed emotional disturbance, ~~as defined in section 245.4871,~~
 436.30 ~~subdivision 15, or a diagnosed mental illness, as defined in section 245.462, subdivision~~
 436.31 ~~20.~~ The services are time-limited interventions that are delivered using various treatment
 436.32 modalities and combinations of services designed to reach treatment outcomes identified
 436.33 in the individual treatment plan.

437.1 ~~(b) "Clinical supervision" means the overall responsibility of the mental health~~
437.2 ~~professional for the control and direction of individualized treatment planning, service~~
437.3 ~~delivery, and treatment review for each client. A mental health professional who is an~~
437.4 ~~enrolled Minnesota health care program provider accepts full professional responsibility~~
437.5 ~~for a supervisee's actions and decisions, instructs the supervisee in the supervisee's work,~~
437.6 ~~and oversees or directs the supervisee's work.~~

437.7 ~~(e)~~ (b) "Clinical trainee" means a mental health practitioner who meets the qualifications
437.8 specified in Minnesota Rules, part 9505.0371, subpart 5, item C means a staff person
437.9 qualified according to section 245I.16, subdivision 6.

437.10 ~~(d) "Crisis assistance" has the meaning given in section 245.4871, subdivision 9a. Crisis~~
437.11 ~~assistance entails the development of a written plan to assist a child's family to contend with~~
437.12 ~~a potential crisis and is distinct from the immediate provision of crisis intervention services.~~

437.13 (c) "Crisis planning" means the support and planning activities described under section
437.14 245.4871, subdivision 9a.

437.15 ~~(e)~~ (d) "Culturally competent provider" means a provider who understands and can
437.16 utilize to a client's benefit the client's culture when providing services to the client. A provider
437.17 may be culturally competent because the provider is of the same cultural or ethnic group
437.18 as the client or the provider has developed the knowledge and skills through training and
437.19 experience to provide services to culturally diverse clients.

437.20 ~~(f)~~ (e) "Day treatment program" for children means a site-based structured mental health
437.21 program consisting of psychotherapy for three or more individuals and individual or group
437.22 skills training provided by a multidisciplinary treatment team, under the clinical treatment
437.23 supervision of a mental health professional.

437.24 ~~(g)~~ (f) "Diagnostic assessment" has the meaning given in Minnesota Rules, part
437.25 9505.0372, subpart 1 means the assessment described under section 256B.0671, subdivisions
437.26 2 and 3.

437.27 ~~(h)~~ (g) "Direct service time" means the time that a mental health professional, clinical
437.28 trainee, mental health practitioner, or mental health behavioral aide spends face-to-face with
437.29 a client and the client's family or providing covered telemedicine services. Direct service
437.30 time includes time in which the provider obtains a client's history, develops a client's
437.31 treatment plan, records individual treatment outcomes, or provides service components of
437.32 children's therapeutic services and supports. Direct service time does not include time doing
437.33 work before and after providing direct services, including scheduling or maintaining clinical
437.34 records.

438.1 ~~(h)~~ (h) "Direction of mental health behavioral aide" means the activities of a mental
 438.2 health professional, clinical trainee, or mental health practitioner in guiding the mental
 438.3 health behavioral aide in providing services to a client. The direction of a mental health
 438.4 behavioral aide must be based on the client's individualized treatment plan and meet the
 438.5 requirements in subdivision 6, paragraph (b), clause (5).

438.6 ~~(i)~~ (i) "Emotional disturbance" has the meaning given in section 245.4871, subdivision
 438.7 15.

438.8 ~~(j)~~ (j) "Individual behavioral plan" means a plan of intervention, treatment, and services
 438.9 for a child written by a mental health professional, clinical trainee, or mental health
 438.10 practitioner, under the ~~clinical~~ treatment supervision of a mental health professional, to
 438.11 guide the work of the mental health behavioral aide. The individual behavioral plan may
 438.12 be incorporated into the child's individual treatment plan so long as the behavioral plan is
 438.13 separately communicable to the mental health behavioral aide.

438.14 ~~(k)~~ (k) "Individual treatment plan" ~~has the meaning given in Minnesota Rules, part~~
 438.15 ~~9505.0371, subpart 7~~ means the plan described under section 256B.0671, subdivisions 5
 438.16 and 6.

438.17 ~~(l)~~ (l) "Mental health behavioral aide services" means medically necessary ~~one-on-one~~
 438.18 activities performed by a trained paraprofessional ~~qualified as provided in subdivision 7,~~
 438.19 ~~paragraph (b), clause (3),~~ to assist a child retain or generalize psychosocial skills as previously
 438.20 trained by a mental health professional, clinical trainee, or mental health practitioner and
 438.21 as described in the child's individual treatment plan and individual behavior plan. Activities
 438.22 involve working directly with the child or child's family as provided in subdivision 9,
 438.23 paragraph (b), clause (4).

438.24 (m) "Mental health certified family peer specialist" means a staff person qualified
 438.25 according to section 245I.16, subdivision 12.

438.26 ~~(n) "Mental health practitioner" has the meaning given in~~ means a staff person qualified
 438.27 according to section 245.462, subdivision 17, except that a practitioner working in a day
 438.28 treatment setting may qualify as a mental health practitioner if the practitioner holds a
 438.29 bachelor's degree in one of the behavioral sciences or related fields from an accredited
 438.30 college or university, and: (1) has at least 2,000 hours of clinically supervised experience
 438.31 in the delivery of mental health services to clients with mental illness; (2) is fluent in the
 438.32 language, other than English, of the cultural group that makes up at least 50 percent of the
 438.33 practitioner's clients, completes 40 hours of training on the delivery of services to clients
 438.34 with mental illness, and receives clinical supervision from a mental health professional at

439.1 ~~least once per week until meeting the required 2,000 hours of supervised experience; or (3)~~
439.2 ~~receives 40 hours of training on the delivery of services to clients with mental illness within~~
439.3 ~~six months of employment, and clinical supervision from a mental health professional at~~
439.4 ~~least once per week until meeting the required 2,000 hours of supervised experience~~ 245I.16,
439.5 subdivision 4.

439.6 (o) "Mental health professional" means ~~an individual as defined in Minnesota Rules,~~
439.7 ~~part 9505.0370, subpart 18~~ a staff person qualified according to section 245I.16, subdivision
439.8 2.

439.9 (p) "Mental health service plan development" includes:

439.10 (1) the development, review, and revision of a child's individual treatment plan, as
439.11 ~~provided in Minnesota Rules, part 9505.0371, subpart 7~~ according to section 256B.0671,
439.12 subdivisions 5 and 6, including involvement of the client or client's parents, primary
439.13 caregiver, or other person authorized to consent to mental health services for the client, and
439.14 including arrangement of treatment and support activities specified in the individual treatment
439.15 plan; and

439.16 (2) administering standardized outcome measurement instruments, determined and
439.17 updated by the commissioner, as periodically needed to evaluate the effectiveness of
439.18 treatment for children receiving clinical services and reporting outcome measures, as required
439.19 by the commissioner.

439.20 (q) "Mental illness," for persons at least age 18 but under age 21, has the meaning given
439.21 in section 245.462, subdivision 20, paragraph (a).

439.22 (r) "Psychotherapy" means the treatment of mental or emotional disorders or
439.23 maladjustment by psychological means. Psychotherapy may be provided in many modalities
439.24 ~~in accordance with Minnesota Rules, part 9505.0372, subpart 6,~~ including patient and/or
439.25 family psychotherapy; family psychotherapy; psychotherapy for crisis; group psychotherapy;
439.26 or multiple-family psychotherapy. ~~Beginning with the American Medical Association's~~
439.27 ~~Current Procedural Terminology, standard edition, 2014, the procedure "individual~~
439.28 ~~psychotherapy" is replaced with "patient and/or family psychotherapy," a substantive change~~
439.29 ~~that permits the therapist to work with the client's family without the client present to obtain~~
439.30 ~~information about the client or to explain the client's treatment plan to the family.~~
439.31 Psychotherapy for crisis is appropriate for crisis response when a child has become
439.32 dysregulated or experienced new trauma since the diagnostic assessment was completed
439.33 and needs psychotherapy to address issues not currently included in the child's individual
439.34 treatment plan.

440.1 (s) "Rehabilitative services" or "psychiatric rehabilitation services" means ~~a series of~~
440.2 ~~multidisciplinary combination of psychiatric and psychosocial~~ interventions to: (1) restore
440.3 a child or adolescent to an age-appropriate developmental trajectory that had been disrupted
440.4 by a psychiatric illness; or (2) enable the child to self-monitor, compensate for, cope with,
440.5 counteract, or replace psychosocial skills deficits or maladaptive skills acquired over the
440.6 course of a psychiatric illness. Psychiatric rehabilitation services for children combine
440.7 coordinated psychotherapy to address internal psychological, emotional, and intellectual
440.8 processing deficits, and skills training to restore personal and social functioning. Psychiatric
440.9 rehabilitation services establish a progressive series of goals with each achievement building
440.10 upon a prior achievement. ~~Continuing progress toward goals is expected, and rehabilitative~~
440.11 ~~potential ceases when successive improvement is not observable over a period of time.~~

440.12 (t) "Skills training" means individual, family, or group training, delivered by or under
440.13 the supervision of a mental health professional, designed to facilitate the acquisition of
440.14 psychosocial skills that are medically necessary to rehabilitate the child to an age-appropriate
440.15 developmental trajectory heretofore disrupted by a psychiatric illness or to enable the child
440.16 to self-monitor, compensate for, cope with, counteract, or replace skills deficits or
440.17 maladaptive skills acquired over the course of a psychiatric illness. Skills training is subject
440.18 to the service delivery requirements under subdivision 9, paragraph (b), clause (2).

440.19 (u) "Treatment supervision" means the supervision described under section 245I.18.

440.20 Sec. 101. Minnesota Statutes 2018, section 256B.0943, subdivision 2, is amended to read:

440.21 Subd. 2. **Covered service components of children's therapeutic services and**
440.22 **supports.** (a) ~~Subject to federal approval,~~ Medical assistance covers medically necessary
440.23 children's therapeutic services and supports as defined in this section that an eligible provider
440.24 entity certified under subdivision 4 provides to a client eligible under subdivision 3.

440.25 (b) The service components of children's therapeutic services and supports are:

440.26 (1) patient and/or family psychotherapy, family psychotherapy, psychotherapy for crisis,
440.27 and group psychotherapy;

440.28 (2) individual, family, or group skills training provided by a mental health professional
440.29 or mental health practitioner;

440.30 (3) crisis ~~assistance~~ planning;

440.31 (4) mental health behavioral aide services;

440.32 (5) direction of a mental health behavioral aide;

441.1 (6) mental health service plan development; and

441.2 (7) children's day treatment.

441.3 Sec. 102. Minnesota Statutes 2018, section 256B.0943, subdivision 3, is amended to read:

441.4 Subd. 3. **Determination of client eligibility.** A client's eligibility to receive children's
 441.5 therapeutic services and supports under this section shall be determined based on a diagnostic
 441.6 assessment by a mental health professional or a ~~mental health practitioner who meets the~~
 441.7 ~~requirements of a clinical trainee as defined in Minnesota Rules, part 9505.0371, subpart~~
 441.8 ~~5, item C,~~ that is performed within one year before the initial start of service. The diagnostic
 441.9 assessment must meet the requirements for a standard ~~or extended~~ diagnostic assessment
 441.10 ~~as defined in Minnesota Rules, part 9505.0372, subpart 1, items B and C,~~ and:

441.11 (1) ~~include current diagnoses, including any differential diagnosis, in accordance with~~
 441.12 ~~all criteria for a complete diagnosis and diagnostic profile as specified in the current edition~~
 441.13 ~~of the Diagnostic and Statistical Manual of the American Psychiatric Association, or, for~~
 441.14 ~~children under age five, as six, follow the requirements~~ specified in the current edition of
 441.15 the Diagnostic Classification of Mental Health Disorders of Infancy and Early Childhood;

441.16 (2) determine whether a child under age 18 has a diagnosis of emotional disturbance or,
 441.17 if the person is between the ages of 18 and 21, whether the person has a mental illness;

441.18 (3) document children's therapeutic services and supports as medically necessary to
 441.19 address an identified disability, functional impairment, and the individual client's needs and
 441.20 goals; and

441.21 (4) be used in the development of the individualized treatment plan; and

441.22 (5) ~~be completed annually until age 18. For individuals between age 18 and 21, unless~~
 441.23 ~~a client's mental health condition has changed markedly since the client's most recent~~
 441.24 ~~diagnostic assessment, annual updating is necessary. For the purpose of this section,~~
 441.25 ~~"updating" means an adult diagnostic update as defined in Minnesota Rules, part 9505.0371,~~
 441.26 ~~subpart 2, item E.~~

441.27 Sec. 103. Minnesota Statutes 2018, section 256B.0943, subdivision 4, is amended to read:

441.28 Subd. 4. **Provider entity certification.** (a) The commissioner shall establish an initial
 441.29 provider entity application and certification process and recertification process to determine
 441.30 whether a provider entity has an administrative and clinical infrastructure that meets the
 441.31 requirements in subdivisions 5 and 6. A provider entity must be certified for the three core
 441.32 rehabilitation services of psychotherapy, skills training, and crisis assistance planning. The

442.1 commissioner shall recertify a provider entity at least every three years. The commissioner
 442.2 shall establish a process for decertification of a provider entity and shall require corrective
 442.3 action, medical assistance repayment, or decertification of a provider entity that no longer
 442.4 meets the requirements in this section or that fails to meet the clinical quality standards or
 442.5 administrative standards provided by the commissioner in the application and certification
 442.6 process.

442.7 (b) For purposes of this section, a provider entity must meet all requirements in chapter
 442.8 245I and be:

442.9 (1) an Indian health services facility or a facility owned and operated by a tribe or tribal
 442.10 organization operating as a 638 facility under Public Law 93-638 certified by the state;

442.11 (2) a county-operated entity certified by the state; or

442.12 (3) a noncounty entity certified by the state.

442.13 Sec. 104. Minnesota Statutes 2018, section 256B.0943, subdivision 5, is amended to read:

442.14 Subd. 5. **Provider entity administrative infrastructure requirements.** (a) To be an
 442.15 eligible provider entity under this section, a provider entity must have an administrative
 442.16 infrastructure that establishes authority and accountability for decision making and oversight
 442.17 of functions, including finance, personnel, system management, clinical practice, and
 442.18 individual treatment outcomes measurement. An eligible provider entity shall demonstrate
 442.19 the availability, by means of employment or contract, of at least one backup mental health
 442.20 professional in the event of the primary mental health professional's absence. The provider
 442.21 must have written policies and procedures that it reviews and updates every three years and
 442.22 distributes to staff initially and upon each subsequent update.

442.23 (b) The administrative infrastructure written policies and procedures must be in
 442.24 accordance with sections 245I.10 and 245I.13 and must include:

442.25 (1) personnel procedures, including a process for: (i) recruiting, hiring, training, and
 442.26 retention of culturally and linguistically competent providers; (ii) conducting a criminal
 442.27 background check on all direct service providers and volunteers; (iii) investigating, reporting,
 442.28 and acting on violations of ethical conduct standards; (iv) investigating, reporting, and acting
 442.29 on violations of data privacy policies that are compliant with federal and state laws; (v)
 442.30 utilizing volunteers, including screening applicants, training and supervising volunteers,
 442.31 and providing liability coverage for volunteers; and (vi) documenting that each ~~mental~~
 442.32 ~~health professional, mental health practitioner, or mental health behavioral aide meets the~~
 442.33 ~~applicable provider qualification criteria~~ staff person meets the applicable qualifications

443.1 ~~under section 245I.16, training criteria under subdivision 8 section 245I.10, and clinical~~
 443.2 ~~treatment supervision or direction of a mental health behavioral aide requirements under~~
 443.3 ~~subdivision 6 section 245I.18;~~

443.4 (2) fiscal procedures, including internal fiscal control practices and a process for collecting
 443.5 revenue that is compliant with federal and state laws;

443.6 (3) a client-specific treatment outcomes measurement system, including baseline
 443.7 measures, to measure a client's progress toward achieving mental health rehabilitation goals.
 443.8 ~~Effective July 1, 2017,~~ To be eligible for medical assistance payment, a provider entity must
 443.9 report individual client outcomes to the commissioner, using instruments and protocols
 443.10 approved by the commissioner; and

443.11 (4) a process to establish and maintain individual client records in accordance with
 443.12 section 245I.32. ~~The client's records must include:~~

443.13 ~~(i) the client's personal information;~~

443.14 ~~(ii) forms applicable to data privacy;~~

443.15 ~~(iii) the client's diagnostic assessment, updates, results of tests, individual treatment~~
 443.16 ~~plan, and individual behavior plan, if necessary;~~

443.17 ~~(iv) documentation of service delivery as specified under subdivision 6;~~

443.18 ~~(v) telephone contacts;~~

443.19 ~~(vi) discharge plan; and~~

443.20 ~~(vii) if applicable, insurance information.~~

443.21 (c) A provider entity that uses a restrictive procedure with a client must meet the
 443.22 requirements of section 245.8261.

443.23 Sec. 105. Minnesota Statutes 2018, section 256B.0943, subdivision 6, is amended to read:

443.24 **Subd. 6. Provider entity clinical infrastructure requirements.** (a) To be an eligible
 443.25 provider entity under this section, a provider entity must have a clinical infrastructure that
 443.26 utilizes diagnostic assessment, individualized treatment plans, service delivery, and individual
 443.27 treatment plan review that are culturally competent, child-centered, and family-driven to
 443.28 achieve maximum benefit for the client. The provider entity must review, and update as
 443.29 necessary, the clinical policies and procedures every three years, must distribute the policies
 443.30 and procedures to staff initially and upon each subsequent update, and must train staff
 443.31 accordingly.

444.1 (b) The clinical infrastructure written policies and procedures must include policies and
444.2 procedures for:

444.3 (1) providing or obtaining a client's diagnostic assessment, including a diagnostic
444.4 assessment performed by an outside or independent clinician, that identifies acute and
444.5 chronic clinical disorders, co-occurring medical conditions, and sources of psychological
444.6 and environmental problems, including baselines, and a functional assessment. The functional
444.7 assessment component must clearly summarize the client's individual strengths and needs.
444.8 When required components of the diagnostic assessment, such as baseline measures, are
444.9 not provided in an outside or independent assessment or when baseline measures cannot be
444.10 attained in a ~~one-session~~ standard diagnostic assessment, the provider entity must determine
444.11 the missing information within 30 days and amend the child's diagnostic assessment or
444.12 incorporate the baselines into the child's individual treatment plan;

444.13 (2) developing an individual treatment plan ~~that~~ according to section 256B.0671,
444.14 subdivisions 5 and 6;

444.15 ~~(i) is based on the information in the client's diagnostic assessment and baselines;~~

444.16 ~~(ii) identified goals and objectives of treatment, treatment strategy, schedule for~~
444.17 ~~accomplishing treatment goals and objectives, and the individuals responsible for providing~~
444.18 ~~treatment services and supports;~~

444.19 ~~(iii) is developed after completion of the client's diagnostic assessment by a mental health~~
444.20 ~~professional or clinical trainee and before the provision of children's therapeutic services~~
444.21 ~~and supports;~~

444.22 ~~(iv) is developed through a child-centered, family-driven, culturally appropriate planning~~
444.23 ~~process, including allowing parents and guardians to observe or participate in individual~~
444.24 ~~and family treatment services, assessment, and treatment planning;~~

444.25 ~~(v) is reviewed at least once every 90 days and revised to document treatment progress~~
444.26 ~~on each treatment objective and next goals or, if progress is not documented, to document~~
444.27 ~~changes in treatment; and~~

444.28 ~~(vi) is signed by the clinical supervisor and by the client or by the client's parent or other~~
444.29 ~~person authorized by statute to consent to mental health services for the client. A client's~~
444.30 ~~parent may approve the client's individual treatment plan by secure electronic signature or~~
444.31 ~~by documented oral approval that is later verified by written signature;~~

445.1 (3) developing an individual behavior plan that documents ~~treatment strategies~~ and
445.2 describes interventions to be provided by the mental health behavioral aide. The individual
445.3 behavior plan must include:

445.4 (i) detailed instructions on the ~~treatment strategies to be provided~~ psychosocial skills to
445.5 be practiced;

445.6 (ii) time allocated to each ~~treatment strategy~~ intervention;

445.7 (iii) methods of documenting the child's behavior;

445.8 (iv) methods of monitoring the child's progress in reaching objectives; and

445.9 (v) goals to increase or decrease targeted behavior as identified in the individual treatment
445.10 plan;

445.11 (4) providing ~~clinical~~ treatment supervision plans for mental health practitioners and
445.12 ~~mental health behavioral aides~~ according to section 245I.18. A mental health professional
445.13 ~~must document the clinical supervision the professional provides by cosigning individual~~
445.14 ~~treatment plans and making entries in the client's record on supervisory activities. The~~
445.15 ~~clinical supervisor also shall document supervisee-specific supervision in the supervisee's~~
445.16 ~~personnel file. Clinical~~ Treatment supervision does not include the authority to make or
445.17 terminate court-ordered placements of the child. A clinical supervisor must be available for
445.18 ~~urgent consultation as required by the individual client's needs or the situation. Clinical~~
445.19 ~~supervision may occur individually or in a small group to discuss treatment and review~~
445.20 ~~progress toward goals. The focus of clinical supervision must be the client's treatment needs~~
445.21 ~~and progress and the mental health practitioner's or behavioral aide's ability to provide~~
445.22 ~~services~~;

445.23 (4a) meeting day treatment program conditions in items (i) to (iii):

445.24 (i) the ~~clinical~~ treatment supervisor must be present and available on the premises more
445.25 than 50 percent of the time in a provider's standard working week during which the supervisee
445.26 is providing a mental health service;

445.27 (ii) the treatment supervisor must review and approve the client's diagnosis and the
445.28 client's individual treatment plan or a change in the diagnosis or individual treatment plan
445.29 ~~must be made by or reviewed, approved, and signed by the clinical supervisor~~; and

445.30 (iii) every 30 days, the ~~clinical~~ treatment supervisor must review and sign the record
445.31 indicating the supervisor has reviewed the client's care for all activities in the preceding
445.32 30-day period;

446.1 (4b) meeting the ~~clinical~~ treatment supervision standards in items (i) to ~~(iv)~~ and (ii) for
 446.2 all other services provided under CTSS:

446.3 ~~(i) medical assistance shall reimburse for services provided by a mental health practitioner~~
 446.4 ~~who is delivering services that fall within the scope of the practitioner's practice and who~~
 446.5 ~~is supervised by a mental health professional who accepts full professional responsibility;~~

446.6 ~~(ii) medical assistance shall reimburse for services provided by a mental health behavioral~~
 446.7 ~~aide who is delivering services that fall within the scope of the aide's practice and who is~~
 446.8 ~~supervised by a mental health professional who accepts full professional responsibility and~~
 446.9 ~~has an approved plan for clinical supervision of the behavioral aide. Plans must be developed~~
 446.10 ~~in accordance with supervision standards defined in Minnesota Rules, part 9505.0371,~~
 446.11 ~~subpart 4, items A to D;~~

446.12 ~~(iii)~~ (i) the mental health professional is required to be present at the site of service
 446.13 delivery for observation as clinically appropriate when the mental health practitioner or
 446.14 mental health behavioral aide is providing CTSS services; and

446.15 ~~(iv)~~ (ii) when conducted, the on-site presence of the mental health professional must be
 446.16 documented in the child's record and signed by the mental health professional who accepts
 446.17 full professional responsibility;

446.18 (5) providing direction to a mental health behavioral aide. For entities that employ mental
 446.19 health behavioral aides, the ~~clinical~~ treatment supervisor must be employed by the provider
 446.20 entity or other provider certified to provide mental health behavioral aide services to ensure
 446.21 necessary and appropriate oversight for the client's treatment and continuity of care. The
 446.22 ~~mental health professional or mental health practitioner~~ staff giving direction must begin
 446.23 with the goals on the individualized treatment plan, and instruct the mental health behavioral
 446.24 aide on how to implement therapeutic activities and interventions that will lead to goal
 446.25 attainment. The ~~professional or practitioner~~ staff giving direction must also instruct the
 446.26 mental health behavioral aide about the client's diagnosis, functional status, and other
 446.27 characteristics that are likely to affect service delivery. Direction must also include
 446.28 determining that the mental health behavioral aide has the skills to interact with the client
 446.29 and the client's family in ways that convey personal and cultural respect and that the aide
 446.30 actively solicits information relevant to treatment from the family. The aide must be able
 446.31 to clearly explain or demonstrate the activities the aide is doing with the client and the
 446.32 activities' relationship to treatment goals. Direction is more didactic than is supervision and
 446.33 requires the ~~professional or practitioner~~ staff providing it to continuously evaluate the mental
 446.34 health behavioral aide's ability to carry out the activities of the individualized treatment

447.1 plan and the individualized behavior plan. When providing direction, the ~~professional or~~
 447.2 ~~practitioner~~ staff must:

447.3 (i) review progress notes prepared by the mental health behavioral aide for accuracy and
 447.4 consistency with diagnostic assessment, treatment plan, and behavior goals and the
 447.5 professional or practitioner must approve and sign the progress notes;

447.6 (ii) identify changes in treatment strategies, revise the individual behavior plan, and
 447.7 communicate treatment instructions and methodologies as appropriate to ensure that treatment
 447.8 is implemented correctly;

447.9 (iii) demonstrate family-friendly behaviors that support healthy collaboration among
 447.10 the child, the child's family, and providers as treatment is planned and implemented;

447.11 (iv) ensure that the mental health behavioral aide is able to effectively communicate
 447.12 with the child, the child's family, and the provider; and

447.13 (v) record the results of any evaluation and corrective actions taken to modify the work
 447.14 of the mental health behavioral aide;

447.15 (6) providing service delivery that implements the individual treatment plan and meets
 447.16 the requirements under subdivision 9; and

447.17 (7) individual treatment plan review. The review must determine the extent to which
 447.18 the services have met each of the goals and objectives in the treatment plan. The review
 447.19 must assess the client's progress and ensure that services and treatment goals continue to
 447.20 be necessary and appropriate to the client and the client's family or foster family. ~~Revision~~
 447.21 ~~of the individual treatment plan does not require a new diagnostic assessment unless the~~
 447.22 ~~client's mental health status has changed markedly. The updated treatment plan must be~~
 447.23 ~~signed by the clinical supervisor and by the client, if appropriate, and by the client's parent~~
 447.24 ~~or other person authorized by statute to give consent to the mental health services for the~~
 447.25 ~~child.~~

447.26 Sec. 106. Minnesota Statutes 2018, section 256B.0943, subdivision 7, is amended to read:

447.27 Subd. 7. **Qualifications of individual and team providers.** (a) An individual or team
 447.28 provider working within the scope of the provider's practice or qualifications may provide
 447.29 service components of children's therapeutic services and supports that are identified as
 447.30 medically necessary in a client's individual treatment plan.

447.31 (b) An individual provider must be qualified as:

447.32 (1) a mental health professional ~~as defined in subdivision 1, paragraph (o); or~~

448.1 (2) a mental health practitioner or clinical trainee. ~~The mental health practitioner or~~
 448.2 ~~clinical trainee must work under the clinical supervision of a mental health professional; or~~

448.3 (3) a mental health behavioral aide ~~working under the clinical supervision of a mental~~
 448.4 ~~health professional to implement the rehabilitative mental health services previously~~
 448.5 ~~introduced by a mental health professional or practitioner and identified in the client's~~
 448.6 ~~individual treatment plan and individual behavior plan.; or~~

448.7 (4) a mental health certified family peer specialist.

448.8 ~~(A) A level I mental health behavioral aide must:~~

448.9 ~~(i) be at least 18 years old;~~

448.10 ~~(ii) have a high school diploma or commissioner of education-selected high school~~
 448.11 ~~equivalency certification or two years of experience as a primary caregiver to a child with~~
 448.12 ~~severe emotional disturbance within the previous ten years; and~~

448.13 ~~(iii) meet preservice and continuing education requirements under subdivision 8.~~

448.14 ~~(B) A level II mental health behavioral aide must:~~

448.15 ~~(i) be at least 18 years old;~~

448.16 ~~(ii) have an associate or bachelor's degree or 4,000 hours of experience in delivering~~
 448.17 ~~clinical services in the treatment of mental illness concerning children or adolescents or~~
 448.18 ~~complete a certificate program established under subdivision 8a; and~~

448.19 ~~(iii) meet preservice and continuing education requirements in subdivision 8.~~

448.20 ~~(e) A day treatment multidisciplinary team must include at least one mental health~~
 448.21 ~~professional or clinical trainee and one mental health practitioner.~~

448.22 Sec. 107. Minnesota Statutes 2018, section 256B.0943, subdivision 8, is amended to read:

448.23 Subd. 8. **Required preservice and continuing education.** ~~(a)~~ A provider entity shall
 448.24 establish a plan to provide preservice and continuing education for staff according to section
 448.25 245I.10. ~~The plan must clearly describe the type of training necessary to maintain current~~
 448.26 ~~skills and obtain new skills and that relates to the provider entity's goals and objectives for~~
 448.27 ~~services offered.~~

448.28 ~~(b) A provider that employs a mental health behavioral aide under this section must~~
 448.29 ~~require the mental health behavioral aide to complete 30 hours of preservice training. The~~
 448.30 ~~preservice training must include parent team training. The preservice training must include~~
 448.31 ~~15 hours of in-person training of a mental health behavioral aide in mental health services~~

449.1 ~~delivery and eight hours of parent team training. Curricula for parent team training must be~~
 449.2 ~~approved in advance by the commissioner. Components of parent team training include:~~

449.3 ~~(1) partnering with parents;~~

449.4 ~~(2) fundamentals of family support;~~

449.5 ~~(3) fundamentals of policy and decision-making;~~

449.6 ~~(4) defining equal partnership;~~

449.7 ~~(5) complexities of the parent and service provider partnership in multiple service delivery~~
 449.8 ~~systems due to system strengths and weaknesses;~~

449.9 ~~(6) sibling impacts;~~

449.10 ~~(7) support networks; and~~

449.11 ~~(8) community resources.~~

449.12 ~~(c) A provider entity that employs a mental health practitioner and a mental health~~
 449.13 ~~behavioral aide to provide children's therapeutic services and supports under this section~~
 449.14 ~~must require the mental health practitioner and mental health behavioral aide to complete~~
 449.15 ~~20 hours of continuing education every two calendar years. The continuing education must~~
 449.16 ~~be related to serving the needs of a child with emotional disturbance in the child's home~~
 449.17 ~~environment and the child's family.~~

449.18 ~~(d) The provider entity must document the mental health practitioner's or mental health~~
 449.19 ~~behavioral aide's annual completion of the required continuing education. The documentation~~
 449.20 ~~must include the date, subject, and number of hours of the continuing education, and~~
 449.21 ~~attendance records, as verified by the staff member's signature, job title, and the instructor's~~
 449.22 ~~name. The provider entity must keep documentation for each employee, including records~~
 449.23 ~~of attendance at professional workshops and conferences, at a central location and in the~~
 449.24 ~~employee's personnel file.~~

449.25 Sec. 108. Minnesota Statutes 2018, section 256B.0943, subdivision 9, is amended to read:

449.26 Subd. 9. **Service delivery criteria.** (a) In delivering services under this section, a certified
 449.27 provider entity must ensure that:

449.28 (1) ~~each individual provider's caseload size permits the provider to deliver services to~~
 449.29 ~~both clients with severe, complex needs and clients with less intensive needs. the provider's~~
 449.30 ~~caseload size should reasonably enable~~ enables the provider to play an active role in service

450.1 planning, monitoring, and delivering services to meet the client's and client's family's needs,
450.2 as specified in each client's individual treatment plan;

450.3 (2) site-based programs, including day treatment programs, provide staffing and facilities
450.4 to ensure the client's health, safety, and protection of rights, and that the programs are able
450.5 to implement each client's individual treatment plan; and

450.6 (3) a day treatment program is provided to a group of clients by a ~~multidisciplinary~~ team
450.7 under the ~~clinical~~ treatment supervision of a mental health professional. The day treatment
450.8 program must be provided in and by: (i) an outpatient hospital accredited by the Joint
450.9 Commission on Accreditation of Health Organizations and licensed under sections 144.50
450.10 to 144.55; (ii) a community mental health center under section 245.62; or (iii) an entity that
450.11 is certified under subdivision 4 to operate a program that meets the requirements of section
450.12 245.4884, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475. The day
450.13 treatment program must stabilize the client's mental health status while developing and
450.14 improving the client's independent living and socialization skills. The goal of the day
450.15 treatment program must be to reduce or relieve the effects of mental illness and provide
450.16 training to enable the client to live in the community. The program must be available
450.17 year-round at least three to five days per week, two or three hours per day, unless the normal
450.18 five-day school week is shortened by a holiday, weather-related cancellation, or other
450.19 districtwide reduction in a school week. A child transitioning into or out of day treatment
450.20 must receive a minimum treatment of one day a week for a two-hour time block. The
450.21 two-hour time block must include at least one hour of patient and/or family or group
450.22 psychotherapy. The remainder of the structured treatment program may include patient
450.23 and/or family or group psychotherapy, and individual or group skills training, if included
450.24 in the client's individual treatment plan. Day treatment programs are not part of inpatient
450.25 or residential treatment services. When a day treatment group that meets the minimum group
450.26 size requirement temporarily falls below the minimum group size because of a member's
450.27 temporary absence, medical assistance covers a group session conducted for the group
450.28 members in attendance. A day treatment program may provide fewer than the minimally
450.29 required hours for a particular child during a billing period in which the child is transitioning
450.30 into, or out of, the program.

450.31 (b) To be eligible for medical assistance payment, a provider entity must deliver the
450.32 service components of children's therapeutic services and supports in compliance with the
450.33 following requirements:

450.34 (1) patient and/or family, family, and group psychotherapy must be delivered as specified
450.35 in ~~Minnesota Rules, part 9505.0372, subpart 6~~ section 256B.0625, subdivision 69.

451.1 Psychotherapy to address the child's underlying mental health disorder must be documented
451.2 as part of the child's ongoing treatment. A provider must deliver, or arrange for, medically
451.3 necessary psychotherapy, unless the child's parent or caregiver chooses not to receive it.
451.4 When a provider delivering other services to a child under this section deems it not medically
451.5 necessary to provide psychotherapy to the child for a period of 90 days or longer, the provider
451.6 entity must document the medical reasons why psychotherapy is not necessary. When a
451.7 provider determines that a child needs psychotherapy but psychotherapy cannot be delivered
451.8 due to a shortage of licensed mental health professionals in the child's community, the
451.9 provider must document the lack of access in the child's medical record;

451.10 (2) individual, family, or group skills training ~~must be provided by a mental health~~
451.11 ~~professional or a mental health practitioner who is delivering services that fall within the~~
451.12 ~~scope of the provider's practice and is supervised by a mental health professional who~~
451.13 ~~accepts full professional responsibility for the training.~~ Skills training is subject to the
451.14 following requirements:

451.15 (i) a mental health professional, clinical trainee, or mental health practitioner shall provide
451.16 skills training;

451.17 (ii) skills training delivered to a child or the child's family must be targeted to the specific
451.18 deficits or maladaptations of the child's mental health disorder and must be prescribed in
451.19 the child's individual treatment plan;

451.20 (iii) the mental health professional delivering or supervising the delivery of skills training
451.21 must document any underlying psychiatric condition and must document how skills training
451.22 is being used in conjunction with psychotherapy to address the underlying condition;

451.23 (iv) skills training delivered to the child's family must teach skills needed by parents or
451.24 primary caregivers to enhance the child's skill development, to help the child utilize daily
451.25 life skills taught by a mental health professional, clinical trainee, or mental health practitioner,
451.26 and to develop or maintain a home environment that supports the child's progressive use of
451.27 skills;

451.28 (v) group skills training may be provided to multiple recipients who, because of the
451.29 nature of their emotional, behavioral, or social dysfunction, can derive mutual benefit from
451.30 interaction in a group setting, which must be staffed as follows:

451.31 (A) one mental health professional or one clinical trainee or mental health practitioner
451.32 ~~under supervision of a licensed mental health professional~~ must work with a group of three
451.33 to eight clients; or

452.1 (B) any combination of two mental health professionals, two clinical trainees, or mental
452.2 health practitioners under supervision of a licensed mental health professional, or one mental
452.3 health professional or clinical trainee and one mental health practitioner must work with a
452.4 group of nine to 12 clients;

452.5 (vi) a mental health professional, clinical trainee, or mental health practitioner must have
452.6 taught the psychosocial skill before a mental health behavioral aide may practice that skill
452.7 with the client; and

452.8 (vii) for group skills training, when a skills group that meets the minimum group size
452.9 requirement temporarily falls below the minimum group size because of a group member's
452.10 temporary absence, the provider may conduct the session for the group members in
452.11 attendance;

452.12 (3) crisis ~~assistance~~ planning to a child and family must include development of a written
452.13 plan that anticipates the particular factors specific to the child that may precipitate a
452.14 psychiatric crisis for the child in the near future. The written plan must document actions
452.15 that the family should be prepared to take to resolve or stabilize a crisis, such as advance
452.16 arrangements for direct intervention and support services to the child and the child's family.
452.17 Crisis ~~assistance~~ planning must include preparing resources designed to address abrupt or
452.18 substantial changes in the functioning of the child or the child's family when sudden change
452.19 in behavior or a loss of usual coping mechanisms is observed, or the child begins to present
452.20 a danger to self or others;

452.21 (4) mental health behavioral aide services must be medically necessary treatment services,
452.22 identified in the child's individual treatment plan and individual behavior plan, ~~which are~~
452.23 ~~performed minimally by a paraprofessional qualified according to subdivision 7, paragraph~~
452.24 ~~(b), clause (3), and~~ which are designed to improve the functioning of the child in the
452.25 progressive use of developmentally appropriate psychosocial skills. Activities involve
452.26 working directly with the child, child-peer groupings, or child-family groupings to practice,
452.27 repeat, reintroduce, and master the skills defined in subdivision 1, paragraph (t), as previously
452.28 taught by a mental health professional, clinical trainee, or mental health practitioner including:

452.29 (i) providing cues or prompts in skill-building peer-to-peer or parent-child interactions
452.30 so that the child progressively recognizes and responds to the cues independently;

452.31 (ii) performing as a practice partner or role-play partner;

452.32 (iii) reinforcing the child's accomplishments;

452.33 (iv) generalizing skill-building activities in the child's multiple natural settings;

453.1 (v) assigning further practice activities; and

453.2 (vi) intervening as necessary to redirect the child's target behavior and to de-escalate
453.3 behavior that puts the child or other person at risk of injury.

453.4 To be eligible for medical assistance payment, mental health behavioral aide services must
453.5 be delivered to a child who has been diagnosed with an emotional disturbance or a mental
453.6 illness, as provided in subdivision 1, paragraph (a). The mental health behavioral aide must
453.7 implement treatment strategies in the individual treatment plan and the individual behavior
453.8 plan as developed by the mental health professional, clinical trainee, or mental health
453.9 practitioner providing direction for the mental health behavioral aide. The mental health
453.10 behavioral aide must document the delivery of services in written progress notes. Progress
453.11 notes must reflect implementation of the treatment strategies, as performed by the mental
453.12 health behavioral aide and the child's responses to the treatment strategies;

453.13 (5) direction of a mental health behavioral aide must include ~~the following:~~

453.14 ~~(i) ongoing face-to-face observation of the mental health behavioral aide delivering~~
453.15 ~~services to a child by a mental health professional or mental health practitioner for at least~~
453.16 ~~a total of one hour during every 40 hours of service provided to a child; and~~

453.17 ~~(ii) immediate accessibility of the mental health professional, clinical trainee, or mental~~
453.18 ~~health practitioner to the mental health behavioral aide during service provision; and~~

453.19 (6) mental health service plan development must be performed in consultation with the
453.20 child's family and, when appropriate, with other key participants in the child's life by the
453.21 child's treating mental health professional or clinical trainee or by a mental health practitioner
453.22 and approved by the treating mental health professional. Treatment plan drafting consists
453.23 of development, review, and revision by face-to-face or electronic communication. The
453.24 provider must document events, including the time spent with the family and other key
453.25 participants in the child's life to ~~review, revise, and sign~~ approve the individual treatment
453.26 plan. ~~Notwithstanding Minnesota Rules, part 9505.0371, subpart 7, medical assistance~~
453.27 ~~covers service plan development before completion of the child's individual treatment plan.~~
453.28 Service plan development is covered only if a treatment plan is completed for the child. If
453.29 upon review it is determined that a treatment plan was not completed for the child, the
453.30 commissioner shall recover the payment for the service plan development; ~~and.~~

453.31 ~~(7) to be eligible for payment, a diagnostic assessment must be complete with regard to~~
453.32 ~~all required components, including multiple assessment appointments required for an~~
453.33 ~~extended diagnostic assessment and the written report. Dates of the multiple assessment~~
453.34 ~~appointments must be noted in the client's clinical record.~~

454.1 Sec. 109. Minnesota Statutes 2018, section 256B.0943, subdivision 11, is amended to
454.2 read:

454.3 Subd. 11. **Documentation and billing.** (a) A provider entity must document the services
454.4 it provides under this section according to section 245I.33. ~~The provider entity must ensure~~
454.5 ~~that documentation complies with Minnesota Rules, parts 9505.2175 and 9505.2197. Services~~
454.6 ~~billed under this section that are not documented according to this subdivision shall be~~
454.7 ~~subject to monetary recovery by the commissioner. Billing for covered service components~~
454.8 ~~under subdivision 2, paragraph (b), must not include anything other than direct service time.~~

454.9 ~~(b) An individual mental health provider must promptly document the following in a~~
454.10 ~~client's record after providing services to the client:~~

454.11 ~~(1) each occurrence of the client's mental health service, including the date, type, start~~
454.12 ~~and stop times, scope of the service as described in the child's individual treatment plan,~~
454.13 ~~and outcome of the service compared to baselines and objectives;~~

454.14 ~~(2) the name, dated signature, and credentials of the person who delivered the service;~~

454.15 ~~(3) contact made with other persons interested in the client, including representatives~~
454.16 ~~of the courts, corrections systems, or schools. The provider must document the name and~~
454.17 ~~date of each contact;~~

454.18 ~~(4) any contact made with the client's other mental health providers, case manager,~~
454.19 ~~family members, primary caregiver, legal representative, or the reason the provider did not~~
454.20 ~~contact the client's family members, primary caregiver, or legal representative, if applicable;~~

454.21 ~~(5) required clinical supervision directly related to the identified client's services and~~
454.22 ~~needs, as appropriate, with co-signatures of the supervisor and supervisee; and~~

454.23 ~~(6) the date when services are discontinued and reasons for discontinuation of services.~~

454.24 Sec. 110. Minnesota Statutes 2018, section 256B.0944, subdivision 1, is amended to read:

454.25 Subdivision 1. **Definitions.** For purposes of this section, the following terms have the
454.26 meanings given them.

454.27 (a) "Mental health crisis" means a child's behavioral, emotional, or psychiatric situation
454.28 that, but for the provision of crisis response services to the child, would likely result in
454.29 significantly reduced levels of functioning in primary activities of daily living, an emergency
454.30 situation, or the child's placement in a more restrictive setting, including, but not limited
454.31 to, inpatient hospitalization.

455.1 (b) "Mental health emergency" means a child's behavioral, emotional, or psychiatric
455.2 situation that causes an immediate need for mental health services and is consistent with
455.3 section 62Q.55. A physician, mental health professional, or ~~crisis mental health practitioner~~
455.4 qualified member of a crisis team determines a mental health crisis or emergency for medical
455.5 assistance reimbursement with input from the client and the client's family, if possible.

455.6 (c) "Mental health crisis assessment" means an immediate face-to-face assessment by
455.7 a physician, mental health professional, or ~~mental health practitioner under the clinical~~
455.8 ~~supervision of a mental health professional~~ qualified member of a crisis team, following a
455.9 screening that suggests the child may be experiencing a mental health crisis or mental health
455.10 emergency situation.

455.11 (d) "Mental health mobile crisis intervention services" means face-to-face, short-term
455.12 intensive mental health services initiated during a mental health crisis or mental health
455.13 emergency. Mental health mobile crisis services must help the recipient cope with immediate
455.14 stressors, identify and utilize available resources and strengths, and begin to return to the
455.15 recipient's baseline level of functioning. Mental health mobile services ~~must be provided~~
455.16 ~~on site by a mobile crisis intervention team outside of an emergency room, urgent care, or~~
455.17 ~~an inpatient hospital setting.~~ including screening and treatment plan recommendations,
455.18 must be culturally and linguistically appropriate.

455.19 (e) "Mental health crisis stabilization services" means individualized mental health
455.20 services provided to a recipient following crisis intervention services that are designed to
455.21 restore the recipient to the recipient's prior functional level. The individual treatment plan
455.22 recommending mental health crisis stabilization must be completed by the intervention team
455.23 or by staff after an inpatient or urgent care visit. Mental health crisis stabilization services
455.24 may be provided in the recipient's home, the home of a family member or friend of the
455.25 recipient, schools, another community setting, or a short-term supervised, licensed residential
455.26 program if the service is not included in the facility's cost pool or per diem. Mental health
455.27 crisis stabilization is not reimbursable when provided as part of a partial hospitalization or
455.28 day treatment program.

455.29 (f) "Clinical trainee" means a person qualified according to section 245I.16, subdivision
455.30 6.

455.31 (g) "Mental health certified family peer specialist" means a person qualified according
455.32 to section 245I.16, subdivision 12.

455.33 (h) "Mental health practitioner" means a person qualified according to section 245I.16,
455.34 subdivision 4.

456.1 (i) "Mental health professional" means a person qualified according to section 245I.16,
456.2 subdivision 2.

456.3 Sec. 111. Minnesota Statutes 2018, section 256B.0944, subdivision 3, is amended to read:

456.4 Subd. 3. **Eligibility.** An eligible recipient is an individual who:

456.5 (1) is eligible for medical assistance;

456.6 (2) is under age 18 or between the ages of 18 and 21;

456.7 (3) is screened as possibly experiencing a mental health crisis or mental health emergency
456.8 where a mental health crisis assessment is needed; and

456.9 (4) is assessed as experiencing a mental health crisis or mental health emergency, and
456.10 mental health mobile crisis intervention or mental health crisis stabilization services are
456.11 determined to be medically necessary; and.

456.12 ~~(5) meets the criteria for emotional disturbance or mental illness.~~

456.13 Sec. 112. Minnesota Statutes 2018, section 256B.0944, subdivision 4, is amended to read:

456.14 Subd. 4. **Provider entity standards.** (a) A crisis intervention and crisis stabilization
456.15 provider entity must meet the administrative and clinical standards specified in ~~section~~
456.16 ~~256B.0943, subdivisions 5 and 6, chapter 245I,~~ meet the standards listed in paragraph (b),
456.17 and be:

456.18 (1) an Indian health service facility or facility owned and operated by a tribe or a tribal
456.19 organization operating under ~~Public Law 93-638 as a 638 facility~~ United States Code, title
456.20 25, section 450f;

456.21 (2) a county board-operated entity; or

456.22 (3) a provider entity that is under contract with the county board in the county where
456.23 the potential crisis or emergency is occurring.

456.24 (b) The children's mental health crisis response services provider entity must:

456.25 (1) ensure that mental health crisis assessment and mobile crisis intervention services
456.26 are available 24 hours a day, seven days a week;

456.27 (2) coordinate with detoxification according to Minnesota Rules, parts 9530.6605 to
456.28 9530.6655, or withdrawal management according to chapter 245F to ensure a recipient
456.29 receives care that is responsive to the recipient's chemical and mental health needs;

457.1 (3) directly provide the services or, if services are subcontracted, the provider entity
 457.2 must maintain clinical responsibility for services and billing;

457.3 ~~(3)~~ (4) ensure that crisis intervention services are provided in a manner consistent with
 457.4 sections 245.487 to 245.4889; ~~and~~

457.5 (5) maintain staff training, documentation, and personnel files, including documentation
 457.6 of staff completion of required training modules according to sections 245I.32 and 245I.33;

457.7 (6) establish and maintain a quality assurance and evaluation plan to evaluate the
 457.8 outcomes of services and recipient satisfaction, including notifying recipients of the process
 457.9 by which the provider, county, or tribe accepts and responds to concerns;

457.10 ~~(4)~~ (7) develop and maintain written policies and procedures regarding service provision
 457.11 that include safety of staff and recipients in high-risk situations;

457.12 (8) respond to a call for crisis services in a designated service area, or according to a
 457.13 written agreement with the local mental health authority for an adjacent area; and

457.14 (9) document protocol used when delivering services by telemedicine, according to
 457.15 sections 62A.67 to 62A.672, including responsibilities of the originating site, the means to
 457.16 promote recipient safety, the timelines for connection and response, and the steps to take
 457.17 in the event of a lost connection.

457.18 Sec. 113. Minnesota Statutes 2018, section 256B.0944, subdivision 5, is amended to read:

457.19 Subd. 5. **Mobile crisis intervention staff qualifications.** ~~(a) To provide children's~~
 457.20 ~~mental health mobile crisis intervention services, a mobile crisis intervention team must~~
 457.21 ~~include:~~

457.22 ~~(1) at least two mental health professionals as defined in section 256B.0943, subdivision~~
 457.23 ~~1, paragraph (o); or~~

457.24 ~~(2) a combination of at least one mental health professional and one mental health~~
 457.25 ~~practitioner as defined in section 245.4871, subdivision 26, with the required mental health~~
 457.26 ~~crisis training and under the clinical supervision of a mental health professional on the team.~~

457.27 (a) Mobile crisis intervention team staff must be qualified to provide services as mental
 457.28 health professionals, mental health practitioners, clinical trainees, or mental health certified
 457.29 family peer specialists.

457.30 (b) A mobile crisis intervention team is comprised of at least two members, one of whom
 457.31 must be qualified as a mental health professional. A second member must be qualified as

458.1 a mental health professional, clinical trainee, or mental health practitioner. Additional staff
458.2 must be added to reflect the needs of the area served.

458.3 (c) Mental health crisis assessment and intervention services must be led by a mental
458.4 health professional, or under the supervision of a mental health professional according to
458.5 subdivision 9, by a clinical trainee or mental health practitioner.

458.6 ~~(b)~~ (d) The team must have ~~at least two people with~~ at least one member providing
458.7 on-site crisis intervention services when needed. Team members must be experienced in
458.8 mental health assessment, crisis intervention techniques, and clinical decision making under
458.9 emergency conditions and have knowledge of local services and resources. The team must
458.10 recommend and coordinate the team's services with appropriate local resources, including
458.11 the county social services agency, mental health service providers, and local law enforcement,
458.12 if necessary.

458.13 Sec. 114. Minnesota Statutes 2018, section 256B.0944, subdivision 6, is amended to read:

458.14 **Subd. 6. Initial screening and crisis assessment planning.** (a) Before initiating mobile
458.15 crisis intervention services, a screening of the potential crisis situation must be conducted.
458.16 The screening may use the resources of crisis assistance and emergency services as defined
458.17 in sections 245.4871, subdivision 14, and 245.4879, subdivisions 1 and 2. The screening
458.18 must gather information, determine whether a crisis situation exists, identify the parties
458.19 involved, and determine an appropriate response.

458.20 (b) In conducting the screening, a provider shall:

458.21 (1) employ evidence-based practices as identified by the commissioner in collaboration
458.22 with the commissioner of health to reduce the risk of the recipient's suicide and self-injurious
458.23 behavior;

458.24 (2) work with the recipient to establish a plan and time frame for responding to the crisis,
458.25 including immediate needs for support by telephone or text message until a face-to-face
458.26 response arrives;

458.27 (3) document significant factors related to the determination of a crisis, including prior
458.28 calls to the crisis team, recent presentation at an emergency department, known calls to 911
458.29 or law enforcement, or the presence of third parties with knowledge of a potential recipient's
458.30 history or current needs;

458.31 (4) screen for the needs of a third-party caller, including a recipient who primarily
458.32 identifies as a family member or a caregiver but also presents signs of a crisis; and

459.1 (5) provide psychoeducation, including education on the available means for reducing
459.2 self-harm, to relevant third parties, including family members or other persons living in the
459.3 home.

459.4 (c) A provider entity shall consider the following to indicate a positive screening unless
459.5 the provider entity documents specific evidence to show why crisis response was clinically
459.6 inappropriate:

459.7 (1) the recipient presented in an emergency department or urgent care setting, and the
459.8 health care team at that location requested crisis services;

459.9 (2) a peace officer requested crisis services for a recipient who may be subject to
459.10 transportation under section 253B.05 for a mental health crisis.

459.11 ~~(b)~~ (d) If a crisis exists, a crisis assessment must be completed. A crisis assessment must
459.12 evaluate any immediate needs for which emergency services are needed and, as time permits,
459.13 the recipient's current life situation, health information including current medications, sources
459.14 of stress, mental health problems and symptoms, strengths, cultural considerations, support
459.15 network, vulnerabilities, and current functioning.

459.16 ~~(e)~~ (e) If the crisis assessment determines mobile crisis intervention services are needed,
459.17 the intervention services must be provided promptly. As the opportunity presents itself
459.18 during the intervention, at least two members of the mobile crisis intervention team must
459.19 confer directly or by telephone about the assessment, treatment plan, and actions taken and
459.20 needed. At least one of the team members must be on site providing crisis intervention
459.21 services. If providing on-site crisis intervention services, a mental health practitioner must
459.22 seek ~~clinical~~ clinical treatment supervision as required under subdivision 9.

459.23 (f) Direct contact with the recipient is not required before initiating a crisis assessment
459.24 or intervention service. A crisis team may gather relevant information from a third party at
459.25 the scene to establish the need for services and potential safety factors. A crisis assessment
459.26 is provided face-to-face by a mobile crisis intervention team outside of an inpatient hospital
459.27 setting. A service must be provided promptly and respond to the recipient's location whenever
459.28 possible, including community or clinical settings. As clinically appropriate, a mobile crisis
459.29 intervention team must coordinate a response with other health care providers if a recipient
459.30 requires detoxification, withdrawal management, or medical stabilization services in addition
459.31 to crisis services.

459.32 ~~(d)~~ (g) The mobile crisis intervention team must develop an initial, brief crisis treatment
459.33 plan as soon as appropriate but no later than 24 hours after the initial face-to-face intervention.
459.34 The plan must address the needs and problems noted in the crisis assessment and include

460.1 measurable short-term goals, cultural considerations, and frequency and type of services to
 460.2 be provided to achieve the goals and reduce or eliminate the crisis. The crisis treatment plan
 460.3 must be updated as needed to reflect current goals and services. The team must involve the
 460.4 client and the client's family in developing and implementing the plan.

460.5 ~~(e)~~ (h) The team must document in progress notes which short-term goals have been
 460.6 met and when no further crisis intervention services are required. If after an assessment a
 460.7 crisis provider entity refers a recipient to an intensive setting, including an emergency
 460.8 department, in-patient hospitalization, or residential treatment, one of the crisis team members
 460.9 who performed or conferred on the assessment must immediately contact the provider entity
 460.10 and consult with the triage nurse or other staff responsible for intake. The crisis team member
 460.11 must convey key findings or concerns that led to the referral. The consultation must occur
 460.12 with the recipient's consent, the recipient's legal guardian's consent, or as allowed by section
 460.13 144.293, subdivision 5. Any available written documentation, including a crisis treatment
 460.14 plan, must be sent no later than the next business day.

460.15 ~~(f)~~ (i) If the client's crisis is stabilized, but the client needs a referral for mental health
 460.16 crisis stabilization services or to other services, the team must provide a referral to these
 460.17 services. If the recipient has a case manager, planning for other services must be coordinated
 460.18 with the case manager.

460.19 (j) If an intervention service is provided without the recipient present, the provider shall
 460.20 document the reasons why the service is more effective without the recipient present.

460.21 Sec. 115. Minnesota Statutes 2018, section 256B.0944, subdivision 7, is amended to read:

460.22 Subd. 7. **Crisis stabilization services.** Crisis stabilization services ~~must be provided by~~
 460.23 ~~a mental health professional or a mental health practitioner, as defined in section 245.462,~~
 460.24 ~~subdivision 17, who works under the clinical supervision of a mental health professional~~
 460.25 ~~and for a crisis stabilization services provider entity and must meet the following standards:~~

460.26 (1) a crisis stabilization treatment plan must be developed which meets the criteria in
 460.27 subdivision 8;

460.28 (2) services must be delivered according to the treatment plan and include face-to-face
 460.29 contact with the recipient by qualified staff for further assessment, help with referrals,
 460.30 updating the crisis stabilization treatment plan, supportive counseling, skills training, and
 460.31 collaboration with other service providers in the community; and

460.32 ~~(3) mental health practitioners must have completed at least 30 hours of training in crisis~~
 460.33 ~~intervention and stabilization during the past two years.~~

461.1 (3) if an intervention is provided without the recipient present, the provider shall
 461.2 document the reasons why the intervention is more effective without the recipient present.

461.3 Sec. 116. Minnesota Statutes 2018, section 256B.0944, subdivision 8, is amended to read:

461.4 Subd. 8. **Treatment plan.** (a) The individual crisis stabilization treatment plan must
 461.5 include, at a minimum:

461.6 (1) a list of problems identified in the assessment;

461.7 (2) a list of the recipient's strengths and resources;

461.8 (3) concrete, measurable short-term goals and tasks to be achieved, including time frames
 461.9 for achievement of the goals;

461.10 (4) specific objectives directed toward the achievement of each goal;

461.11 (5) documentation of the participants involved in the service planning;

461.12 (6) planned frequency and type of services initiated;

461.13 (7) a crisis response action plan if a crisis should occur; and

461.14 (8) clear progress notes on the outcome of goals.

461.15 (b) The client, if clinically appropriate, must be a participant in the development of the
 461.16 crisis stabilization treatment plan. The client or the client's legal guardian must sign the
 461.17 service plan or documentation must be provided why this was not possible. A copy of the
 461.18 plan must be given to the client and the client's legal guardian. The plan should include
 461.19 services arranged, including specific providers where applicable.

461.20 (c) A treatment plan must be developed by a mental health professional, clinical trainee,
 461.21 or mental health practitioner under the clinical supervision of a mental health professional.
 461.22 A written plan must be completed within 24 hours of beginning services with the client.

461.23 Sec. 117. Minnesota Statutes 2018, section 256B.0944, subdivision 9, is amended to read:

461.24 Subd. 9. **Supervision.** ~~(a)~~ A mental health practitioner or clinical trainee may provide
 461.25 crisis assessment and mobile crisis intervention services if the following ~~clinical~~ treatment
 461.26 supervision requirements are met:

461.27 (1) the mental health provider entity must accept full responsibility for the services
 461.28 provided;

462.1 (2) the mental health professional of the provider entity, who is an employee or under
 462.2 contract with the provider entity, must be immediately available by telephone or in person
 462.3 for ~~clinical~~ treatment supervision;

462.4 (3) the mental health professional is consulted, in person or by telephone, during the
 462.5 first three hours when a mental health practitioner provides on-site service; and

462.6 (4) the mental health professional must review and approve the tentative crisis assessment
 462.7 and crisis treatment plan, document the consultation, and sign the crisis assessment and
 462.8 treatment plan within the next business day.

462.9 ~~(b) If the mobile crisis intervention services continue into a second calendar day, a mental~~
 462.10 ~~health professional must contact the client face-to-face on the second day to provide services~~
 462.11 ~~and update the crisis treatment plan. The on-site observation must be documented in the~~
 462.12 ~~client's record and signed by the mental health professional.~~

462.13 Sec. 118. Minnesota Statutes 2018, section 256B.0946, subdivision 1, is amended to read:

462.14 Subdivision 1. **Required covered service components.** (a) ~~Effective May 23, 2013,~~
 462.15 ~~and subject to federal approval,~~ Medical assistance covers medically necessary intensive
 462.16 treatment services described under paragraph (b) that are provided by a provider entity
 462.17 eligible under subdivision 3 to a client eligible under subdivision 2 who is placed in a foster
 462.18 home licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or placed in a foster
 462.19 home licensed under the regulations established by a federally recognized Minnesota tribe.

462.20 (b) Intensive treatment services to children with mental illness residing in foster family
 462.21 settings that comprise specific required service components provided in clauses (1) to (5)
 462.22 are reimbursed by medical assistance when they meet the following standards:

462.23 (1) psychotherapy provided by a mental health professional ~~as defined in Minnesota~~
 462.24 ~~Rules, part 9505.0371, subpart 5, item A,~~ or a clinical trainee, ~~as defined in Minnesota~~
 462.25 ~~Rules, part 9505.0371, subpart 5, item C;~~

462.26 (2) crisis ~~assistance~~ planning provided according to standards for children's therapeutic
 462.27 services and supports in section 256B.0943;

462.28 (3) individual, family, and group psychoeducation services, defined in subdivision 1a,
 462.29 paragraph ~~(q)~~ (o), provided by a mental health professional or a clinical trainee;

462.30 (4) clinical care consultation, as defined in subdivision 1a, and provided by a mental
 462.31 health professional or a clinical trainee; and

462.32 (5) service delivery payment requirements as provided under subdivision 4.

463.1 Sec. 119. Minnesota Statutes 2018, section 256B.0946, subdivision 1a, is amended to
463.2 read:

463.3 Subd. 1a. **Definitions.** For the purposes of this section, the following terms have the
463.4 meanings given them.

463.5 (a) "Clinical care consultation" means communication from a treating clinician to other
463.6 providers working with the same client to inform, inquire, and instruct regarding the client's
463.7 symptoms, strategies for effective engagement, care and intervention needs, and treatment
463.8 expectations across service settings, including but not limited to the client's school, social
463.9 services, day care, probation, home, primary care, medication prescribers, disabilities
463.10 services, and other mental health providers and to direct and coordinate clinical service
463.11 components provided to the client and family.

463.12 ~~(b) "Clinical supervision" means the documented time a clinical supervisor and supervisee~~
463.13 ~~spend together to discuss the supervisee's work, to review individual client cases, and for~~
463.14 ~~the supervisee's professional development. It includes the documented oversight and~~
463.15 ~~supervision responsibility for planning, implementation, and evaluation of services for a~~
463.16 ~~client's mental health treatment.~~

463.17 ~~(c) "Clinical supervisor" means the mental health professional who is responsible for~~
463.18 ~~clinical supervision.~~

463.19 ~~(d) (b) "Clinical trainee" has the meaning given in Minnesota Rules, part 9505.0371,~~
463.20 ~~subpart 5, item C means a staff person qualified according to section 245I.16, subdivision~~
463.21 ~~6;~~

463.22 ~~(e) (c) "Crisis assistance planning" has the meaning given in section 245.4871, subdivision~~
463.23 ~~9a, including the development of a plan that addresses prevention and intervention strategies~~
463.24 ~~to be used in a potential crisis, but does not include actual crisis intervention.~~

463.25 ~~(f) (d) "Culturally appropriate" means providing mental health services in a manner that~~
463.26 ~~incorporates the child's cultural influences, as defined in Minnesota Rules, part 9505.0370,~~
463.27 ~~subpart 9, into interventions as a way to maximize resiliency factors and utilize cultural~~
463.28 ~~strengths and resources to promote overall wellness.~~

463.29 ~~(g) (e) "Culture" means the distinct ways of living and understanding the world that are~~
463.30 ~~used by a group of people and are transmitted from one generation to another or adopted~~
463.31 ~~by an individual.~~

464.1 ~~(h)~~ (f) "Diagnostic assessment" ~~has the meaning given in Minnesota Rules, part~~
464.2 ~~9505.0370, subpart 11~~ means an assessment described under section 256B.0671, subdivisions
464.3 2 and 3.

464.4 ~~(i)~~ (g) "Family" means a person who is identified by the client or the client's parent or
464.5 guardian as being important to the client's mental health treatment. Family may include,
464.6 but is not limited to, parents, foster parents, children, spouse, committed partners, former
464.7 spouses, persons related by blood or adoption, persons who are a part of the client's
464.8 permanency plan, or persons who are presently residing together as a family unit.

464.9 ~~(j)~~ (h) "Foster care" has the meaning given in section 260C.007, subdivision 18.

464.10 ~~(k)~~ (i) "Foster family setting" means the foster home in which the license holder resides.

464.11 ~~(l)~~ (j) "Individual treatment plan" ~~has the meaning given in Minnesota Rules, part~~
464.12 ~~9505.0370, subpart 15~~ means the plan described under section 256B.0671, subdivisions 5
464.13 and 6.

464.14 ~~(m)~~ "Mental health practitioner" has the meaning given in section 245.462, subdivision
464.15 17, and a mental health practitioner working as a clinical trainee according to Minnesota
464.16 Rules, part 9505.0371, subpart 5, item C.

464.17 (k) "Mental health certified family peer specialist" means a staff person qualified
464.18 according to section 245I.16, subdivision 12.

464.19 ~~(n)~~ (1) "Mental health professional" ~~has the meaning given in Minnesota Rules, part~~
464.20 ~~9505.0370, subpart 18~~ means a staff person qualified according to section 245I.16,
464.21 subdivision 2.

464.22 ~~(o)~~ (m) "Mental illness" has the meaning given in ~~Minnesota Rules, part 9505.0370,~~
464.23 ~~subpart 20~~ section 245.462, subdivision 20, paragraph (a), and includes emotional disturbance
464.24 as defined in section 245.4871, subdivision 15.

464.25 ~~(p)~~ (n) "Parent" has the meaning given in section 260C.007, subdivision 25.

464.26 ~~(q)~~ (o) "Psychoeducation services" means information or demonstration provided to an
464.27 individual, family, or group to explain, educate, and support the individual, family, or group
464.28 in understanding a child's symptoms of mental illness, the impact on the child's development,
464.29 and needed components of treatment and skill development so that the individual, family,
464.30 or group can help the child to prevent relapse, prevent the acquisition of comorbid disorders,
464.31 and achieve optimal mental health and long-term resilience.

465.1 ~~(r)~~ (p) "Psychotherapy" has the meaning given in ~~Minnesota Rules, part 9505.0370,~~
 465.2 ~~subpart 27~~ section 256B.0625, subdivision 69.

465.3 ~~(s)~~ (q) "Team consultation and treatment planning" means the coordination of treatment
 465.4 plans and consultation among providers in a group concerning the treatment needs of the
 465.5 child, including disseminating the child's treatment service schedule to all members of the
 465.6 service team. Team members must include all mental health professionals working with the
 465.7 child, a parent, the child unless the team lead or parent deem it clinically inappropriate, and
 465.8 at least two of the following: an individualized education program case manager; probation
 465.9 agent; children's mental health case manager; child welfare worker, including adoption or
 465.10 guardianship worker; primary care provider; foster parent; and any other member of the
 465.11 child's service team.

465.12 (r) "Trauma" has the meaning given in section 245I.02, subdivision 24.

465.13 (s) "Treatment supervision" means the supervision described under section 245I.18.

465.14 (t) "Treatment supervisor" means the mental health professional who is responsible for
 465.15 treatment supervision.

465.16 Sec. 120. Minnesota Statutes 2018, section 256B.0946, subdivision 2, is amended to read:

465.17 Subd. 2. **Determination of client eligibility.** (a) An eligible recipient is an individual,
 465.18 from birth through age 20, who is currently placed in a foster home licensed under Minnesota
 465.19 Rules, parts 2960.3000 to 2960.3340, and has received a diagnostic assessment and an
 465.20 evaluation of level of care needed, as defined in paragraphs ~~(a)~~ (b) and ~~(b)~~ (c).

465.21 ~~(a)~~ (b) The diagnostic assessment must:

465.22 ~~(1) meet criteria described in Minnesota Rules, part 9505.0372, subpart 1, and be~~
 465.23 ~~conducted by a mental health professional or a clinical trainee;~~

465.24 ~~(2) determine whether or not a child meets the criteria for mental illness, as defined in~~
 465.25 ~~Minnesota Rules, part 9505.0370, subpart 20;~~

465.26 ~~(3)~~ (1) document that intensive treatment services are medically necessary within a foster
 465.27 family setting to ameliorate identified symptoms and functional impairments; and

465.28 ~~(4)~~ (2) be performed within 180 days before the start of service; ~~and.~~

465.29 ~~(5) be completed as either a standard or extended diagnostic assessment annually to~~
 465.30 ~~determine continued eligibility for the service.~~

466.1 ~~(b)~~ (c) The evaluation of level of care must be conducted by the placing county, tribe,
 466.2 or case manager in conjunction with the diagnostic assessment ~~as described by Minnesota~~
 466.3 ~~Rules, part 9505.0372, subpart 1, item B,~~ using a validated tool approved by the
 466.4 commissioner of human services and not subject to the rulemaking process, consistent with
 466.5 section 245.4885, subdivision 1, paragraph (d), the result of which evaluation demonstrates
 466.6 that the child requires intensive intervention without 24-hour medical monitoring. The
 466.7 commissioner shall update the list of approved level of care tools annually and publish on
 466.8 the department's website.

466.9 Sec. 121. Minnesota Statutes 2018, section 256B.0946, subdivision 3, is amended to read:

466.10 Subd. 3. **Eligible mental health services providers.** (a) Eligible providers for intensive
 466.11 children's mental health services in a foster family setting must be certified by the state and
 466.12 have a service provision contract with a county board or a reservation tribal council and
 466.13 must be able to demonstrate the ability to provide all of the services required in this section
 466.14 and meet the requirements under chapter 245I.

466.15 (b) For purposes of this section, a provider agency must be:

466.16 (1) a county-operated entity certified by the state;

466.17 (2) an Indian Health Services facility operated by a tribe or tribal organization under
 466.18 funding authorized by United States Code, title 25, sections 450f to 450n, or title 3 of the
 466.19 Indian Self-Determination Act, Public Law 93-638, section 638 (facilities or providers); or

466.20 (3) a noncounty entity.

466.21 (c) Certified providers that do not meet the service delivery standards required in this
 466.22 section shall be subject to a decertification process.

466.23 (d) For the purposes of this section, all services delivered to a client must be provided
 466.24 by a mental health professional ~~or~~ a clinical trainee, or a mental health certified family peer
 466.25 specialist.

466.26 Sec. 122. Minnesota Statutes 2018, section 256B.0946, subdivision 4, is amended to read:

466.27 Subd. 4. **Service delivery payment requirements.** (a) To be eligible for payment under
 466.28 this section, a provider must develop and practice written policies and procedures for
 466.29 intensive treatment in foster care, consistent with subdivision 1, paragraph (b), and comply
 466.30 with the following requirements in paragraphs (b) to ~~(n)~~ (m).

467.1 ~~(b) A qualified clinical supervisor, as defined in and performing in compliance with~~
 467.2 ~~Minnesota Rules, part 9505.0371, subpart 5, item D, must supervise the treatment and~~
 467.3 ~~provision of services described in this section.~~

467.4 ~~(c) Each client receiving treatment services must receive an extended diagnostic~~
 467.5 ~~assessment, as described in Minnesota Rules, part 9505.0372, subpart 1, item C, within 30~~
 467.6 ~~days of enrollment in this service unless the client has a previous extended diagnostic~~
 467.7 ~~assessment that the client, parent, and mental health professional agree still accurately~~
 467.8 ~~describes the client's current mental health functioning.~~

467.9 (b) For children under age six, each client must receive a diagnostic assessment according
 467.10 to the requirements in the current edition of the Diagnostic Classification of Mental Health
 467.11 Disorders of Infancy and Early Childhood.

467.12 ~~(d)~~ (c) Each previous and current mental health, school, and physical health treatment
 467.13 provider must be contacted to request documentation of treatment and assessments that the
 467.14 eligible client has received. This information must be reviewed and incorporated into the
 467.15 diagnostic assessment and team consultation and treatment planning review process.

467.16 ~~(e)~~ (d) Each client receiving treatment must be assessed for a trauma history, and the
 467.17 client's treatment plan must document how the results of the assessment will be incorporated
 467.18 into treatment.

467.19 ~~(f)~~ (e) Each client receiving treatment services must have an individual treatment plan
 467.20 that is reviewed, evaluated, and ~~signed~~ approved every 90 days using the team consultation
 467.21 and treatment planning process, as defined in subdivision 1a, paragraph ~~(s)~~ (p).

467.22 ~~(g)~~ (f) Clinical care consultation, as defined in subdivision 1a, paragraph (a), must be
 467.23 provided in accordance with the client's individual treatment plan.

467.24 ~~(h)~~ (g) Each client must have a crisis ~~assistance~~ plan within ten days of initiating services
 467.25 and must have access to clinical phone support 24 hours per day, seven days per week,
 467.26 during the course of treatment. The crisis plan must demonstrate coordination with the local
 467.27 or regional mobile crisis intervention team.

467.28 ~~(i)~~ (h) Services must be delivered and documented at least three days per week, equaling
 467.29 at least six hours of treatment per week, unless reduced units of service are specified on the
 467.30 treatment plan as part of transition or on a discharge plan to another service or level of care.
 467.31 ~~Documentation must comply with Minnesota Rules, parts 9505.2175 and 9505.2197.~~

468.1 ~~(i)~~ (i) Location of service delivery must be in the client's home, day care setting, school,
 468.2 or other community-based setting that is specified on the client's individualized treatment
 468.3 plan.

468.4 ~~(j)~~ (j) Treatment must be developmentally and culturally appropriate for the client.

468.5 ~~(k)~~ (k) Services must be delivered in continual collaboration and consultation with the
 468.6 client's medical providers and, in particular, with prescribers of psychotropic medications,
 468.7 including those prescribed on an off-label basis. Members of the service team must be aware
 468.8 of the medication regimen and potential side effects.

468.9 ~~(l)~~ (l) Parents, siblings, foster parents, and members of the child's permanency plan
 468.10 must be involved in treatment and service delivery unless otherwise noted in the treatment
 468.11 plan.

468.12 ~~(m)~~ (m) Transition planning for the child must be conducted starting with the first
 468.13 treatment plan and must be addressed throughout treatment to support the child's permanency
 468.14 plan and postdischarge mental health service needs.

468.15 Sec. 123. Minnesota Statutes 2018, section 256B.0946, subdivision 6, is amended to read:

468.16 Subd. 6. **Excluded services.** (a) Services in clauses (1) to (7) are not covered under this
 468.17 section and are not eligible for medical assistance payment as components of intensive
 468.18 treatment in foster care services, but may be billed separately:

468.19 (1) inpatient psychiatric hospital treatment;

468.20 (2) mental health targeted case management;

468.21 (3) partial hospitalization;

468.22 (4) medication management;

468.23 (5) children's mental health day treatment services;

468.24 (6) crisis response services under section 256B.0944; and

468.25 (7) transportation.

468.26 (b) Children receiving intensive treatment in foster care services are not eligible for
 468.27 medical assistance reimbursement for the following services while receiving intensive
 468.28 treatment in foster care:

468.29 (1) psychotherapy and skills training components of children's therapeutic services and
 468.30 supports under section 256B.0625, subdivision 35b;

469.1 (2) mental health behavioral aide services as defined in section 256B.0943, subdivision
469.2 1, paragraph ~~(m)~~ (l);

469.3 (3) home and community-based waiver services;

469.4 (4) mental health residential treatment; and

469.5 (5) room and board costs as defined in section 256I.03, subdivision 6.

469.6 Sec. 124. Minnesota Statutes 2018, section 256B.0947, subdivision 1, is amended to read:

469.7 Subdivision 1. **Scope.** ~~Effective November 1, 2011, and subject to federal approval,~~
469.8 Medical assistance covers medically necessary, intensive nonresidential rehabilitative mental
469.9 health services as defined in subdivision 2, for recipients as defined in subdivision 3, when
469.10 the services are provided by an entity meeting the standards in this section.

469.11 Sec. 125. Minnesota Statutes 2018, section 256B.0947, subdivision 2, is amended to read:

469.12 Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings
469.13 given them.

469.14 (a) "Intensive nonresidential rehabilitative mental health services" means child
469.15 rehabilitative mental health services as defined in section 256B.0943, except that these
469.16 services are provided by a multidisciplinary staff using ~~a total team~~ an approach consistent
469.17 with assertive community treatment, as adapted for youth, and are directed to recipients
469.18 ~~ages 16, 17, 18, 19, or 20 with a serious mental illness or co-occurring mental illness and~~
469.19 ~~substance abuse addiction~~ who require intensive services to prevent admission to an inpatient
469.20 psychiatric hospital or placement in a residential treatment facility or who require intensive
469.21 services to step down from inpatient or residential care to community-based care.

469.22 (b) "Co-occurring mental illness and substance abuse addiction" means a dual diagnosis
469.23 of at least one form of mental illness and at least one substance use disorder. Substance use
469.24 disorders include alcohol or drug abuse or dependence, excluding nicotine use.

469.25 (c) "Diagnostic assessment" ~~has the meaning given to it in Minnesota Rules, part~~
469.26 ~~9505.0370, subpart 11. A diagnostic assessment must be provided according to Minnesota~~
469.27 ~~Rules, part 9505.0372, subpart 1,~~ means the assessment described under section 256B.0671,
469.28 subdivisions 2 and 3, and for this section must incorporate a determination of the youth's
469.29 necessary level of care using a standardized functional assessment instrument approved and
469.30 periodically updated by the commissioner.

470.1 (d) "Education specialist" means an individual with knowledge and experience working
 470.2 with youth regarding special education requirements and goals, special education plans,
 470.3 and coordination of educational activities with health care activities.

470.4 (e) "Housing access support" means an ancillary activity to help an individual find,
 470.5 obtain, retain, and move to safe and adequate housing. Housing access support does not
 470.6 provide monetary assistance for rent, damage deposits, or application fees.

470.7 (f) "Integrated dual disorders treatment" means the integrated treatment of co-occurring
 470.8 mental illness and substance use disorders by a team of cross-trained clinicians within the
 470.9 same program, and is characterized by assertive outreach, stage-wise comprehensive
 470.10 treatment, treatment goal setting, and flexibility to work within each stage of treatment.

470.11 (g) "Medication education services" means services provided individually or in groups,
 470.12 which focus on:

470.13 (1) educating the client and client's family or significant nonfamilial supporters about
 470.14 mental illness and symptoms;

470.15 (2) the role and effects of medications in treating symptoms of mental illness; and

470.16 (3) the side effects of medications.

470.17 Medication education is coordinated with medication management services and does not
 470.18 duplicate it. Medication education services are provided by physicians, pharmacists, or
 470.19 registered nurses with certification in psychiatric and mental health care.

470.20 (h) "Peer specialist" means an employed team member who is a mental health certified
 470.21 peer specialist according to section 256B.0615 and also a former children's mental health
 470.22 consumer who:

470.23 ~~(1) provides direct services to clients including social, emotional, and instrumental~~
 470.24 ~~support and outreach;~~

470.25 ~~(2) assists younger peers to identify and achieve specific life goals;~~

470.26 ~~(3) works directly with clients to promote the client's self-determination, personal~~
 470.27 ~~responsibility, and empowerment;~~

470.28 ~~(4) assists youth with mental illness to regain control over their lives and their~~
 470.29 ~~developmental process in order to move effectively into adulthood;~~

470.30 ~~(5) provides training and education to other team members, consumer advocacy~~
 470.31 ~~organizations, and clients on resiliency and peer support; and~~

471.1 ~~(6) meets the following criteria:~~

471.2 ~~(i) is at least 22 years of age;~~

471.3 ~~(ii) has had a diagnosis of mental illness, as defined in Minnesota Rules, part 9505.0370,~~
 471.4 ~~subpart 20, or co-occurring mental illness and substance abuse addiction;~~

471.5 ~~(iii) is a former consumer of child and adolescent mental health services, or a former or~~
 471.6 ~~current consumer of adult mental health services for a period of at least two years;~~

471.7 ~~(iv) has at least a high school diploma or equivalent;~~

471.8 ~~(v) has successfully completed training requirements determined and periodically updated~~
 471.9 ~~by the commissioner;~~

471.10 ~~(vi) is willing to disclose the individual's own mental health history to team members~~
 471.11 ~~and clients; and~~

471.12 ~~(vii) must be free of substance use problems for at least one year.~~

471.13 ~~(i) "Provider agency" means a for-profit or nonprofit organization established to~~
 471.14 ~~administer an assertive community treatment for youth team.~~

471.15 ~~(j)~~ (i) "Substance use disorders" means one or more of the disorders defined in the
 471.16 Diagnostic and Statistical Manual of Mental Disorders, current edition.

471.17 ~~(k)~~ (j) "Transition services" means:

471.18 (1) activities, materials, consultation, and coordination that ensures continuity of the
 471.19 client's care in advance of and in preparation for the client's move from one stage of care
 471.20 or life to another by maintaining contact with the client and assisting the client to establish
 471.21 provider relationships;

471.22 (2) providing the client with knowledge and skills needed posttransition;

471.23 (3) establishing communication between sending and receiving entities;

471.24 (4) supporting a client's request for service authorization and enrollment; and

471.25 (5) establishing and enforcing procedures and schedules.

471.26 A youth's transition from the children's mental health system and services to the adult
 471.27 mental health system and services and return to the client's home and entry or re-entry into
 471.28 community-based mental health services following discharge from an out-of-home placement
 471.29 or inpatient hospital stay.

472.1 ~~(j)~~ (k) "Treatment team" means all staff who provide services to recipients under this
472.2 section.

472.3 Sec. 126. Minnesota Statutes 2018, section 256B.0947, subdivision 3, is amended to read:

472.4 Subd. 3. **Client eligibility.** An eligible recipient is an individual who:

472.5 (1) is age 16, 17, 18, 19, or 20; and

472.6 (2) is diagnosed with a serious mental illness or co-occurring mental illness and substance
472.7 abuse addiction, for which intensive nonresidential rehabilitative mental health services are
472.8 needed;

472.9 (3) has received a level-of-care determination, using an instrument approved by the
472.10 commissioner, that indicates a need for intensive integrated intervention without 24-hour
472.11 medical monitoring and a need for extensive collaboration among multiple providers;

472.12 (4) has a functional impairment and a history of difficulty in functioning safely and
472.13 successfully in the community, school, home, or job; or who is likely to need services from
472.14 the adult mental health system within the next two years; and

472.15 (5) has had a recent diagnostic assessment, ~~as provided in Minnesota Rules, part~~
472.16 ~~9505.0372, subpart 1, by a mental health professional who is qualified under Minnesota~~
472.17 ~~Rules, part 9505.0371, subpart 5, item A,~~ that documents that intensive nonresidential
472.18 rehabilitative mental health services are medically necessary to ameliorate identified
472.19 symptoms and functional impairments and to achieve individual transition goals.

472.20 Sec. 127. Minnesota Statutes 2018, section 256B.0947, subdivision 3a, is amended to
472.21 read:

472.22 Subd. 3a. **Required service components.** ~~(a) Subject to federal approval, medical~~
472.23 ~~assistance covers all medically necessary intensive nonresidential rehabilitative mental~~
472.24 ~~health services and supports, as defined in this section, under a single daily rate per client.~~
472.25 ~~Services and supports must be delivered by an eligible provider under subdivision 5 to an~~
472.26 ~~eligible client under subdivision 3.~~

472.27 ~~(b)~~ (a) Intensive nonresidential rehabilitative mental health services, supports, and
472.28 ancillary activities covered by the single daily rate per client must include the following,
472.29 as needed by the individual client:

472.30 (1) individual, family, and group psychotherapy;

473.1 (2) individual, family, and group skills training, as defined in section 256B.0943,
473.2 subdivision 1, paragraph (t);

473.3 (3) ~~crisis assistance planning~~ as defined in section ~~245.4871, subdivision 9a, which~~
473.4 ~~includes recognition of factors precipitating a mental health crisis, identification of behaviors~~
473.5 ~~related to the crisis, and the development of a plan to address prevention, intervention, and~~
473.6 ~~follow-up strategies to be used in the lead-up to or onset of, and conclusion of, a mental~~
473.7 ~~health crisis; crisis assistance does not mean crisis response services or crisis intervention~~
473.8 ~~services provided in section 256B.0944~~ 256B.0943, subdivision 1, paragraph (c);

473.9 (4) medication management provided by a physician or an advanced practice registered
473.10 nurse with certification in psychiatric and mental health care;

473.11 (5) mental health case management as provided in section 256B.0625, subdivision 20;

473.12 (6) medication education services ~~as defined in this section;~~

473.13 (7) care coordination by a client-specific lead worker assigned by and responsible to the
473.14 treatment team;

473.15 (8) psychoeducation of and consultation and coordination with the client's biological,
473.16 adoptive, or foster family and, in the case of a youth living independently, the client's
473.17 immediate nonfamilial support network;

473.18 (9) clinical consultation to a client's employer or school or to other service agencies or
473.19 to the courts to assist in managing the mental illness or co-occurring disorder and to develop
473.20 client support systems;

473.21 (10) coordination with, or performance of, crisis intervention and stabilization services
473.22 as defined in section 256B.0944;

473.23 (11) assessment of a client's treatment progress and effectiveness of services using
473.24 standardized outcome measures published by the commissioner;

473.25 (12) transition services as defined in this section;

473.26 (13) integrated dual disorders treatment as defined in this section; and

473.27 (14) housing access support.

473.28 ~~(e)~~ (b) The provider shall ensure and document the following by means of performing
473.29 the required function or by contracting with a qualified person or entity:

473.30 (1) client access to crisis intervention services, as defined in section 256B.0944, and
473.31 available 24 hours per day and seven days per week; and

474.1 ~~(2) completion of an extended diagnostic assessment, as defined in Minnesota Rules,~~
 474.2 ~~part 9505.0372, subpart 1, item C; and~~

474.3 ~~(3)~~ (2) determination of the client's needed level of care using an instrument approved
 474.4 and periodically updated by the commissioner.

474.5 Sec. 128. Minnesota Statutes 2018, section 256B.0947, subdivision 5, is amended to read:

474.6 Subd. 5. **Standards for intensive nonresidential rehabilitative providers.** (a) Services
 474.7 must be provided by a provider entity as provided in subdivision 4.

474.8 (b) The treatment team for intensive nonresidential rehabilitative mental health services
 474.9 comprises both permanently employed core team members and client-specific team members
 474.10 as follows:

474.11 (1) ~~The core treatment team is an entity that operates under the direction of an~~
 474.12 ~~independently licensed mental health professional, who is qualified under Minnesota Rules,~~
 474.13 ~~part 9505.0371, subpart 5, item A, and that assumes comprehensive clinical responsibility~~
 474.14 ~~for clients.~~ Based on professional qualifications and client needs, clinically qualified core
 474.15 team members are assigned on a rotating basis as the client's lead worker to coordinate a
 474.16 client's care. The core team must comprise at least four full-time equivalent direct care staff
 474.17 and must include, ~~but is not limited to~~ at a minimum:

474.18 (i) ~~an independently licensed~~ a mental health professional, ~~qualified under Minnesota~~
 474.19 ~~Rules, part 9505.0371, subpart 5, item A,~~ who serves as team leader to provide administrative
 474.20 direction and ~~clinical~~ treatment supervision to the team;

474.21 (ii) an advanced-practice registered nurse with certification in psychiatric or mental
 474.22 health care or a board-certified child and adolescent psychiatrist, either of which must be
 474.23 credentialed to prescribe medications;

474.24 (iii) a licensed alcohol and drug counselor who is also trained in mental health
 474.25 interventions; and

474.26 (iv) a peer specialist ~~as defined in subdivision 2, paragraph (h).~~

474.27 (2) The core team may also include any of the following:

474.28 (i) additional mental health professionals;

474.29 (ii) a vocational specialist;

474.30 (iii) an educational specialist;

474.31 (iv) a child and adolescent psychiatrist who may be retained on a consultant basis;

475.1 (v) a mental health practitioner, ~~as defined in~~ qualified according to section 245.4871,
475.2 ~~subdivision 26~~ 245I.16, subdivision 4;

475.3 (vi) a mental health manager, as defined in section 245.4871, subdivision 4; ~~and~~

475.4 (vii) a housing access specialist; and

475.5 (viii) a clinical trainee qualified according to section 245I.16, subdivision 6.

475.6 (3) A treatment team may include, in addition to those in ~~clause~~ clauses (1) or (2),
475.7 ad hoc members not employed by the team who consult on a specific client and who must
475.8 accept overall clinical direction from the treatment team for the duration of the client's
475.9 placement with the treatment team and must be paid by the provider ~~agency at the rate for~~
475.10 ~~a typical session by that provider with that client or at a rate negotiated with the client-specific~~
475.11 ~~member~~ entity. Client-specific treatment team members may include:

475.12 (i) the mental health professional treating the client prior to placement with the treatment
475.13 team;

475.14 (ii) the client's current substance abuse counselor, if applicable;

475.15 (iii) a lead member of the client's individualized education program team or school-based
475.16 mental health provider, if applicable;

475.17 (iv) a representative from the client's health care home or primary care clinic, as needed
475.18 to ensure integration of medical and behavioral health care;

475.19 (v) the client's probation officer or other juvenile justice representative, if applicable;
475.20 and

475.21 (vi) the client's current vocational or employment counselor, if applicable.

475.22 (c) The ~~clinical~~ treatment supervisor shall be an active member of the treatment team
475.23 and shall function as a practicing clinician at least on a part-time basis. The treatment team
475.24 shall meet with the ~~clinical~~ treatment supervisor at least weekly to discuss recipients' progress
475.25 and make rapid adjustments to meet recipients' needs. The team meeting must include
475.26 client-specific case reviews and general treatment discussions among team members.
475.27 Client-specific case reviews and planning must be documented in the individual client's
475.28 treatment record.

475.29 (d) The staffing ratio must not exceed ten clients to one full-time equivalent treatment
475.30 team position.

476.1 (e) The treatment team shall serve no more than 80 clients at any one time. Should local
476.2 demand exceed the team's capacity, an additional team must be established rather than
476.3 exceed this limit.

476.4 (f) Nonclinical staff shall have prompt access in person or by telephone to a mental
476.5 health practitioner or mental health professional. The provider shall have the capacity to
476.6 promptly and appropriately respond to emergent needs and make any necessary staffing
476.7 adjustments to assure the health and safety of clients.

476.8 (g) The intensive nonresidential rehabilitative mental health services provider shall
476.9 participate in evaluation of the assertive community treatment for youth (Youth ACT) model
476.10 as conducted by the commissioner, including the collection and reporting of data and the
476.11 reporting of performance measures as specified by contract with the commissioner.

476.12 (h) A regional treatment team may serve multiple counties.

476.13 Sec. 129. Minnesota Statutes 2018, section 256B.0947, subdivision 6, is amended to read:

476.14 Subd. 6. **Service standards.** The standards in this subdivision apply to intensive
476.15 nonresidential rehabilitative mental health services.

476.16 (a) The treatment team shall use team treatment, not an individual treatment model.

476.17 (b) Services must be available at times that meet client needs.

476.18 (c) The initial functional assessment must be completed within ten days of intake and
476.19 updated at least every three months or prior to discharge from the service, whichever comes
476.20 first.

476.21 (d) An individual treatment plan must be completed for each client, according to criteria
476.22 specified in section ~~256B.0943, subdivision 6, paragraph (b), clause (2)~~ 256B.0671,
476.23 subdivisions 5 and 6, and, additionally, must:

476.24 (1) be completed in consultation with the client's current therapist and key providers and
476.25 provide for ongoing consultation with the client's current therapist to ensure therapeutic
476.26 continuity and to facilitate the client's return to the community;

476.27 (2) if a need for substance use disorder treatment is indicated by validated assessment;

476.28 (i) identify goals, objectives, and strategies of substance use disorder treatment; develop
476.29 a schedule for accomplishing treatment goals and objectives; and identify the individuals
476.30 responsible for providing treatment services and supports; and

476.31 ~~(ii) be reviewed at least once every 90 days and revised, if necessary;~~

477.1 ~~(3) be signed by the clinical supervisor and by the client and, if the client is a minor, by~~
477.2 ~~the client's parent or other person authorized by statute to consent to mental health treatment~~
477.3 ~~and substance use disorder treatment for the client; and~~

477.4 ~~(4)~~ (3) provide for the client's transition out of intensive nonresidential rehabilitative
477.5 mental health services by defining the team's actions to assist the client and subsequent
477.6 providers in the transition to less intensive or "stepped down" services.

477.7 (e) The treatment team shall actively and assertively engage the client's family members
477.8 and significant others by establishing communication and collaboration with the family and
477.9 significant others and educating the family and significant others about the client's mental
477.10 illness, symptom management, and the family's role in treatment, unless the team knows or
477.11 has reason to suspect that the client has suffered or faces a threat of suffering any physical
477.12 or mental injury, abuse, or neglect from a family member or significant other.

477.13 (f) For a client age 18 or older, the treatment team may disclose to a family member,
477.14 other relative, or a close personal friend of the client, or other person identified by the client,
477.15 the protected health information directly relevant to such person's involvement with the
477.16 client's care, as provided in Code of Federal Regulations, title 45, part 164.502(b). If the
477.17 client is present, the treatment team shall obtain the client's agreement, provide the client
477.18 with an opportunity to object, or reasonably infer from the circumstances, based on the
477.19 exercise of professional judgment, that the client does not object. If the client is not present
477.20 or is unable, by incapacity or emergency circumstances, to agree or object, the treatment
477.21 team may, in the exercise of professional judgment, determine whether the disclosure is in
477.22 the best interests of the client and, if so, disclose only the protected health information that
477.23 is directly relevant to the family member's, relative's, friend's, or client-identified person's
477.24 involvement with the client's health care. The client may orally agree or object to the
477.25 disclosure and may prohibit or restrict disclosure to specific individuals.

477.26 (g) The treatment team shall provide interventions to promote positive interpersonal
477.27 relationships.

477.28 Sec. 130. Minnesota Statutes 2018, section 256B.0947, subdivision 7a, is amended to
477.29 read:

477.30 Subd. 7a. **Noncovered services.** (a) The rate for intensive rehabilitative mental health
477.31 services does not include medical assistance payment for services in clauses (1) to (7).
477.32 Services not covered under this paragraph may be billed separately:

477.33 (1) inpatient psychiatric hospital treatment;

- 478.1 (2) partial hospitalization;
- 478.2 (3) children's mental health day treatment services;
- 478.3 (4) physician services outside of care provided by a psychiatrist serving as a member of
- 478.4 the treatment team;
- 478.5 (5) room and board costs, as defined in section 256I.03, subdivision 6;
- 478.6 (6) home and community-based waiver services; and
- 478.7 (7) other mental health services identified in the child's individualized education program.

478.8 (b) The following services are not covered under this section and are not eligible for

478.9 medical assistance payment while youth are receiving intensive rehabilitative mental health

478.10 services:

- 478.11 (1) mental health residential treatment; and
- 478.12 (2) mental health behavioral aide services, as defined in section 256B.0943, subdivision
- 478.13 1, paragraph ~~(m)~~ (l).

478.14 Sec. 131. Minnesota Statutes 2018, section 256B.0949, subdivision 2, is amended to read:

478.15 Subd. 2. **Definitions.** (a) The terms used in this section have the meanings given in this

478.16 subdivision.

478.17 (b) "Agency" means the legal entity that is enrolled with Minnesota health care programs

478.18 as a medical assistance provider according to Minnesota Rules, part 9505.0195, to provide

478.19 EIDBI services and that has the legal responsibility to ensure that its employees or contractors

478.20 carry out the responsibilities defined in this section. Agency includes a licensed individual

478.21 professional who practices independently and acts as an agency.

478.22 (c) "Autism spectrum disorder or a related condition" or "ASD or a related condition"

478.23 means either autism spectrum disorder (ASD) as defined in the current version of the

478.24 Diagnostic and Statistical Manual of Mental Disorders (DSM) or a condition that is found

478.25 to be closely related to ASD, as identified under the current version of the DSM, and meets

478.26 all of the following criteria:

- 478.27 (1) is severe and chronic;
- 478.28 (2) results in impairment of adaptive behavior and function similar to that of a person
- 478.29 with ASD;
- 478.30 (3) requires treatment or services similar to those required for a person with ASD; and

479.1 (4) results in substantial functional limitations in three core developmental deficits of
479.2 ASD: social interaction; nonverbal or social communication; and restrictive, repetitive
479.3 behaviors or hyperreactivity or hyporeactivity to sensory input; and may include deficits or
479.4 a high level of support in one or more of the following domains:

479.5 (i) self-regulation;

479.6 (ii) self-care;

479.7 (iii) behavioral challenges;

479.8 (iv) expressive communication;

479.9 (v) receptive communication;

479.10 (vi) cognitive functioning; or

479.11 (vii) safety.

479.12 (d) "Person" means a person under 21 years of age.

479.13 (e) "Clinical supervision" means the overall responsibility for the control and direction
479.14 of EIDBI service delivery, including individual treatment planning, staff supervision,
479.15 individual treatment plan progress monitoring, and treatment review for each person. Clinical
479.16 supervision is provided by a qualified supervising professional (QSP) who takes full
479.17 professional responsibility for the service provided by each supervisee.

479.18 (f) "Commissioner" means the commissioner of human services, unless otherwise
479.19 specified.

479.20 (g) "Comprehensive multidisciplinary evaluation" or "CMDE" means a comprehensive
479.21 evaluation of a person to determine medical necessity for EIDBI services based on the
479.22 requirements in subdivision 5.

479.23 (h) "Department" means the Department of Human Services, unless otherwise specified.

479.24 (i) "Early intensive developmental and behavioral intervention benefit" or "EIDBI
479.25 benefit" means a variety of individualized, intensive treatment modalities approved by the
479.26 commissioner that are based in behavioral and developmental science consistent with best
479.27 practices on effectiveness.

479.28 (j) "Generalizable goals" means results or gains that are observed during a variety of
479.29 activities over time with different people, such as providers, family members, other adults,
479.30 and people, and in different environments including, but not limited to, clinics, homes,
479.31 schools, and the community.

480.1 (k) "Incident" means when any of the following occur:

480.2 (1) an illness, accident, or injury that requires first aid treatment;

480.3 (2) a bump or blow to the head; or

480.4 (3) an unusual or unexpected event that jeopardizes the safety of a person or staff,

480.5 including a person leaving the agency unattended.

480.6 (l) "Individual treatment plan" or "ITP" means the person-centered, individualized written

480.7 plan of care that integrates and coordinates person and family information from the CMDE

480.8 for a person who meets medical necessity for the EIDBI benefit. An individual treatment

480.9 plan must meet the standards in subdivision 6.

480.10 (m) "Legal representative" means the parent of a child who is under 18 years of age, a

480.11 court-appointed guardian, or other representative with legal authority to make decisions

480.12 about service for a person. For the purpose of this subdivision, "other representative with

480.13 legal authority to make decisions" includes a health care agent or an attorney-in-fact

480.14 authorized through a health care directive or power of attorney.

480.15 (n) "Mental health professional" has the meaning given in section 245.4871, subdivision

480.16 ~~27, clauses (1) to (6).~~

480.17 (o) "Person-centered" means a service that both responds to the identified needs, interests,

480.18 values, preferences, and desired outcomes of the person or the person's legal representative

480.19 and respects the person's history, dignity, and cultural background and allows inclusion and

480.20 participation in the person's community.

480.21 (p) "Qualified EIDBI provider" means a person who is a QSP or a level I, level II, or

480.22 level III treatment provider.

480.23 Sec. 132. Minnesota Statutes 2018, section 256B.0949, subdivision 4, is amended to read:

480.24 Subd. 4. **Diagnosis.** (a) A diagnosis of ASD or a related condition must:

480.25 (1) be based upon current DSM criteria including direct observations of the person and

480.26 information from the person's legal representative or primary caregivers;

480.27 (2) be completed by either (i) a licensed physician or advanced practice registered nurse

480.28 or (ii) a mental health professional; and

480.29 (3) meet the requirements of ~~Minnesota Rules, part 9505.0372, subpart 1, items B and~~

480.30 € section 256B.071, subdivisions 2 and 3.

481.1 (b) Additional assessment information may be considered to complete a diagnostic
481.2 assessment including specialized tests administered through special education evaluations
481.3 and licensed school personnel, and from professionals licensed in the fields of medicine,
481.4 speech and language, psychology, occupational therapy, and physical therapy. A diagnostic
481.5 assessment may include treatment recommendations.

481.6 Sec. 133. Minnesota Statutes 2018, section 256B.0949, subdivision 5a, is amended to
481.7 read:

481.8 Subd. 5a. **Comprehensive multidisciplinary evaluation provider qualification.** A
481.9 CMDE provider must:

481.10 (1) be a licensed physician, advanced practice registered nurse, a mental health
481.11 professional, or a ~~mental health practitioner who meets the requirements of a clinical trainee~~
481.12 ~~as defined in Minnesota Rules, part 9505.0371, subpart 5, item C~~ described under section
481.13 245I.16, subdivision 6;

481.14 (2) have at least 2,000 hours of clinical experience in the evaluation and treatment of
481.15 people with ASD or a related condition or equivalent documented coursework at the graduate
481.16 level by an accredited university in the following content areas: ASD or a related condition
481.17 diagnosis, ASD or a related condition treatment strategies, and child development; and

481.18 (3) be able to diagnose, evaluate, or provide treatment within the provider's scope of
481.19 practice and professional license.

481.20 Sec. 134. **DIRECTION TO COMMISSIONER; SINGLE COMPREHENSIVE**
481.21 **LICENSE STRUCTURE.**

481.22 The commissioner of human services, in consultation with stakeholders including but
481.23 not limited to counties, tribes, managed care organizations, provider organizations, advocacy
481.24 groups, and individuals and families served, shall develop recommendations to provide a
481.25 single comprehensive license structure for mental health service programs, including
481.26 community mental health centers according to Minnesota Rules, part 9520.0750, intensive
481.27 residential treatment services, assertive community treatment, adult rehabilitative mental
481.28 health services, children's therapeutic services and supports, intensive rehabilitative mental
481.29 health services, intensive treatment in foster care, and children's residential treatment
481.30 programs currently approved under Minnesota Rules, chapter 2960. The recommendations
481.31 must prioritize program integrity, the welfare of individuals and families served, improved
481.32 integration of mental health and substance use disorder services, and the reduction of
481.33 administrative burden on providers.

482.1 Sec. 135. **REPEALER.**

482.2 (a) Minnesota Statutes 2018, sections 245.462, subdivision 4a; 256B.0615, subdivisions
 482.3 2, 4, and 5; 256B.0616, subdivisions 2, 4, and 5; 256B.0624, subdivision 10; 256B.0943,
 482.4 subdivision 10; 256B.0944, subdivision 10; 256B.0946, subdivision 5; and 256B.0947,
 482.5 subdivision 9, are repealed.

482.6 (b) Minnesota Rules, parts 9505.0370; 9505.0371; 9505.0372; 9520.0010; 9520.0020;
 482.7 9520.0030; 9520.0040; 9520.0050; 9520.0060; 9520.0070; 9520.0080; 9520.0090;
 482.8 9520.0100; 9520.0110; 9520.0120; 9520.0130; 9520.0140; 9520.0150; 9520.0160;
 482.9 9520.0170; 9520.0180; 9520.0190; 9520.0200; 9520.0210; and 9520.0230, are repealed.

482.10 **ARTICLE 8**

482.11 **HEALTH CARE**

482.12 Section 1. Minnesota Statutes 2018, section 13.69, subdivision 1, is amended to read:

482.13 Subdivision 1. **Classifications.** (a) The following government data of the Department
 482.14 of Public Safety are private data:

482.15 (1) medical data on driving instructors, licensed drivers, and applicants for parking
 482.16 certificates and special license plates issued to physically disabled persons;

482.17 (2) other data on holders of a disability certificate under section 169.345, except that (i)
 482.18 data that are not medical data may be released to law enforcement agencies, and (ii) data
 482.19 necessary for enforcement of sections 169.345 and 169.346 may be released to parking
 482.20 enforcement employees or parking enforcement agents of statutory or home rule charter
 482.21 cities and towns;

482.22 (3) Social Security numbers in driver's license and motor vehicle registration records,
 482.23 except that Social Security numbers must be provided to the Department of Revenue for
 482.24 purposes of tax administration, the Department of Labor and Industry for purposes of
 482.25 workers' compensation administration and enforcement, the judicial branch for purposes of
 482.26 debt collection, and the Department of Natural Resources for purposes of license application
 482.27 administration, and except that the last four digits of the Social Security number must be
 482.28 provided to the Department of Human Services for purposes of recovery of Minnesota health
 482.29 care program benefits paid; and

482.30 (4) data on persons listed as standby or temporary custodians under section 171.07,
 482.31 subdivision 11, except that the data must be released to:

483.1 (i) law enforcement agencies for the purpose of verifying that an individual is a designated
483.2 caregiver; or

483.3 (ii) law enforcement agencies who state that the license holder is unable to communicate
483.4 at that time and that the information is necessary for notifying the designated caregiver of
483.5 the need to care for a child of the license holder.

483.6 The department may release the Social Security number only as provided in clause (3)
483.7 and must not sell or otherwise provide individual Social Security numbers or lists of Social
483.8 Security numbers for any other purpose.

483.9 (b) The following government data of the Department of Public Safety are confidential
483.10 data: data concerning an individual's driving ability when that data is received from a member
483.11 of the individual's family.

483.12 **EFFECTIVE DATE.** This section is effective July 1, 2019.

483.13 Sec. 2. Minnesota Statutes 2018, section 16A.724, subdivision 2, is amended to read:

483.14 Subd. 2. **Transfers.** (a) Notwithstanding section 295.581, to the extent available resources
483.15 in the health care access fund exceed expenditures in that fund, effective for the biennium
483.16 beginning July 1, 2007, the commissioner of management and budget shall transfer the
483.17 excess funds from the health care access fund to the general fund on June 30 of each year,
483.18 provided that the amount transferred in fiscal year 2016 shall not exceed \$48,000,000, the
483.19 amount in fiscal year 2017 shall not exceed \$122,000,000, and the amount in any fiscal
483.20 biennium thereafter shall not exceed \$244,000,000. The purpose of this transfer is to meet
483.21 the rate increase required under ~~Laws 2003, First Special Session chapter 14, article 13C,~~
483.22 ~~section 2, subdivision 6~~ section 256B.688.

483.23 (b) For fiscal years 2006 to 2011, MinnesotaCare shall be a forecasted program, and, if
483.24 necessary, the commissioner shall reduce these transfers from the health care access fund
483.25 to the general fund to meet annual MinnesotaCare expenditures or, if necessary, transfer
483.26 sufficient funds from the general fund to the health care access fund to meet annual
483.27 MinnesotaCare expenditures.

483.28 Sec. 3. Minnesota Statutes 2018, section 62Q.184, subdivision 1, is amended to read:

483.29 Subdivision 1. **Definitions.** (a) For the purposes of this section, the terms in this
483.30 subdivision have the meanings given them.

483.31 (b) "Clinical practice guideline" means a systematically developed statement to assist
483.32 health care providers and enrollees in making decisions about appropriate health care services

484.1 for specific clinical circumstances and conditions developed independently of a health plan
 484.2 company, pharmaceutical manufacturer, or any entity with a conflict of interest. A clinical
 484.3 practice guideline also includes a preferred drug list developed in accordance with section
 484.4 256B.0625.

484.5 (c) "Clinical review criteria" means the written screening procedures, decision abstracts,
 484.6 clinical protocols, and clinical practice guidelines used by a health plan company to determine
 484.7 the medical necessity and appropriateness of health care services.

484.8 (d) "Health plan company" has the meaning given in section 62Q.01, subdivision 4, but
 484.9 ~~does not include a managed care organization or~~ also includes a county-based purchasing
 484.10 plan participating in a public program under chapter 256B or 256L, ~~or~~ and an integrated
 484.11 health partnership under section 256B.0755.

484.12 (e) "Step therapy protocol" means a protocol or program that establishes the specific
 484.13 sequence in which prescription drugs for a specified medical condition, including
 484.14 self-administered and physician-administered drugs, are medically appropriate for a particular
 484.15 enrollee and are covered under a health plan.

484.16 (f) "Step therapy override" means that the step therapy protocol is overridden in favor
 484.17 of coverage of the selected prescription drug of the prescribing health care provider because
 484.18 at least one of the conditions of subdivision 3, paragraph (a), exists.

484.19 Sec. 4. Minnesota Statutes 2018, section 62Q.184, subdivision 3, is amended to read:

484.20 Subd. 3. **Step therapy override process; transparency.** (a) When coverage of a
 484.21 prescription drug for the treatment of a medical condition is restricted for use by a health
 484.22 plan company through the use of a step therapy protocol, enrollees and prescribing health
 484.23 care providers shall have access to a clear, readily accessible, and convenient process to
 484.24 request a step therapy override. The process shall be made easily accessible on the health
 484.25 plan company's website. A health plan company may use its existing medical exceptions
 484.26 process to satisfy this requirement. A health plan company shall grant an override to the
 484.27 step therapy protocol if at least one of the following conditions exist:

484.28 (1) the prescription drug required under the step therapy protocol is contraindicated
 484.29 pursuant to the pharmaceutical manufacturer's prescribing information for the drug or, due
 484.30 to a documented adverse event with a previous use or a documented medical condition,
 484.31 including a comorbid condition, is likely to do any of the following:

484.32 (i) cause an adverse reaction to the enrollee;

485.1 (ii) decrease the ability of the enrollee to achieve or maintain reasonable functional
485.2 ability in performing daily activities; or

485.3 (iii) cause physical or mental harm to the enrollee;

485.4 (2) the enrollee has had a trial of the required prescription drug covered by their current
485.5 or previous health plan, or another prescription drug in the same pharmacologic class or
485.6 with the same mechanism of action, and was adherent during such trial for a period of time
485.7 sufficient to allow for a positive treatment outcome, and the prescription drug was
485.8 discontinued by the enrollee's health care provider due to lack of effectiveness, or an adverse
485.9 event. This clause does not prohibit a health plan company from requiring an enrollee to
485.10 try another drug in the same pharmacologic class or with the same mechanism of action if
485.11 that therapy sequence is supported by the evidence-based and peer-reviewed clinical practice
485.12 guideline, Food and Drug Administration label, or pharmaceutical manufacturer's prescribing
485.13 information; or

485.14 (3) the enrollee is currently receiving a positive therapeutic outcome on a prescription
485.15 drug for the medical condition under consideration if, while on their current health plan or
485.16 the immediately preceding health plan, the enrollee received coverage for the prescription
485.17 drug and the enrollee's prescribing health care provider gives documentation to the health
485.18 plan company that the change in prescription drug required by the step therapy protocol is
485.19 expected to be ineffective or cause harm to the enrollee based on the known characteristics
485.20 of the specific enrollee and the known characteristics of the required prescription drug.

485.21 (b) Upon granting a step therapy override, a health plan company shall authorize coverage
485.22 for the prescription drug if the prescription drug is a covered prescription drug under the
485.23 enrollee's health plan.

485.24 (c) The enrollee, or the prescribing health care provider if designated by the enrollee,
485.25 may appeal the denial of a step therapy override by a health plan company using the
485.26 complaint procedure under sections 62Q.68 to 62Q.73 or 256.045.

485.27 (d) In a denial of an override request and any subsequent appeal, a health plan company's
485.28 decision must specifically state why the step therapy override request did not meet the
485.29 condition under paragraph (a) cited by the prescribing health care provider in requesting
485.30 the step therapy override and information regarding the procedure to request external review
485.31 of the denial pursuant to section 62Q.73. A denial of a request for a step therapy override
485.32 that is upheld on appeal is a final adverse determination for purposes of section 62Q.73 and
485.33 is eligible for a request for external review by an enrollee pursuant to section 62Q.73.

486.1 (e) A health plan company shall respond to a step therapy override request or an appeal
486.2 within five days of receipt of a complete request. In cases where exigent circumstances
486.3 exist, a health plan company shall respond within 72 hours of receipt of a complete request.
486.4 If a health plan company does not send a response to the enrollee or prescribing health care
486.5 provider if designated by the enrollee within the time allotted, the override request or appeal
486.6 is granted and binding on the health plan company.

486.7 (f) Step therapy override requests must be accessible to and submitted by health care
486.8 providers, and accepted by group purchasers electronically through secure electronic
486.9 transmission, as described under section 62J.497, subdivision 5.

486.10 (g) Nothing in this section prohibits a health plan company from:

486.11 (1) requesting relevant documentation from an enrollee's medical record in support of
486.12 a step therapy override request; or

486.13 (2) requiring an enrollee to try a generic equivalent drug pursuant to section 151.21, or
486.14 a biosimilar, as defined under United States Code, chapter 42, section 262(i)(2), prior to
486.15 providing coverage for the equivalent branded prescription drug.

486.16 (h) This section shall not be construed to allow the use of a pharmaceutical sample for
486.17 the primary purpose of meeting the requirements for a step therapy override.

486.18 Sec. 5. Minnesota Statutes 2018, section 245A.02, subdivision 5a, is amended to read:

486.19 Subd. 5a. **Controlling individual.** (a) "Controlling individual" means an owner of a
486.20 program or service provider licensed under this chapter and the following individuals, if
486.21 applicable:

486.22 (1) each officer of the organization, including the chief executive officer and chief
486.23 financial officer;

486.24 (2) the individual designated as the authorized agent under section 245A.04, subdivision
486.25 1, paragraph (b);

486.26 (3) the individual designated as the compliance officer under section 256B.04, subdivision
486.27 21, paragraph ~~(b)~~ (g); and

486.28 (4) each managerial official whose responsibilities include the direction of the
486.29 management or policies of a program.

486.30 (b) Controlling individual does not include:

487.1 (1) a bank, savings bank, trust company, savings association, credit union, industrial
487.2 loan and thrift company, investment banking firm, or insurance company unless the entity
487.3 operates a program directly or through a subsidiary;

487.4 (2) an individual who is a state or federal official, or state or federal employee, or a
487.5 member or employee of the governing body of a political subdivision of the state or federal
487.6 government that operates one or more programs, unless the individual is also an officer,
487.7 owner, or managerial official of the program, receives remuneration from the program, or
487.8 owns any of the beneficial interests not excluded in this subdivision;

487.9 (3) an individual who owns less than five percent of the outstanding common shares of
487.10 a corporation:

487.11 (i) whose securities are exempt under section 80A.45, clause (6); or

487.12 (ii) whose transactions are exempt under section 80A.46, clause (2);

487.13 (4) an individual who is a member of an organization exempt from taxation under section
487.14 290.05, unless the individual is also an officer, owner, or managerial official of the program
487.15 or owns any of the beneficial interests not excluded in this subdivision. This clause does
487.16 not exclude from the definition of controlling individual an organization that is exempt from
487.17 taxation; or

487.18 (5) an employee stock ownership plan trust, or a participant or board member of an
487.19 employee stock ownership plan, unless the participant or board member is a controlling
487.20 individual according to paragraph (a).

487.21 (c) For purposes of this subdivision, "managerial official" means an individual who has
487.22 the decision-making authority related to the operation of the program, and the responsibility
487.23 for the ongoing management of or direction of the policies, services, or employees of the
487.24 program. A site director who has no ownership interest in the program is not considered to
487.25 be a managerial official for purposes of this definition.

487.26 **EFFECTIVE DATE.** This section is effective July 1, 2019.

487.27 Sec. 6. Minnesota Statutes 2018, section 245D.081, subdivision 3, is amended to read:

487.28 Subd. 3. **Program management and oversight.** (a) The license holder must designate
487.29 a managerial staff person or persons to provide program management and oversight of the
487.30 services provided by the license holder. The designated manager is responsible for the
487.31 following:

488.1 (1) maintaining a current understanding of the licensing requirements sufficient to ensure
488.2 compliance throughout the program as identified in section 245A.04, subdivision 1, paragraph
488.3 (e), and when applicable, as identified in section 256B.04, subdivision 21, paragraph ~~(b)~~
488.4 (g);

488.5 (2) ensuring the duties of the designated coordinator are fulfilled according to the
488.6 requirements in subdivision 2;

488.7 (3) ensuring the program implements corrective action identified as necessary by the
488.8 program following review of incident and emergency reports according to the requirements
488.9 in section 245D.11, subdivision 2, clause (7). An internal review of incident reports of
488.10 alleged or suspected maltreatment must be conducted according to the requirements in
488.11 section 245A.65, subdivision 1, paragraph (b);

488.12 (4) evaluation of satisfaction of persons served by the program, the person's legal
488.13 representative, if any, and the case manager, with the service delivery and progress ~~towards~~
488.14 toward accomplishing outcomes identified in sections 245D.07 and 245D.071, and ensuring
488.15 and protecting each person's rights as identified in section 245D.04;

488.16 (5) ensuring staff competency requirements are met according to the requirements in
488.17 section 245D.09, subdivision 3, and ensuring staff orientation and training is provided
488.18 according to the requirements in section 245D.09, subdivisions 4, 4a, and 5;

488.19 (6) ensuring corrective action is taken when ordered by the commissioner and that the
488.20 terms and conditions of the license and any variances are met; and

488.21 (7) evaluating the information identified in clauses (1) to (6) to develop, document, and
488.22 implement ongoing program improvements.

488.23 (b) The designated manager must be competent to perform the duties as required and
488.24 must minimally meet the education and training requirements identified in subdivision 2,
488.25 paragraph (b), and have a minimum of three years of supervisory level experience in a
488.26 program providing direct support services to persons with disabilities or persons age 65 and
488.27 older.

488.28 **EFFECTIVE DATE.** This section is effective July 1, 2019.

488.29 Sec. 7. Minnesota Statutes 2018, section 256.962, subdivision 5, is amended to read:

488.30 Subd. 5. **Incentive program.** Beginning January 1, 2008, the commissioner shall establish
488.31 an incentive program for organizations and licensed insurance producers under chapter 60K
488.32 that directly identify and assist potential enrollees in filling out and submitting an application.

489.1 For each applicant who is successfully enrolled in MinnesotaCare or medical assistance,
489.2 the commissioner, within the available appropriation, shall pay the organization or licensed
489.3 insurance producer a ~~\$25~~ \$70 application assistance bonus. The organization or licensed
489.4 insurance producer may provide an applicant a gift certificate or other incentive upon
489.5 enrollment.

489.6 **EFFECTIVE DATE.** This section is effective July 1, 2019.

489.7 Sec. 8. Minnesota Statutes 2018, section 256.969, subdivision 2b, is amended to read:

489.8 Subd. 2b. **Hospital payment rates.** (a) For discharges occurring on or after November
489.9 1, 2014, hospital inpatient services for hospitals located in Minnesota shall be paid according
489.10 to the following:

489.11 (1) critical access hospitals as defined by Medicare shall be paid using a cost-based
489.12 methodology;

489.13 (2) long-term hospitals as defined by Medicare shall be paid on a per diem methodology
489.14 under subdivision 25;

489.15 (3) rehabilitation hospitals or units of hospitals that are recognized as rehabilitation
489.16 distinct parts as defined by Medicare shall be paid according to the methodology under
489.17 subdivision 12; and

489.18 (4) all other hospitals shall be paid on a diagnosis-related group (DRG) methodology.

489.19 (b) For the period beginning January 1, 2011, through October 31, 2014, rates shall not
489.20 be rebased, except that a Minnesota long-term hospital shall be rebased effective January
489.21 1, 2011, based on its most recent Medicare cost report ending on or before September 1,
489.22 2008, with the provisions under subdivisions 9 and 23, based on the rates in effect on
489.23 December 31, 2010. For rate setting periods after November 1, 2014, in which the base
489.24 years are updated, a Minnesota long-term hospital's base year shall remain within the same
489.25 period as other hospitals.

489.26 (c) Effective for discharges occurring on and after November 1, 2014, payment rates
489.27 for hospital inpatient services provided by hospitals located in Minnesota or the local trade
489.28 area, except for the hospitals paid under the methodologies described in paragraph (a),
489.29 clauses (2) and (3), shall be rebased, incorporating cost and payment methodologies in a
489.30 manner similar to Medicare. The base year for the rates effective November 1, 2014, shall
489.31 be calendar year 2012. The rebasing under this paragraph shall be budget neutral, ensuring
489.32 that the total aggregate payments under the rebased system are equal to the total aggregate
489.33 payments that were made for the same number and types of services in the base year. Separate

490.1 budget neutrality calculations shall be determined for payments made to critical access
490.2 hospitals and payments made to hospitals paid under the DRG system. Only the rate increases
490.3 or decreases under subdivision 3a or 3c that applied to the hospitals being rebased during
490.4 the entire base period shall be incorporated into the budget neutrality calculation.

490.5 (d) For discharges occurring on or after November 1, 2014, through the next rebasing
490.6 that occurs, the rebased rates under paragraph (c) that apply to hospitals under paragraph
490.7 (a), clause (4), shall include adjustments to the projected rates that result in no greater than
490.8 a five percent increase or decrease from the base year payments for any hospital. Any
490.9 adjustments to the rates made by the commissioner under this paragraph and paragraph (e)
490.10 shall maintain budget neutrality as described in paragraph (c).

490.11 (e) For discharges occurring on or after November 1, 2014, ~~through the next two rebasing~~
490.12 ~~periods~~ the commissioner may make additional adjustments to the rebased rates, and when
490.13 evaluating whether additional adjustments should be made, the commissioner shall consider
490.14 the impact of the rates on the following:

490.15 (1) pediatric services;

490.16 (2) behavioral health services;

490.17 (3) trauma services as defined by the National Uniform Billing Committee;

490.18 (4) transplant services;

490.19 (5) obstetric services, newborn services, and behavioral health services provided by
490.20 hospitals outside the seven-county metropolitan area;

490.21 (6) outlier admissions;

490.22 (7) low-volume providers; and

490.23 (8) services provided by small rural hospitals that are not critical access hospitals.

490.24 (f) Hospital payment rates established under paragraph (c) must incorporate the following:

490.25 (1) for hospitals paid under the DRG methodology, the base year payment rate per
490.26 admission is standardized by the applicable Medicare wage index and adjusted by the
490.27 hospital's disproportionate population adjustment;

490.28 (2) for critical access hospitals, payment rates for discharges between November 1, 2014,
490.29 and June 30, 2015, shall be set to the same rate of payment that applied for discharges on
490.30 October 31, 2014;

491.1 (3) the cost and charge data used to establish hospital payment rates must only reflect
491.2 inpatient services covered by medical assistance; and

491.3 (4) in determining hospital payment rates for discharges occurring on or after the rate
491.4 year beginning January 1, 2011, through December 31, 2012, the hospital payment rate per
491.5 discharge shall be based on the cost-finding methods and allowable costs of the Medicare
491.6 program in effect during the base year or years. In determining hospital payment rates for
491.7 discharges in subsequent base years, the per discharge rates shall be based on the cost-finding
491.8 methods and allowable costs of the Medicare program in effect during the base year or
491.9 years.

491.10 (g) The commissioner shall validate the rates effective November 1, 2014, by applying
491.11 the rates established under paragraph (c), and any adjustments made to the rates under
491.12 paragraph (d) or (e), to hospital claims paid in calendar year 2013 to determine whether the
491.13 total aggregate payments for the same number and types of services under the rebased rates
491.14 are equal to the total aggregate payments made during calendar year 2013.

491.15 (h) Effective for discharges occurring on or after July 1, 2017, and every two years
491.16 thereafter, payment rates under this section shall be rebased to reflect only those changes
491.17 in hospital costs between the existing base year and the next base year. Changes in costs
491.18 between base years shall be measured using the lower of the hospital cost index defined in
491.19 subdivision 1, paragraph (a), or the percentage change in the case mix adjusted cost per
491.20 claim. The commissioner shall establish the base year for each rebasing period considering
491.21 the most recent year for which filed Medicare cost reports are available. The estimated
491.22 change in the average payment per hospital discharge resulting from a scheduled rebasing
491.23 must be calculated and made available to the legislature by January 15 of each year in which
491.24 rebasing is scheduled to occur, and must include by hospital the differential in payment
491.25 rates compared to the individual hospital's costs.

491.26 (i) Effective for discharges occurring on or after July 1, 2015, inpatient payment rates
491.27 for critical access hospitals located in Minnesota or the local trade area shall be determined
491.28 using a new cost-based methodology. The commissioner shall establish within the
491.29 methodology tiers of payment designed to promote efficiency and cost-effectiveness.
491.30 Payment rates for hospitals under this paragraph shall be set at a level that does not exceed
491.31 the total cost for critical access hospitals as reflected in base year cost reports. Until the
491.32 next rebasing that occurs, the new methodology shall result in no greater than a five percent
491.33 decrease from the base year payments for any hospital, except a hospital that had payments
491.34 that were greater than 100 percent of the hospital's costs in the base year shall have their
491.35 rate set equal to 100 percent of costs in the base year. The rates paid for discharges on and

492.1 after July 1, 2016, covered under this paragraph shall be increased by the inflation factor
492.2 in subdivision 1, paragraph (a). The new cost-based rate shall be the final rate and shall not
492.3 be settled to actual incurred costs. Hospitals shall be assigned a payment tier based on the
492.4 following criteria:

492.5 (1) hospitals that had payments at or below 80 percent of their costs in the base year
492.6 shall have a rate set that equals 85 percent of their base year costs;

492.7 (2) hospitals that had payments that were above 80 percent, up to and including 90
492.8 percent of their costs in the base year shall have a rate set that equals 95 percent of their
492.9 base year costs; and

492.10 (3) hospitals that had payments that were above 90 percent of their costs in the base year
492.11 shall have a rate set that equals 100 percent of their base year costs.

492.12 (j) The commissioner may refine the payment tiers and criteria for critical access hospitals
492.13 to coincide with the next rebasing under paragraph (h). The factors used to develop the new
492.14 methodology may include, but are not limited to:

492.15 (1) the ratio between the hospital's costs for treating medical assistance patients and the
492.16 hospital's charges to the medical assistance program;

492.17 (2) the ratio between the hospital's costs for treating medical assistance patients and the
492.18 hospital's payments received from the medical assistance program for the care of medical
492.19 assistance patients;

492.20 (3) the ratio between the hospital's charges to the medical assistance program and the
492.21 hospital's payments received from the medical assistance program for the care of medical
492.22 assistance patients;

492.23 (4) the statewide average increases in the ratios identified in clauses (1), (2), and (3);

492.24 (5) the proportion of that hospital's costs that are administrative and trends in
492.25 administrative costs; and

492.26 (6) geographic location.

492.27 Sec. 9. Minnesota Statutes 2018, section 256.969, subdivision 3a, is amended to read:

492.28 Subd. 3a. **Payments.** (a) Acute care hospital billings under the medical assistance program
492.29 must not be submitted until the recipient is discharged. However, the commissioner shall
492.30 establish monthly interim payments for inpatient hospitals that have individual patient
492.31 lengths of stay over 30 days regardless of diagnostic category. Except as provided in section
492.32 256.9693, medical assistance reimbursement for treatment of mental illness shall be

493.1 reimbursed based on diagnostic classifications. Individual hospital payments established
493.2 under this section and sections 256.9685, 256.9686, and 256.9695, in addition to third-party
493.3 and recipient liability, for discharges occurring during the rate year shall not exceed, ~~in~~
493.4 ~~aggregate~~ on a per claim basis, the charges for the medical assistance covered inpatient
493.5 services paid for the same period of time to the hospital. Services that have rates established
493.6 under subdivision 12, must be limited separately from other services. After consulting with
493.7 the affected hospitals, the commissioner may consider related hospitals one entity and may
493.8 merge the payment rates while maintaining separate provider numbers. The operating and
493.9 property base rates per admission or per day shall be derived from the best Medicare and
493.10 claims data available when rates are established. The commissioner shall determine the best
493.11 Medicare and claims data, taking into consideration variables of recency of the data, audit
493.12 disposition, settlement status, and the ability to set rates in a timely manner. The
493.13 commissioner shall notify hospitals of payment rates 30 days prior to implementation. The
493.14 rate setting data must reflect the admissions data used to establish relative values. The
493.15 commissioner may adjust base year cost, relative value, and case mix index data to exclude
493.16 the costs of services that have been discontinued by October 1 of the year preceding the
493.17 rate year or that are paid separately from inpatient services. Inpatient stays that encompass
493.18 portions of two or more rate years shall have payments established based on payment rates
493.19 in effect at the time of admission unless the date of admission preceded the rate year in
493.20 effect by six months or more. In this case, operating payment rates for services rendered
493.21 during the rate year in effect and established based on the date of admission shall be adjusted
493.22 to the rate year in effect by the hospital cost index.

493.23 (b) For fee-for-service admissions occurring on or after July 1, 2002, the total payment,
493.24 before third-party liability and spenddown, made to hospitals for inpatient services is reduced
493.25 by .5 percent from the current statutory rates.

493.26 (c) In addition to the reduction in paragraph (b), the total payment for fee-for-service
493.27 admissions occurring on or after July 1, 2003, made to hospitals for inpatient services before
493.28 third-party liability and spenddown, is reduced five percent from the current statutory rates.
493.29 Mental health services within diagnosis related groups 424 to 432 or corresponding
493.30 APR-DRGs, and facilities defined under subdivision 16 are excluded from this paragraph.

493.31 (d) In addition to the reduction in paragraphs (b) and (c), the total payment for
493.32 fee-for-service admissions occurring on or after August 1, 2005, made to hospitals for
493.33 inpatient services before third-party liability and spenddown, is reduced 6.0 percent from
493.34 the current statutory rates. Mental health services within diagnosis related groups 424 to
493.35 432 or corresponding APR-DRGs, and facilities defined under subdivision 16 are excluded

494.1 from this paragraph. Payments made to managed care plans shall be reduced for services
494.2 provided on or after January 1, 2006, to reflect this reduction.

494.3 (e) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for
494.4 fee-for-service admissions occurring on or after July 1, 2008, through June 30, 2009, made
494.5 to hospitals for inpatient services before third-party liability and spenddown, is reduced
494.6 3.46 percent from the current statutory rates. Mental health services with diagnosis related
494.7 groups 424 to 432 or corresponding APR-DRGs, and facilities defined under subdivision
494.8 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced
494.9 for services provided on or after January 1, 2009, through June 30, 2009, to reflect this
494.10 reduction.

494.11 (f) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for
494.12 fee-for-service admissions occurring on or after July 1, 2009, through June 30, 2011, made
494.13 to hospitals for inpatient services before third-party liability and spenddown, is reduced 1.9
494.14 percent from the current statutory rates. Mental health services with diagnosis related groups
494.15 424 to 432 or corresponding APR-DRGs, and facilities defined under subdivision 16 are
494.16 excluded from this paragraph. Payments made to managed care plans shall be reduced for
494.17 services provided on or after July 1, 2009, through June 30, 2011, to reflect this reduction.

494.18 (g) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for
494.19 fee-for-service admissions occurring on or after July 1, 2011, made to hospitals for inpatient
494.20 services before third-party liability and spenddown, is reduced 1.79 percent from the current
494.21 statutory rates. Mental health services with diagnosis related groups 424 to 432 or
494.22 corresponding APR-DRGs, and facilities defined under subdivision 16 are excluded from
494.23 this paragraph. Payments made to managed care plans shall be reduced for services provided
494.24 on or after July 1, 2011, to reflect this reduction.

494.25 (h) In addition to the reductions in paragraphs (b), (c), (d), (f), and (g), the total payment
494.26 for fee-for-service admissions occurring on or after July 1, 2009, made to hospitals for
494.27 inpatient services before third-party liability and spenddown, is reduced one percent from
494.28 the current statutory rates. Facilities defined under subdivision 16 are excluded from this
494.29 paragraph. Payments made to managed care plans shall be reduced for services provided
494.30 on or after October 1, 2009, to reflect this reduction.

494.31 (i) In addition to the reductions in paragraphs (b), (c), (d), (g), and (h), the total payment
494.32 for fee-for-service admissions occurring on or after July 1, 2011, made to hospitals for
494.33 inpatient services before third-party liability and spenddown, is reduced 1.96 percent from
494.34 the current statutory rates. Facilities defined under subdivision 16 are excluded from this

495.1 paragraph. Payments made to managed care plans shall be reduced for services provided
495.2 on or after January 1, 2011, to reflect this reduction.

495.3 (j) Effective for discharges on and after November 1, 2014, from hospitals paid under
495.4 subdivision 2b, paragraph (a), clauses (1) and (4), the rate adjustments in this subdivision
495.5 must be incorporated into the rebased rates established under subdivision 2b, paragraph (c),
495.6 and must not be applied to each claim.

495.7 (k) Effective for discharges on and after July 1, 2015, from hospitals paid under
495.8 subdivision 2b, paragraph (a), clauses (2) and (3), the rate adjustments in this subdivision
495.9 must be incorporated into the rates and must not be applied to each claim.

495.10 (l) Effective for discharges on and after July 1, 2017, from hospitals paid under
495.11 subdivision 2b, paragraph (a), clause (2), the rate adjustments in this subdivision must be
495.12 incorporated into the rates and must not be applied to each claim.

495.13 Sec. 10. Minnesota Statutes 2018, section 256.969, subdivision 9, is amended to read:

495.14 Subd. 9. **Disproportionate numbers of low-income patients served.** (a) For admissions
495.15 occurring on or after July 1, 1993, the medical assistance disproportionate population
495.16 adjustment shall comply with federal law and shall be paid to a hospital, excluding regional
495.17 treatment centers and facilities of the federal Indian Health Service, with a medical assistance
495.18 inpatient utilization rate in excess of the arithmetic mean. The adjustment must be determined
495.19 as follows:

495.20 (1) for a hospital with a medical assistance inpatient utilization rate above the arithmetic
495.21 mean for all hospitals excluding regional treatment centers and facilities of the federal Indian
495.22 Health Service but less than or equal to one standard deviation above the mean, the
495.23 adjustment must be determined by multiplying the total of the operating and property
495.24 payment rates by the difference between the hospital's actual medical assistance inpatient
495.25 utilization rate and the arithmetic mean for all hospitals excluding regional treatment centers
495.26 and facilities of the federal Indian Health Service; and

495.27 (2) for a hospital with a medical assistance inpatient utilization rate above one standard
495.28 deviation above the mean, the adjustment must be determined by multiplying the adjustment
495.29 that would be determined under clause (1) for that hospital by 1.1. The commissioner shall
495.30 report annually on the number of hospitals likely to receive the adjustment authorized by
495.31 this paragraph. The commissioner shall specifically report on the adjustments received by
495.32 public hospitals and public hospital corporations located in cities of the first class.

496.1 (b) Certified public expenditures made by Hennepin County Medical Center shall be
496.2 considered Medicaid disproportionate share hospital payments. Hennepin County and
496.3 Hennepin County Medical Center shall report by June 15, 2007, on payments made beginning
496.4 July 1, 2005, or another date specified by the commissioner, that may qualify for
496.5 reimbursement under federal law. Based on these reports, the commissioner shall apply for
496.6 federal matching funds.

496.7 (c) Upon federal approval of the related state plan amendment, paragraph (b) is effective
496.8 retroactively from July 1, 2005, or the earliest effective date approved by the Centers for
496.9 Medicare and Medicaid Services.

496.10 (d) Effective July 1, 2015, disproportionate share hospital (DSH) payments shall be paid
496.11 in accordance with a new methodology using 2012 as the base year. Annual payments made
496.12 under this paragraph shall equal the total amount of payments made for 2012. A licensed
496.13 children's hospital shall receive only a single DSH factor for children's hospitals. Other
496.14 DSH factors may be combined to arrive at a single factor for each hospital that is eligible
496.15 for DSH payments. The new methodology shall make payments only to hospitals located
496.16 in Minnesota and include the following factors:

496.17 (1) a licensed children's hospital with at least 1,000 fee-for-service discharges in the
496.18 base year shall receive a factor of 0.868. A licensed children's hospital with less than 1,000
496.19 fee-for-service discharges in the base year shall receive a factor of 0.7880;

496.20 (2) a hospital that has in effect for the initial rate year a contract with the commissioner
496.21 to provide extended psychiatric inpatient services under section 256.9693 shall receive a
496.22 factor of 0.0160;

496.23 (3) a hospital that has received payment from the fee-for-service program for at least 20
496.24 transplant services in the base year shall receive a factor of 0.0435;

496.25 (4) a hospital that has a medical assistance utilization rate in the base year between 20
496.26 percent up to one standard deviation above the statewide mean utilization rate shall receive
496.27 a factor of 0.0468;

496.28 (5) a hospital that has a medical assistance utilization rate in the base year that is at least
496.29 one standard deviation above the statewide mean utilization rate but is less than three standard
496.30 deviations above the mean shall receive a factor of 0.2300; and

496.31 (6) a hospital that has a medical assistance utilization rate in the base year that is at least
496.32 ~~three~~ two and one-half standard deviations above the statewide mean utilization rate shall
496.33 receive a factor of 0.3711.

497.1 (e) Any payments or portion of payments made to a hospital under this subdivision that
497.2 are subsequently returned to the commissioner because the payments are found to exceed
497.3 the hospital-specific DSH limit for that hospital shall be redistributed, proportionate to the
497.4 number of fee-for-service discharges, to other DSH-eligible non-children's hospitals that
497.5 have a medical assistance utilization rate that is at least one standard deviation above the
497.6 mean.

497.7 (f) An additional payment adjustment shall be established by the commissioner under
497.8 this subdivision for a hospital that provides high levels of administering high-cost drugs to
497.9 enrollees in fee-for-service medical assistance. The commissioner shall consider factors
497.10 including fee-for-service medical assistance utilization rates and payments made for drugs
497.11 purchased through the 340B drug purchasing program and administered to fee-for-service
497.12 enrollees. If any part of this adjustment exceeds a hospital's hospital-specific disproportionate
497.13 share hospital limit, the commissioner shall make a payment to the hospital that equals the
497.14 nonfederal share of the amount that exceeds the limit. The total nonfederal share of the
497.15 amount of the payment adjustment under this paragraph shall not exceed \$1,500,000.

497.16 **EFFECTIVE DATE.** This section is effective July 1, 2019, except paragraph (f) is
497.17 effective for discharges on or after April 1, 2019.

497.18 Sec. 11. Minnesota Statutes 2018, section 256.969, subdivision 17, is amended to read:

497.19 Subd. 17. **Out-of-state hospitals in local trade areas.** Out-of-state hospitals that are
497.20 located within a Minnesota local trade area and that have ~~more than~~ 20 admissions in the
497.21 base year or years shall have rates established using the same procedures and methods that
497.22 apply to Minnesota hospitals. For this subdivision and subdivision 18, local trade area means
497.23 a county contiguous to Minnesota and located in a metropolitan statistical area as determined
497.24 by Medicare for October 1 prior to the most current rebased rate year. Hospitals that are
497.25 not required by law to file information in a format necessary to establish rates shall have
497.26 rates established based on the commissioner's estimates of the information. Relative values
497.27 of the diagnostic categories shall not be redetermined under this subdivision until required
497.28 by statute. Hospitals affected by this subdivision shall then be included in determining
497.29 relative values. However, hospitals that have rates established based upon the commissioner's
497.30 estimates of information shall not be included in determining relative values. This subdivision
497.31 is effective for hospital fiscal years beginning on or after July 1, 1988. A hospital shall
497.32 provide the information necessary to establish rates under this subdivision at least 90 days
497.33 before the start of the hospital's fiscal year.

498.1 Sec. 12. Minnesota Statutes 2018, section 256.969, subdivision 19, is amended to read:

498.2 Subd. 19. **Metabolic disorder testing of medical assistance recipients.** Medical
498.3 assistance inpatient payment rates must include the cost incurred by hospitals to pay the
498.4 Department of Health for metabolic disorder testing of newborns who are medical assistance
498.5 recipients, if the cost is not recognized by another payment source. This payment increase
498.6 remains in effect until the increase is fully recognized in the base year cost under subdivision
498.7 2b.

498.8 Sec. 13. Minnesota Statutes 2018, section 256B.04, subdivision 14, is amended to read:

498.9 Subd. 14. **Competitive bidding.** (a) When determined to be effective, economical, and
498.10 feasible, the commissioner may utilize volume purchase through competitive bidding and
498.11 negotiation under the provisions of chapter 16C, to provide items under the medical assistance
498.12 program including but not limited to the following:

498.13 (1) eyeglasses;

498.14 (2) oxygen. The commissioner shall provide for oxygen needed in an emergency situation
498.15 on a short-term basis, until the vendor can obtain the necessary supply from the contract
498.16 dealer;

498.17 (3) hearing aids and supplies; ~~and~~

498.18 (4) durable medical equipment, including but not limited to:

498.19 (i) hospital beds;

498.20 (ii) commodes;

498.21 (iii) glide-about chairs;

498.22 (iv) patient lift apparatus;

498.23 (v) wheelchairs and accessories;

498.24 (vi) oxygen administration equipment;

498.25 (vii) respiratory therapy equipment;

498.26 (viii) electronic diagnostic, therapeutic and life-support systems; and

498.27 (ix) allergen-reducing products as described in section 256B.0625, subdivision 66,

498.28 paragraph (c);

499.1 (5) nonemergency medical transportation level of need determinations, disbursement of
499.2 public transportation passes and tokens, and volunteer and recipient mileage and parking
499.3 reimbursements; and

499.4 (6) drugs.

499.5 (b) Rate changes and recipient cost-sharing under this chapter and chapter 256L do not
499.6 affect contract payments under this subdivision unless specifically identified.

499.7 (c) The commissioner may not utilize volume purchase through competitive bidding
499.8 and negotiation for special transportation services under the provisions of chapter 16C.

499.9 Sec. 14. Minnesota Statutes 2018, section 256B.04, subdivision 21, is amended to read:

499.10 Subd. 21. **Provider enrollment.** (a) The commissioner shall enroll providers and conduct
499.11 screening activities as required by Code of Federal Regulations, title 42, section 455, subpart
499.12 E. A provider providing services from multiple locations must enroll each location separately.
499.13 The commissioner may deny a provider's incomplete application if a provider fails to respond
499.14 to the commissioner's request for additional information within 60 days of the request. The
499.15 commissioner must conduct a background study under chapter 245C, including a review
499.16 of databases in section 245C.08, subdivision 1, paragraph (a), clauses (1) to (5), for a provider
499.17 described in this paragraph. The background study requirement may be satisfied if the
499.18 commissioner conducted a fingerprint-based background study on the provider that includes
499.19 a review of databases in section 245C.08, subdivision 1, paragraph (a), clauses (1) to (5).

499.20 (b) The commissioner shall revalidate each: (1) provider under this subdivision at least
499.21 once every five years; and (2) personal care assistance agency under this subdivision once
499.22 every three years.

499.23 (c) The commissioner shall conduct revalidation as follows:

499.24 (1) provide 30-day notice of the revalidation due date including instructions for
499.25 revalidation and a list of materials the provider must submit;

499.26 (2) if a provider fails to submit all required materials by the due date, notify the provider
499.27 of the deficiency within 30 days after the due date and allow the provider an additional 30
499.28 days from the notification date to comply; and

499.29 (3) if a provider fails to remedy a deficiency within the 30-day time period, give 60-day
499.30 notice of termination and immediately suspend the provider's ability to bill. The provider
499.31 does not have the right to appeal suspension of ability to bill.

500.1 (d) If a provider fails to comply with any individual provider requirement or condition
500.2 of participation, the commissioner may suspend the provider's ability to bill until the provider
500.3 comes into compliance. The commissioner's decision to suspend the provider is not subject
500.4 to an administrative appeal.

500.5 (e) All correspondence and notifications, including notifications of termination and other
500.6 actions, must be delivered electronically to a provider's MN-ITS mailbox. For a provider
500.7 that does not have a MN-ITS account and mailbox, notice must be sent by first-class mail.
500.8 This paragraph does not apply to correspondences and notifications related to background
500.9 studies.

500.10 (f) If the commissioner or the Centers for Medicare and Medicaid Services determines
500.11 that a provider is designated "high-risk," the commissioner may withhold payment from
500.12 providers within that category upon initial enrollment for a 90-day period. The withholding
500.13 for each provider must begin on the date of the first submission of a claim.

500.14 ~~(b)~~ (g) An enrolled provider that is also licensed by the commissioner under chapter
500.15 245A, or is licensed as a home care provider by the Department of Health under chapter
500.16 144A and has a home and community-based services designation on the home care license
500.17 under section 144A.484, must designate an individual as the entity's compliance officer.
500.18 The compliance officer must:

500.19 (1) develop policies and procedures to assure adherence to medical assistance laws and
500.20 regulations and to prevent inappropriate claims submissions;

500.21 (2) train the employees of the provider entity, and any agents or subcontractors of the
500.22 provider entity including billers, on the policies and procedures under clause (1);

500.23 (3) respond to allegations of improper conduct related to the provision or billing of
500.24 medical assistance services, and implement action to remediate any resulting problems;

500.25 (4) use evaluation techniques to monitor compliance with medical assistance laws and
500.26 regulations;

500.27 (5) promptly report to the commissioner any identified violations of medical assistance
500.28 laws or regulations; and

500.29 (6) within 60 days of discovery by the provider of a medical assistance reimbursement
500.30 overpayment, report the overpayment to the commissioner and make arrangements with
500.31 the commissioner for the commissioner's recovery of the overpayment.

501.1 The commissioner may require, as a condition of enrollment in medical assistance, that a
 501.2 provider within a particular industry sector or category establish a compliance program that
 501.3 contains the core elements established by the Centers for Medicare and Medicaid Services.

501.4 ~~(e)~~ (h) The commissioner may revoke the enrollment of an ordering or rendering provider
 501.5 for a period of not more than one year, if the provider fails to maintain and, upon request
 501.6 from the commissioner, provide access to documentation relating to written orders or requests
 501.7 for payment for durable medical equipment, certifications for home health services, or
 501.8 referrals for other items or services written or ordered by such provider, when the
 501.9 commissioner has identified a pattern of a lack of documentation. A pattern means a failure
 501.10 to maintain documentation or provide access to documentation on more than one occasion.
 501.11 Nothing in this paragraph limits the authority of the commissioner to sanction a provider
 501.12 under the provisions of section 256B.064.

501.13 ~~(d)~~ (i) The commissioner shall terminate or deny the enrollment of any individual or
 501.14 entity if the individual or entity has been terminated from participation in Medicare or under
 501.15 the Medicaid program or Children's Health Insurance Program of any other state.

501.16 ~~(e)~~ (j) As a condition of enrollment in medical assistance, the commissioner shall require
 501.17 that a provider designated "moderate" or "high-risk" by the Centers for Medicare and
 501.18 Medicaid Services or the commissioner permit the Centers for Medicare and Medicaid
 501.19 Services, its agents, or its designated contractors and the state agency, its agents, or its
 501.20 designated contractors to conduct unannounced on-site inspections of any provider location.
 501.21 The commissioner shall publish in the Minnesota Health Care Program Provider Manual a
 501.22 list of provider types designated "limited," "moderate," or "high-risk," based on the criteria
 501.23 and standards used to designate Medicare providers in Code of Federal Regulations, title
 501.24 42, section 424.518. The list and criteria are not subject to the requirements of chapter 14.
 501.25 The commissioner's designations are not subject to administrative appeal.

501.26 ~~(f)~~ (k) As a condition of enrollment in medical assistance, the commissioner shall require
 501.27 that a high-risk provider, or a person with a direct or indirect ownership interest in the
 501.28 provider of five percent or higher, consent to criminal background checks, including
 501.29 fingerprinting, when required to do so under state law or by a determination by the
 501.30 commissioner or the Centers for Medicare and Medicaid Services that a provider is designated
 501.31 high-risk for fraud, waste, or abuse.

501.32 ~~(g)~~ (l)(1) Upon initial enrollment, reenrollment, and notification of revalidation, all
 501.33 durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) medical suppliers
 501.34 meeting the durable medical equipment provider and supplier definition in clause (3),

502.1 operating in Minnesota and receiving Medicaid funds must purchase a surety bond that is
502.2 annually renewed and designates the Minnesota Department of Human Services as the
502.3 obligee, and must be submitted in a form approved by the commissioner. For purposes of
502.4 this clause, the following medical suppliers are not required to obtain a surety bond: a
502.5 federally qualified health center, a home health agency, the Indian Health Service, a
502.6 pharmacy, and a rural health clinic.

502.7 (2) At the time of initial enrollment or reenrollment, durable medical equipment providers
502.8 and suppliers defined in clause (3) must purchase a surety bond of \$50,000. If a revalidating
502.9 provider's Medicaid revenue in the previous calendar year is up to and including \$300,000,
502.10 the provider agency must purchase a surety bond of \$50,000. If a revalidating provider's
502.11 Medicaid revenue in the previous calendar year is over \$300,000, the provider agency must
502.12 purchase a surety bond of \$100,000. The surety bond must allow for recovery of costs and
502.13 fees in pursuing a claim on the bond.

502.14 (3) "Durable medical equipment provider or supplier" means a medical supplier that can
502.15 purchase medical equipment or supplies for sale or rental to the general public and is able
502.16 to perform or arrange for necessary repairs to and maintenance of equipment offered for
502.17 sale or rental.

502.18 ~~(h)~~ (m) The Department of Human Services may require a provider to purchase a surety
502.19 bond as a condition of initial enrollment, reenrollment, reinstatement, or continued enrollment
502.20 if: (1) the provider fails to demonstrate financial viability, (2) the department determines
502.21 there is significant evidence of or potential for fraud and abuse by the provider, or (3) the
502.22 provider or category of providers is designated high-risk pursuant to paragraph ~~(a)~~ (f) and
502.23 as per Code of Federal Regulations, title 42, section 455.450. The surety bond must be in
502.24 an amount of \$100,000 or ten percent of the provider's payments from Medicaid during the
502.25 immediately preceding 12 months, whichever is greater. The surety bond must name the
502.26 Department of Human Services as an obligee and must allow for recovery of costs and fees
502.27 in pursuing a claim on the bond. This paragraph does not apply if the provider currently
502.28 maintains a surety bond under the requirements in section 256B.0659 or 256B.85.

502.29 **EFFECTIVE DATE.** This section is effective July 1, 2019.

502.30 Sec. 15. Minnesota Statutes 2018, section 256B.04, subdivision 22, is amended to read:

502.31 Subd. 22. **Application fee.** (a) The commissioner must collect and retain federally
502.32 required nonrefundable application fees to pay for provider screening activities in accordance
502.33 with Code of Federal Regulations, title 42, section 455, subpart E. The enrollment application
502.34 must be made under the procedures specified by the commissioner, in the form specified

503.1 by the commissioner, and accompanied by an application fee described in paragraph (b),
503.2 or a request for a hardship exception as described in the specified procedures. Application
503.3 fees must be deposited in the provider screening account in the special revenue fund.
503.4 Amounts in the provider screening account are appropriated to the commissioner for costs
503.5 associated with the provider screening activities required in Code of Federal Regulations,
503.6 title 42, section 455, subpart E. ~~The commissioner shall conduct screening activities as~~
503.7 ~~required by Code of Federal Regulations, title 42, section 455, subpart E, and as otherwise~~
503.8 ~~provided by law, to include database checks, unannounced pre- and postenrollment site~~
503.9 ~~visits, fingerprinting, and criminal background studies. The commissioner must revalidate~~
503.10 ~~all providers under this subdivision at least once every five years.~~

503.11 (b) The application fee under this subdivision is \$532 for the calendar year 2013. For
503.12 calendar year 2014 and subsequent years, the fee:

503.13 (1) is adjusted by the percentage change to the Consumer Price Index for all urban
503.14 consumers, United States city average, for the 12-month period ending with June of the
503.15 previous year. The resulting fee must be announced in the Federal Register;

503.16 (2) is effective from January 1 to December 31 of a calendar year;

503.17 (3) is required on the submission of an initial application, an application to establish a
503.18 new practice location, an application for reenrollment when the provider is not enrolled at
503.19 the time of application of reenrollment, or at revalidation when required by federal regulation;
503.20 and

503.21 (4) must be in the amount in effect for the calendar year during which the application
503.22 for enrollment, new practice location, or reenrollment is being submitted.

503.23 (c) The application fee under this subdivision cannot be charged to:

503.24 (1) providers who are enrolled in Medicare or who provide documentation of payment
503.25 of the fee to, and enrollment with, another state, unless the commissioner is required to
503.26 rescreen the provider;

503.27 (2) providers who are enrolled but are required to submit new applications for purposes
503.28 of reenrollment;

503.29 (3) a provider who enrolls as an individual; and

503.30 (4) group practices and clinics that bill on behalf of individually enrolled providers
503.31 within the practice who have reassigned their billing privileges to the group practice or
503.32 clinic.

504.1 **EFFECTIVE DATE.** This section is effective July 1, 2019.

504.2 Sec. 16. Minnesota Statutes 2018, section 256B.055, subdivision 2, is amended to read:

504.3 Subd. 2. **Subsidized foster children.** Medical assistance may be paid for a child eligible
504.4 for or receiving foster care maintenance payments under Title IV-E of the Social Security
504.5 Act, United States Code, title 42, sections 670 to 676, and for a child who is not eligible for
504.6 Title IV-E of the Social Security Act but who is determined eligible for foster care or kinship
504.7 assistance under chapter 256N.

504.8 **EFFECTIVE DATE.** This section is effective January 1, 2020, or upon federal approval,
504.9 whichever is later. The commissioner of human services shall notify the revisor of statutes
504.10 when federal approval is obtained.

504.11 Sec. 17. Minnesota Statutes 2018, section 256B.056, subdivision 3, is amended to read:

504.12 Subd. 3. **Asset limitations for certain individuals.** (a) To be eligible for medical
504.13 assistance, a person must not individually own more than \$3,000 in assets, or if a member
504.14 of a household with two family members, husband and wife, or parent and child, the
504.15 household must not own more than \$6,000 in assets, plus \$200 for each additional legal
504.16 dependent. In addition to these maximum amounts, an eligible individual or family may
504.17 accrue interest on these amounts, but they must be reduced to the maximum at the time of
504.18 an eligibility redetermination. The accumulation of the clothing and personal needs allowance
504.19 according to section 256B.35 must also be reduced to the maximum at the time of the
504.20 eligibility redetermination. The value of assets that are not considered in determining
504.21 eligibility for medical assistance is the value of those assets excluded under the Supplemental
504.22 Security Income program for aged, blind, and disabled persons, with the following
504.23 exceptions:

504.24 (1) household goods and personal effects are not considered;

504.25 (2) capital and operating assets of a trade or business that the local agency determines
504.26 are necessary to the person's ability to earn an income are not considered;

504.27 (3) motor vehicles are excluded to the same extent excluded by the Supplemental Security
504.28 Income program;

504.29 (4) assets designated as burial expenses are excluded to the same extent excluded by the
504.30 Supplemental Security Income program. Burial expenses funded by annuity contracts or
504.31 life insurance policies must irrevocably designate the individual's estate as contingent
504.32 beneficiary to the extent proceeds are not used for payment of selected burial expenses;

505.1 (5) for a person who no longer qualifies as an employed person with a disability due to
505.2 loss of earnings, assets allowed while eligible for medical assistance under section 256B.057,
505.3 subdivision 9, are not considered for 12 months, beginning with the first month of ineligibility
505.4 as an employed person with a disability, to the extent that the person's total assets remain
505.5 within the allowed limits of section 256B.057, subdivision 9, paragraph (d);

505.6 ~~(6) when a person enrolled in medical assistance under section 256B.057, subdivision~~
505.7 ~~9, is age 65 or older and has been enrolled during each of the 24 consecutive months before~~
505.8 ~~the person's 65th birthday, the assets owned by the person and the person's spouse must be~~
505.9 ~~disregarded, up to the limits of section 256B.057, subdivision 9, paragraph (d), when~~
505.10 ~~determining eligibility for medical assistance under section 256B.055, subdivision 7. a~~
505.11 designated employment incentives asset account is disregarded when determining eligibility
505.12 for medical assistance for a person age 65 years or older under section 256B.055, subdivision
505.13 7. An employment incentives asset account must only be designated by a person who has
505.14 been enrolled in medical assistance under section 256B.057, subdivision 9, for a
505.15 24-consecutive-month period. A designated employment incentives asset account contains
505.16 qualified assets owned by the person and the person's spouse in the last month of enrollment
505.17 in medical assistance under section 256B.057, subdivision 9. Qualified assets include
505.18 retirement and pension accounts, medical expense accounts, and up to \$17,000 of the person's
505.19 other nonexcluded assets. An employment incentives asset account is no longer designated
505.20 when a person loses medical assistance eligibility for a calendar month or more before
505.21 turning age 65. A person who loses medical assistance eligibility before age 65 can establish
505.22 a new designated employment incentives asset account by establishing a new
505.23 24-consecutive-month period of enrollment under section 256B.057, subdivision 9. The
505.24 income of a spouse of a person enrolled in medical assistance under section 256B.057,
505.25 subdivision 9, during each of the 24 consecutive months before the person's 65th birthday
505.26 must be disregarded when determining eligibility for medical assistance under section
505.27 256B.055, subdivision 7. Persons eligible under this clause are not subject to the provisions
505.28 in section 256B.059; and

505.29 (7) effective July 1, 2009, certain assets owned by American Indians are excluded as
505.30 required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public
505.31 Law 111-5. For purposes of this clause, an American Indian is any person who meets the
505.32 definition of Indian according to Code of Federal Regulations, title 42, section 447.50.

505.33 (b) No asset limit shall apply to persons eligible under section 256B.055, subdivision
505.34 15.

505.35 **EFFECTIVE DATE.** This section is effective July 1, 2019.

506.1 Sec. 18. Minnesota Statutes 2018, section 256B.0625, subdivision 9, is amended to read:

506.2 Subd. 9. **Dental services.** (a) Medical assistance covers dental services.

506.3 (b) Medical assistance dental coverage for nonpregnant adults is limited to the following
506.4 services:

506.5 (1) comprehensive exams, limited to once every five years;

506.6 (2) periodic exams, limited to one per year;

506.7 (3) limited exams;

506.8 (4) bitewing x-rays, limited to one per year;

506.9 (5) periapical x-rays;

506.10 (6) panoramic x-rays, limited to one every five years except (1) when medically necessary
506.11 for the diagnosis and follow-up of oral and maxillofacial pathology and trauma or (2) once
506.12 every two years for patients who cannot cooperate for intraoral film due to a developmental
506.13 disability or medical condition that does not allow for intraoral film placement;

506.14 (7) prophylaxis, limited to one per year;

506.15 (8) application of fluoride varnish, limited to one per year;

506.16 (9) posterior fillings, all at the amalgam rate;

506.17 (10) anterior fillings;

506.18 (11) endodontics, limited to root canals on the anterior and premolars only;

506.19 (12) removable prostheses, each dental arch limited to one every six years;

506.20 (13) oral surgery, limited to extractions, biopsies, and incision and drainage of abscesses;

506.21 (14) palliative treatment and sedative fillings for relief of pain; ~~and~~

506.22 (15) full-mouth debridement, limited to one every five years; and

506.23 (16) nonsurgical treatment for periodontal disease, including scaling and root planing
506.24 once every two years for each quadrant, and routine periodontal maintenance procedures.

506.25 (c) In addition to the services specified in paragraph (b), medical assistance covers the
506.26 following services for adults, if provided in an outpatient hospital setting or freestanding
506.27 ambulatory surgical center as part of outpatient dental surgery:

506.28 (1) periodontics, limited to periodontal scaling and root planing once every two years;

506.29 (2) general anesthesia; and

507.1 (3) full-mouth survey once every five years.

507.2 (d) Medical assistance covers medically necessary dental services for children and
507.3 pregnant women. The following guidelines apply:

507.4 (1) posterior fillings are paid at the amalgam rate;

507.5 (2) application of sealants are covered once every five years per permanent molar for
507.6 children only;

507.7 (3) application of fluoride varnish is covered once every six months; and

507.8 (4) orthodontia is eligible for coverage for children only.

507.9 (e) In addition to the services specified in paragraphs (b) and (c), medical assistance
507.10 covers the following services for adults:

507.11 (1) house calls or extended care facility calls for on-site delivery of covered services;

507.12 (2) behavioral management when additional staff time is required to accommodate
507.13 behavioral challenges and sedation is not used;

507.14 (3) oral or IV sedation, if the covered dental service cannot be performed safely without
507.15 it or would otherwise require the service to be performed under general anesthesia in a
507.16 hospital or surgical center; and

507.17 (4) prophylaxis, in accordance with an appropriate individualized treatment plan, but
507.18 no more than four times per year.

507.19 (f) The commissioner shall not require prior authorization for the services included in
507.20 paragraph (e), clauses (1) to (3), and shall prohibit managed care and county-based purchasing
507.21 plans from requiring prior authorization for the services included in paragraph (e), clauses
507.22 (1) to (3), when provided under sections 256B.69, 256B.692, and 256L.12.

507.23 Sec. 19. Minnesota Statutes 2018, section 256B.0625, subdivision 13, is amended to read:

507.24 Subd. 13. **Drugs.** (a) Medical assistance covers drugs, except for fertility drugs when
507.25 specifically used to enhance fertility, if prescribed by a licensed practitioner and dispensed
507.26 by a licensed pharmacist, by a physician enrolled in the medical assistance program as a
507.27 dispensing physician, or by a physician, physician assistant, or a nurse practitioner employed
507.28 by or under contract with a community health board as defined in section 145A.02,
507.29 subdivision 5, for the purposes of communicable disease control.

507.30 (b) The dispensed quantity of a prescription drug must not exceed a 34-day supply,
507.31 unless authorized by the commissioner.

508.1 (c) For the purpose of this subdivision and subdivision 13d, an "active pharmaceutical
508.2 ingredient" is defined as a substance that is represented for use in a drug and when used in
508.3 the manufacturing, processing, or packaging of a drug becomes an active ingredient of the
508.4 drug product. An "excipient" is defined as an inert substance used as a diluent or vehicle
508.5 for a drug. The commissioner shall establish a list of active pharmaceutical ingredients and
508.6 excipients which are included in the medical assistance formulary. Medical assistance covers
508.7 selected active pharmaceutical ingredients and excipients used in compounded prescriptions
508.8 when the compounded combination is specifically approved by the commissioner or when
508.9 a commercially available product:

508.10 (1) is not a therapeutic option for the patient;

508.11 (2) does not exist in the same combination of active ingredients in the same strengths
508.12 as the compounded prescription; and

508.13 (3) cannot be used in place of the active pharmaceutical ingredient in the compounded
508.14 prescription.

508.15 (d) Medical assistance covers the following over-the-counter drugs when prescribed by
508.16 a licensed practitioner or by a licensed pharmacist who meets standards established by the
508.17 commissioner, in consultation with the board of pharmacy: antacids, acetaminophen, family
508.18 planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults
508.19 with documented vitamin deficiencies, vitamins for children under the age of seven and
508.20 pregnant or nursing women, and any other over-the-counter drug identified by the
508.21 commissioner, in consultation with the Formulary Committee, as necessary, appropriate,
508.22 and cost-effective for the treatment of certain specified chronic diseases, conditions, or
508.23 disorders, and this determination shall not be subject to the requirements of chapter 14. A
508.24 pharmacist may prescribe over-the-counter medications as provided under this paragraph
508.25 for purposes of receiving reimbursement under Medicaid. When prescribing over-the-counter
508.26 drugs under this paragraph, licensed pharmacists must consult with the recipient to determine
508.27 necessity, provide drug counseling, review drug therapy for potential adverse interactions,
508.28 and make referrals as needed to other health care professionals. ~~Over-the-counter medications
508.29 must be dispensed in a quantity that is the lowest of: (1) the number of dosage units contained
508.30 in the manufacturer's original package; (2) the number of dosage units required to complete
508.31 the patient's course of therapy; or (3) if applicable, the number of dosage units dispensed
508.32 from a system using retrospective billing, as provided under subdivision 13e, paragraph
508.33 (b).~~

509.1 (e) Effective January 1, 2006, medical assistance shall not cover drugs that are coverable
 509.2 under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and
 509.3 Modernization Act of 2003, Public Law 108-173, section 1860D-2(e), for individuals eligible
 509.4 for drug coverage as defined in the Medicare Prescription Drug, Improvement, and
 509.5 Modernization Act of 2003, Public Law 108-173, section 1860D-1(a)(3)(A). For these
 509.6 individuals, medical assistance may cover drugs from the drug classes listed in United States
 509.7 Code, title 42, section 1396r-8(d)(2), subject to this subdivision and subdivisions 13a to
 509.8 13g, except that drugs listed in United States Code, title 42, section 1396r-8(d)(2)(E), shall
 509.9 not be covered.

509.10 (f) Medical assistance covers drugs acquired through the federal 340B Drug Pricing
 509.11 Program and dispensed by 340B covered entities and ambulatory pharmacies under common
 509.12 ownership of the 340B covered entity. Medical assistance does not cover drugs acquired
 509.13 through the federal 340B Drug Pricing Program and dispensed by 340B contract pharmacies.

509.14 **EFFECTIVE DATE.** This section is effective April 1, 2019, or upon federal approval,
 509.15 whichever is later. The commissioner of human services shall notify the revisor of statutes
 509.16 when federal approval is obtained.

509.17 Sec. 20. Minnesota Statutes 2018, section 256B.0625, subdivision 13d, is amended to
 509.18 read:

509.19 Subd. 13d. **Drug formulary.** (a) The commissioner shall establish a drug formulary. Its
 509.20 establishment and publication shall not be subject to the requirements of the Administrative
 509.21 Procedure Act, but the Formulary Committee shall review and comment on the formulary
 509.22 contents.

509.23 (b) The formulary shall not include:

509.24 (1) drugs, active pharmaceutical ingredients, or products for which there is no federal
 509.25 funding;

509.26 (2) over-the-counter drugs, except as provided in subdivision 13;

509.27 ~~(3) drugs or active pharmaceutical ingredients used for weight loss, except that medically~~
 509.28 ~~necessary lipase inhibitors may be covered for a recipient with type II diabetes;~~

509.29 ~~(4)~~ (3) drugs or active pharmaceutical ingredients when used for the treatment of
 509.30 impotence or erectile dysfunction;

509.31 ~~(5)~~ (4) drugs or active pharmaceutical ingredients for which medical value has not been
 509.32 established;

510.1 ~~(6)~~ (5) drugs from manufacturers who have not signed a rebate agreement with the
 510.2 Department of Health and Human Services pursuant to section 1927 of title XIX of the
 510.3 Social Security Act; and

510.4 ~~(7)~~ (6) medical cannabis as defined in section 152.22, subdivision 6.

510.5 (c) If a single-source drug used by at least two percent of the fee-for-service medical
 510.6 assistance recipients is removed from the formulary due to the failure of the manufacturer
 510.7 to sign a rebate agreement with the Department of Health and Human Services, the
 510.8 commissioner shall notify prescribing practitioners within 30 days of receiving notification
 510.9 from the Centers for Medicare and Medicaid Services (CMS) that a rebate agreement was
 510.10 not signed.

510.11 Sec. 21. Minnesota Statutes 2018, section 256B.0625, subdivision 13e, is amended to
 510.12 read:

510.13 Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall
 510.14 be the lower of the ~~actual acquisition~~ ingredient costs of the drugs ~~or the maximum allowable~~
 510.15 ~~cost by the commissioner~~ plus the fixed professional dispensing fee; or the usual and
 510.16 customary price charged to the public. The usual and customary price means the lowest
 510.17 price charged by the provider to a patient who pays for the prescription by cash, check, or
 510.18 charge account and includes prices the pharmacy charges to a patient enrolled in a
 510.19 prescription savings club or prescription discount club administered by the pharmacy or
 510.20 pharmacy chain. The amount of payment basis must be reduced to reflect all discount
 510.21 amounts applied to the charge by any third-party provider/insurer agreement or contract for
 510.22 submitted charges to medical assistance programs. The net submitted charge may not be
 510.23 greater than the patient liability for the service. The ~~pharmacy~~ professional dispensing fee
 510.24 shall be ~~\$3.65~~ \$10.48 for ~~legend prescription drugs, except that~~ prescriptions filled with
 510.25 legend drugs meeting the definition of "covered outpatient drugs" according to United States
 510.26 Code, title 42, section 1396r-8(k)(2). The dispensing fee for intravenous solutions ~~which~~
 510.27 that must be compounded by the pharmacist shall be ~~\$8~~ \$10.48 per bag; ~~\$14 per bag for~~
 510.28 ~~cancer chemotherapy products, and \$30 per bag for total parenteral nutritional products~~
 510.29 ~~dispensed in one-liter quantities, or \$44 per bag for total parenteral nutritional products~~
 510.30 ~~dispensed in quantities greater than one liter.~~ The professional dispensing fee for
 510.31 prescriptions filled with over-the-counter drugs meeting the definition of covered outpatient
 510.32 drugs shall be \$10.48 for dispensed quantities equal to or greater than the number of units
 510.33 contained in the manufacturer's original package. The professional dispensing fee shall be
 510.34 prorated based on the percentage of the package dispensed when the pharmacy dispenses

511.1 a quantity less than the number of units contained in the manufacturer's original package.
511.2 The pharmacy dispensing fee for prescribed over-the-counter drugs not meeting the definition
511.3 of covered outpatient drugs shall be \$3.65, ~~except that the fee shall be \$1.31 for~~
511.4 ~~retrospectively billing pharmacies when billing for quantities less than the number of units~~
511.5 ~~contained in the manufacturer's original package. Actual acquisition cost includes quantity~~
511.6 ~~and other special discounts except time and cash discounts. The actual acquisition cost of~~
511.7 ~~a drug shall be estimated by the commissioner at wholesale acquisition cost plus four percent~~
511.8 ~~for independently owned pharmacies located in a designated rural area within Minnesota,~~
511.9 ~~and at wholesale acquisition cost plus two percent for all other pharmacies. A pharmacy is~~
511.10 ~~"independently owned" if it is one of four or fewer pharmacies under the same ownership~~
511.11 ~~nationally. A "designated rural area" means an area defined as a small rural area or isolated~~
511.12 ~~rural area according to the four-category classification of the Rural Urban Commuting Area~~
511.13 ~~system developed for the United States Health Resources and Services Administration.~~
511.14 Effective January 1, 2014, the actual acquisition for quantities equal to or greater than the
511.15 number of units contained in the manufacturer's original package and shall be prorated based
511.16 on the percentage of the package dispensed when the pharmacy dispenses a quantity less
511.17 than the number of units contained in the manufacturer's original package. The National
511.18 Average Drug Acquisition Cost (NADAC) shall be used to determine the ingredient cost
511.19 of a drug. For drugs for which a NADAC is not reported, the commissioner shall estimate
511.20 the ingredient cost at the wholesale acquisition cost minus two percent. The ingredient cost
511.21 of a drug acquired through for a provider participating in the federal 340B Drug Pricing
511.22 Program shall be estimated by the commissioner at wholesale acquisition cost minus 40
511.23 percent either the 340B Drug Pricing Program ceiling price established by the Health
511.24 Resources and Services Administration or NADAC, whichever is lower. Wholesale
511.25 acquisition cost is defined as the manufacturer's list price for a drug or biological to
511.26 wholesalers or direct purchasers in the United States, not including prompt pay or other
511.27 discounts, rebates, or reductions in price, for the most recent month for which information
511.28 is available, as reported in wholesale price guides or other publications of drug or biological
511.29 pricing data. The maximum allowable cost of a multisource drug may be set by the
511.30 commissioner and it shall be comparable to, but the actual acquisition cost of the drug
511.31 product and no higher than, the maximum amount paid by other third-party payors in this
511.32 state who have maximum allowable cost programs the NADAC of the generic product.
511.33 Establishment of the amount of payment for drugs shall not be subject to the requirements
511.34 of the Administrative Procedure Act.

511.35 (b) Pharmacies dispensing prescriptions to residents of long-term care facilities using
511.36 an automated drug distribution system meeting the requirements of section 151.58, or a

512.1 packaging system meeting the packaging standards set forth in Minnesota Rules, part
512.2 6800.2700, that govern the return of unused drugs to the pharmacy for reuse, may employ
512.3 retrospective billing for prescription drugs dispensed to long-term care facility residents. A
512.4 retrospectively billing pharmacy must submit a claim only for the quantity of medication
512.5 used by the enrolled recipient during the defined billing period. A retrospectively billing
512.6 pharmacy must use a billing period not less than one calendar month or 30 days.

512.7 (c) ~~An additional dispensing fee of \$.30 may be added to the dispensing fee paid to~~
512.8 ~~pharmacists for legend drug prescriptions dispensed to residents of long-term care facilities~~
512.9 ~~when a unit dose blister card system, approved by the department, is used. Under this type~~
512.10 ~~of dispensing system, the pharmacist must dispense a 30-day supply of drug. The National~~
512.11 ~~Drug Code (NDC) from the drug container used to fill the blister card must be identified~~
512.12 ~~on the claim to the department. The unit dose blister card containing the drug must meet~~
512.13 ~~the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return~~
512.14 ~~of unused drugs to the pharmacy for reuse.~~ A pharmacy provider using packaging that meets
512.15 the standards set forth in Minnesota Rules, part 6800.2700, is required to credit the
512.16 department for the actual acquisition cost of all unused drugs that are eligible for reuse,
512.17 unless the pharmacy is using retrospective billing. The commissioner may permit the drug
512.18 clozapine to be dispensed in a quantity that is less than a 30-day supply.

512.19 (d) ~~Whenever a maximum allowable cost has been set for~~ If a pharmacy dispenses a
512.20 multisource drug, payment shall be the lower of the usual and customary price charged to
512.21 the public or the ingredient cost shall be the NADAC of the generic product or the maximum
512.22 allowable cost established by the commissioner unless prior authorization for the brand
512.23 name product has been granted according to the criteria established by the Drug Formulary
512.24 Committee as required by subdivision 13f, paragraph (a), and the prescriber has indicated
512.25 "dispense as written" on the prescription in a manner consistent with section 151.21,
512.26 subdivision 2.

512.27 (e) The basis for determining the amount of payment for drugs administered in an
512.28 outpatient setting shall be the lower of the usual and customary cost submitted by the
512.29 provider, 106 percent of the average sales price as determined by the United States
512.30 Department of Health and Human Services pursuant to title XVIII, section 1847a of the
512.31 federal Social Security Act, the specialty pharmacy rate, or the maximum allowable cost
512.32 set by the commissioner. If average sales price is unavailable, the amount of payment must
512.33 be lower of the usual and customary cost submitted by the provider, the wholesale acquisition
512.34 cost, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner.
512.35 ~~Effective January 1, 2014,~~ The commissioner shall discount the payment rate for drugs

513.1 obtained through the federal 340B Drug Pricing Program by ~~20~~ 28.6 percent. The payment
513.2 for drugs administered in an outpatient setting shall be made to the administering facility
513.3 or practitioner. A retail or specialty pharmacy dispensing a drug for administration in an
513.4 outpatient setting is not eligible for direct reimbursement.

513.5 (f) The commissioner may ~~negotiate lower reimbursement~~ establish maximum allowable
513.6 cost rates for specialty pharmacy products than the rates that are lower than the ingredient
513.7 cost formulas specified in paragraph (a). The commissioner may require individuals enrolled
513.8 in the health care programs administered by the department to obtain specialty pharmacy
513.9 products from providers with whom the commissioner has negotiated lower reimbursement
513.10 rates. Specialty pharmacy products are defined as those used by a small number of recipients
513.11 or recipients with complex and chronic diseases that require expensive and challenging drug
513.12 regimens. Examples of these conditions include, but are not limited to: multiple sclerosis,
513.13 HIV/AIDS, transplantation, hepatitis C, growth hormone deficiency, Crohn's Disease,
513.14 rheumatoid arthritis, and certain forms of cancer. Specialty pharmaceutical products include
513.15 injectable and infusion therapies, biotechnology drugs, antihemophilic factor products,
513.16 high-cost therapies, and therapies that require complex care. The commissioner shall consult
513.17 with the Formulary Committee to develop a list of specialty pharmacy products subject to
513.18 ~~this paragraph~~ maximum allowable cost reimbursement. In consulting with the Formulary
513.19 Committee in developing this list, the commissioner shall take into consideration the
513.20 population served by specialty pharmacy products, the current delivery system and standard
513.21 of care in the state, and access to care issues. The commissioner shall have the discretion
513.22 to adjust the ~~reimbursement rate~~ maximum allowable cost to prevent access to care issues.

513.23 (g) Home infusion therapy services provided by home infusion therapy pharmacies must
513.24 be paid at rates according to subdivision 8d.

513.25 (h) The commissioner shall contract with a vendor to conduct a cost of dispensing survey
513.26 for all pharmacies that are physically located in the state of Minnesota that dispense outpatient
513.27 drugs under medical assistance. The commissioner shall ensure that the vendor has prior
513.28 experience in conducting cost of dispensing surveys. Each pharmacy enrolled with the
513.29 department to dispense outpatient prescription drugs to fee-for-service members must
513.30 respond to the cost of dispensing survey. The commissioner may sanction a pharmacy under
513.31 section 256B.064 for failure to respond. The commissioner shall require the vendor to
513.32 measure a single statewide cost of dispensing for all responding pharmacies to measure the
513.33 mean, mean weighted by total prescription volume, mean weighted by medical assistance
513.34 prescription volume, median, median weighted by total prescription volume, and median
513.35 weighted by total medical assistance prescription volume. The commissioner shall post a

514.1 copy of the final cost of dispensing survey report on the department's website. The initial
 514.2 survey must be completed no later than January 1, 2021, and repeated every three years.
 514.3 The commissioner shall provide a summary of the results of each cost of dispensing survey
 514.4 and provide recommendations for any changes to the dispensing fee to the chairs and ranking
 514.5 members of the legislative committees with jurisdiction over medical assistance pharmacy
 514.6 reimbursement.

514.7 (i) The commissioner shall increase the ingredient cost reimbursement calculated in
 514.8 paragraphs (a) and (f) by two percent for prescription and nonprescription drugs subject to
 514.9 the wholesale drug distributor tax under section 295.52.

514.10 **EFFECTIVE DATE.** This section is effective April 1, 2019, or upon federal approval,
 514.11 whichever is later. Paragraph (i) expires if federal approval is denied. The commissioner
 514.12 of human services shall inform the revisor of statutes when federal approval is obtained or
 514.13 denied.

514.14 Sec. 22. Minnesota Statutes 2018, section 256B.0625, subdivision 13f, is amended to read:

514.15 Subd. 13f. **Prior authorization.** (a) The Formulary Committee shall review and
 514.16 recommend drugs which require prior authorization. The Formulary Committee shall
 514.17 establish general criteria to be used for the prior authorization of brand-name drugs for
 514.18 which generically equivalent drugs are available, but the committee is not required to review
 514.19 each brand-name drug for which a generically equivalent drug is available.

514.20 (b) Prior authorization may be required by the commissioner before certain formulary
 514.21 drugs are eligible for payment. The Formulary Committee may recommend drugs for prior
 514.22 authorization directly to the commissioner. The commissioner may also request that the
 514.23 Formulary Committee review a drug for prior authorization. Before the commissioner may
 514.24 require prior authorization for a drug:

514.25 (1) the commissioner must provide information to the Formulary Committee on the
 514.26 impact that placing the drug on prior authorization may have on the quality of patient care
 514.27 and on program costs, information regarding whether the drug is subject to clinical abuse
 514.28 or misuse, and relevant data from the state Medicaid program if such data is available;

514.29 (2) the Formulary Committee must review the drug, taking into account medical and
 514.30 clinical data and the information provided by the commissioner; and

514.31 (3) the Formulary Committee must hold a public forum and receive public comment for
 514.32 an additional 15 days.

515.1 The commissioner must provide a 15-day notice period before implementing the prior
515.2 authorization.

515.3 (c) Except as provided in subdivision 13j, prior authorization shall not be required or
515.4 utilized for any atypical antipsychotic drug prescribed for the treatment of mental illness
515.5 if:

515.6 (1) there is no generically equivalent drug available; and

515.7 (2) the drug was initially prescribed for the recipient prior to July 1, 2003; or

515.8 (3) the drug is part of the recipient's current course of treatment.

515.9 This paragraph applies to any multistate preferred drug list or supplemental drug rebate
515.10 program established or administered by the commissioner. Prior authorization shall
515.11 automatically be granted for 60 days for brand name drugs prescribed for treatment of mental
515.12 illness within 60 days of when a generically equivalent drug becomes available, provided
515.13 that the brand name drug was part of the recipient's course of treatment at the time the
515.14 generically equivalent drug became available.

515.15 ~~(d) Prior authorization shall not be required or utilized for any antihemophilic factor~~
515.16 ~~drug prescribed for the treatment of hemophilia and blood disorders where there is no~~
515.17 ~~generically equivalent drug available if the prior authorization is used in conjunction with~~
515.18 ~~any supplemental drug rebate program or multistate preferred drug list established or~~
515.19 ~~administered by the commissioner.~~

515.20 ~~(e)~~ (d) The commissioner may require prior authorization for brand name drugs whenever
515.21 a generically equivalent product is available, even if the prescriber specifically indicates
515.22 "dispense as written-brand necessary" on the prescription as required by section 151.21,
515.23 subdivision 2.

515.24 ~~(f)~~ (e) Notwithstanding this subdivision, the commissioner may automatically require
515.25 prior authorization, for a period not to exceed 180 days, for any drug that is approved by
515.26 the United States Food and Drug Administration on or after July 1, 2005. The 180-day
515.27 period begins no later than the first day that a drug is available for shipment to pharmacies
515.28 within the state. The Formulary Committee shall recommend to the commissioner general
515.29 criteria to be used for the prior authorization of the drugs, but the committee is not required
515.30 to review each individual drug. In order to continue prior authorizations for a drug after the
515.31 180-day period has expired, the commissioner must follow the provisions of this subdivision.

515.32 (f) Prior authorization under this subdivision shall comply with section 62Q.184.

515.33 **EFFECTIVE DATE.** This section is effective the day following final enactment.

516.1 Sec. 23. Minnesota Statutes 2018, section 256B.0625, subdivision 17, is amended to read:

516.2 Subd. 17. **Transportation costs.** (a) "Nonemergency medical transportation service"
516.3 means motor vehicle transportation provided by a public or private person that serves
516.4 Minnesota health care program beneficiaries who do not require emergency ambulance
516.5 service, as defined in section 144E.001, subdivision 3, to obtain covered medical services.

516.6 (b) Medical assistance covers medical transportation costs incurred solely for obtaining
516.7 emergency medical care or transportation costs incurred by eligible persons in obtaining
516.8 emergency or nonemergency medical care when paid directly to an ambulance company,
516.9 nonemergency medical transportation company, or other recognized providers of
516.10 transportation services. Medical transportation must be provided by:

516.11 (1) nonemergency medical transportation providers who meet the requirements of this
516.12 subdivision;

516.13 (2) ambulances, as defined in section 144E.001, subdivision 2;

516.14 (3) taxicabs that meet the requirements of this subdivision;

516.15 (4) public transit, as defined in section 174.22, subdivision 7; or

516.16 (5) not-for-hire vehicles, including volunteer drivers.

516.17 (c) Medical assistance covers nonemergency medical transportation provided by
516.18 nonemergency medical transportation providers enrolled in the Minnesota health care
516.19 programs. All nonemergency medical transportation providers must comply with the
516.20 operating standards for special transportation service as defined in sections 174.29 to 174.30
516.21 and Minnesota Rules, chapter 8840, and ~~in consultation with the Minnesota Department of~~
516.22 ~~Transportation~~ all drivers must be individually enrolled with the commissioner and reported
516.23 on the claim as the individual who provided the service. All nonemergency medical
516.24 transportation providers shall bill for nonemergency medical transportation services in
516.25 accordance with Minnesota health care programs criteria. Publicly operated transit systems,
516.26 volunteers, and not-for-hire vehicles are exempt from the requirements outlined in this
516.27 paragraph.

516.28 (d) An organization may be terminated, denied, or suspended from enrollment if:

516.29 (1) the provider has not initiated background studies on the individuals specified in
516.30 section 174.30, subdivision 10, paragraph (a), clauses (1) to (3); or

516.31 (2) the provider has initiated background studies on the individuals specified in section
516.32 174.30, subdivision 10, paragraph (a), clauses (1) to (3), and:

517.1 (i) the commissioner has sent the provider a notice that the individual has been
517.2 disqualified under section 245C.14; and

517.3 (ii) the individual has not received a disqualification set-aside specific to the special
517.4 transportation services provider under sections 245C.22 and 245C.23.

517.5 (e) The administrative agency of nonemergency medical transportation must:

517.6 (1) adhere to the policies defined by the commissioner in consultation with the
517.7 Nonemergency Medical Transportation Advisory Committee;

517.8 (2) pay nonemergency medical transportation providers for services provided to
517.9 Minnesota health care programs beneficiaries to obtain covered medical services;

517.10 (3) provide data monthly to the commissioner on appeals, complaints, no-shows, canceled
517.11 trips, and number of trips by mode; and

517.12 (4) by July 1, 2016, in accordance with subdivision 18e, utilize a web-based single
517.13 administrative structure assessment tool that meets the technical requirements established
517.14 by the commissioner, reconciles trip information with claims being submitted by providers,
517.15 and ensures prompt payment for nonemergency medical transportation services.

517.16 (f) Until the commissioner implements the single administrative structure and delivery
517.17 system under subdivision 18e, clients shall obtain their level-of-service certificate from the
517.18 commissioner or an entity approved by the commissioner that does not dispatch rides for
517.19 clients using modes of transportation under paragraph (i), clauses (4), (5), (6), and (7).

517.20 (g) The commissioner may use an order by the recipient's attending physician or a medical
517.21 or mental health professional to certify that the recipient requires nonemergency medical
517.22 transportation services. Nonemergency medical transportation providers shall perform
517.23 driver-assisted services for eligible individuals, when appropriate. Driver-assisted service
517.24 includes passenger pickup at and return to the individual's residence or place of business,
517.25 assistance with admittance of the individual to the medical facility, and assistance in
517.26 passenger securement or in securing of wheelchairs, child seats, or stretchers in the vehicle.

517.27 Nonemergency medical transportation providers must take clients to the health care
517.28 provider using the most direct route, and must not exceed 30 miles for a trip to a primary
517.29 care provider or 60 miles for a trip to a specialty care provider, unless the client receives
517.30 authorization from the local agency.

517.31 Nonemergency medical transportation providers may not bill for separate base rates for
517.32 the continuation of a trip beyond the original destination. Nonemergency medical
517.33 transportation providers must maintain trip logs, which include pickup and drop-off times,

518.1 signed by the medical provider or client, whichever is deemed most appropriate, attesting
518.2 to mileage traveled to obtain covered medical services. Clients requesting client mileage
518.3 reimbursement must sign the trip log attesting mileage traveled to obtain covered medical
518.4 services.

518.5 (h) The administrative agency shall use the level of service process established by the
518.6 commissioner in consultation with the Nonemergency Medical Transportation Advisory
518.7 Committee to determine the client's most appropriate mode of transportation. If public transit
518.8 or a certified transportation provider is not available to provide the appropriate service mode
518.9 for the client, the client may receive a onetime service upgrade.

518.10 (i) The covered modes of transportation are:

518.11 (1) client reimbursement, which includes client mileage reimbursement provided to
518.12 clients who have their own transportation, or to family or an acquaintance who provides
518.13 transportation to the client;

518.14 (2) volunteer transport, which includes transportation by volunteers using their own
518.15 vehicle;

518.16 (3) unassisted transport, which includes transportation provided to a client by a taxicab
518.17 or public transit. If a taxicab or public transit is not available, the client can receive
518.18 transportation from another nonemergency medical transportation provider;

518.19 (4) assisted transport, which includes transport provided to clients who require assistance
518.20 by a nonemergency medical transportation provider;

518.21 (5) lift-equipped/ramp transport, which includes transport provided to a client who is
518.22 dependent on a device and requires a nonemergency medical transportation provider with
518.23 a vehicle containing a lift or ramp;

518.24 (6) protected transport, which includes transport provided to a client who has received
518.25 a prescreening that has deemed other forms of transportation inappropriate and who requires
518.26 a provider: (i) with a protected vehicle that is not an ambulance or police car and has safety
518.27 locks, a video recorder, and a transparent thermoplastic partition between the passenger and
518.28 the vehicle driver; and (ii) who is certified as a protected transport provider; and

518.29 (7) stretcher transport, which includes transport for a client in a prone or supine position
518.30 and requires a nonemergency medical transportation provider with a vehicle that can transport
518.31 a client in a prone or supine position.

518.32 (j) The local agency shall be the single administrative agency and shall administer and
518.33 reimburse for modes defined in paragraph (i) according to paragraphs (m) and (n) when the

519.1 commissioner has developed, made available, and funded the web-based single administrative
519.2 structure, assessment tool, and level of need assessment under subdivision 18e. The local
519.3 agency's financial obligation is limited to funds provided by the state or federal government.

519.4 (k) The commissioner shall:

519.5 (1) in consultation with the Nonemergency Medical Transportation Advisory Committee,
519.6 verify that the mode and use of nonemergency medical transportation is appropriate;

519.7 (2) verify that the client is going to an approved medical appointment; and

519.8 (3) investigate all complaints and appeals.

519.9 (l) The administrative agency shall pay for the services provided in this subdivision and
519.10 seek reimbursement from the commissioner, if appropriate. As vendors of medical care,
519.11 local agencies are subject to the provisions in section 256B.041, the sanctions and monetary
519.12 recovery actions in section 256B.064, and Minnesota Rules, parts 9505.2160 to 9505.2245.

519.13 (m) Payments for nonemergency medical transportation must be paid based on the client's
519.14 assessed mode under paragraph (h), not the type of vehicle used to provide the service. The
519.15 medical assistance reimbursement rates for nonemergency medical transportation services
519.16 that are payable by or on behalf of the commissioner for nonemergency medical
519.17 transportation services are:

519.18 (1) \$0.22 per mile for client reimbursement;

519.19 (2) up to 100 percent of the Internal Revenue Service business deduction rate for volunteer
519.20 transport;

519.21 (3) equivalent to the standard fare for unassisted transport when provided by public
519.22 transit, and \$11 for the base rate and \$1.30 per mile when provided by a nonemergency
519.23 medical transportation provider;

519.24 (4) \$13 for the base rate and \$1.30 per mile for assisted transport;

519.25 (5) \$18 for the base rate and \$1.55 per mile for lift-equipped/ramp transport;

519.26 (6) \$75 for the base rate and \$2.40 per mile for protected transport; and

519.27 (7) \$60 for the base rate and \$2.40 per mile for stretcher transport, and \$9 per trip for
519.28 an additional attendant if deemed medically necessary.

519.29 (n) The base rate for nonemergency medical transportation services in areas defined
519.30 under RUCA to be super rural is equal to 111.3 percent of the respective base rate in

520.1 paragraph (m), clauses (1) to (7). The mileage rate for nonemergency medical transportation
520.2 services in areas defined under RUCA to be rural or super rural areas is:

520.3 (1) for a trip equal to 17 miles or less, equal to 125 percent of the respective mileage
520.4 rate in paragraph (m), clauses (1) to (7); and

520.5 (2) for a trip between 18 and 50 miles, equal to 112.5 percent of the respective mileage
520.6 rate in paragraph (m), clauses (1) to (7).

520.7 (o) For purposes of reimbursement rates for nonemergency medical transportation
520.8 services under paragraphs (m) and (n), the zip code of the recipient's place of residence
520.9 shall determine whether the urban, rural, or super rural reimbursement rate applies.

520.10 (p) For purposes of this subdivision, "rural urban commuting area" or "RUCA" means
520.11 a census-tract based classification system under which a geographical area is determined
520.12 to be urban, rural, or super rural.

520.13 (q) The commissioner, when determining reimbursement rates for nonemergency medical
520.14 transportation under paragraphs (m) and (n), shall exempt all modes of transportation listed
520.15 under paragraph (i) from Minnesota Rules, part 9505.0445, item R, subitem (2).

520.16 **EFFECTIVE DATE.** This section is effective July 1, 2019.

520.17 Sec. 24. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision
520.18 to read:

520.19 **Subd. 17d. Transportation services oversight.** The commissioner shall contract with
520.20 a vendor or dedicate staff to oversee providers of nonemergency medical transportation
520.21 services pursuant to the commissioner's authority in section 256B.04 and Minnesota Rules,
520.22 parts 9505.2160 to 9505.2245.

520.23 **EFFECTIVE DATE.** This section is effective July 1, 2019.

520.24 Sec. 25. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision
520.25 to read:

520.26 **Subd. 17e. Transportation provider termination.** (a) A terminated nonemergency
520.27 medical transportation provider, including all named individuals on the current enrollment
520.28 disclosure form and known or discovered affiliates of the nonemergency medical
520.29 transportation provider, is not eligible to enroll as a nonemergency medical transportation
520.30 provider for five years following the termination.

521.1 (b) After the five-year period in paragraph (a), if a provider seeks to reenroll as a
 521.2 nonemergency medical transportation provider, the provider must be placed on a one-year
 521.3 probation period. During a provider's probation period the commissioner shall complete
 521.4 unannounced site visits and request documentation to review compliance with program
 521.5 requirements.

521.6 **EFFECTIVE DATE.** This section is effective the day following final enactment.

521.7 Sec. 26. Minnesota Statutes 2018, section 256B.0625, subdivision 30, is amended to read:

521.8 Subd. 30. **Other clinic services.** (a) Medical assistance covers rural health clinic services,
 521.9 federally qualified health center services, nonprofit community health clinic services, and
 521.10 public health clinic services. Rural health clinic services and federally qualified health center
 521.11 services mean services defined in United States Code, title 42, section 1396d(a)(2)(B) and
 521.12 (C). Payment for rural health clinic and federally qualified health center services shall be
 521.13 made according to applicable federal law and regulation.

521.14 (b) A federally qualified health center (FQHC) that is beginning initial operation shall
 521.15 submit an estimate of budgeted costs and visits for the initial reporting period in the form
 521.16 and detail required by the commissioner. ~~A federally qualified health center~~ An FQHC that
 521.17 is already in operation shall submit an initial report using actual costs and visits for the
 521.18 initial reporting period. Within 90 days of the end of its reporting period, ~~a federally qualified~~
 521.19 ~~health center~~ an FQHC shall submit, in the form and detail required by the commissioner,
 521.20 a report of its operations, including allowable costs actually incurred for the period and the
 521.21 actual number of visits for services furnished during the period, and other information
 521.22 required by the commissioner. ~~Federally qualified health centers~~ FQHCs that file Medicare
 521.23 cost reports shall provide the commissioner with a copy of the most recent Medicare cost
 521.24 report filed with the Medicare program intermediary for the reporting year which support
 521.25 the costs claimed on their cost report to the state.

521.26 (c) In order to continue cost-based payment under the medical assistance program
 521.27 according to paragraphs (a) and (b), ~~a federally qualified health center~~ an FQHC or rural
 521.28 health clinic must apply for designation as an essential community provider within six
 521.29 months of final adoption of rules by the Department of Health according to section 62Q.19,
 521.30 subdivision 7. For those ~~federally qualified health centers~~ FQHCs and rural health clinics
 521.31 that have applied for essential community provider status within the six-month time
 521.32 prescribed, medical assistance payments will continue to be made according to paragraphs
 521.33 (a) and (b) for the first three years after application. For ~~federally qualified health centers~~
 521.34 FQHCs and rural health clinics that either do not apply within the time specified above or

522.1 who have had essential community provider status for three years, medical assistance
522.2 payments for health services provided by these entities shall be according to the same rates
522.3 and conditions applicable to the same service provided by health care providers that are not
522.4 ~~federally qualified health centers~~ FQHCs or rural health clinics.

522.5 (d) Effective July 1, 1999, the provisions of paragraph (c) requiring a ~~federally qualified~~
522.6 ~~health center~~ an FQHC or a rural health clinic to make application for an essential community
522.7 provider designation in order to have cost-based payments made according to paragraphs
522.8 (a) and (b) no longer apply.

522.9 (e) Effective January 1, 2000, payments made according to paragraphs (a) and (b) shall
522.10 be limited to the cost phase-out schedule of the Balanced Budget Act of 1997.

522.11 (f) Effective January 1, 2001, through December 31, 2020, each ~~federally qualified~~
522.12 ~~health center~~ FQHC and rural health clinic may elect to be paid either under the prospective
522.13 payment system established in United States Code, title 42, section 1396a(aa), or under an
522.14 alternative payment methodology consistent with the requirements of United States Code,
522.15 title 42, section 1396a(aa), and approved by the Centers for Medicare and Medicaid Services.
522.16 The alternative payment methodology shall be 100 percent of cost as determined according
522.17 to Medicare cost principles.

522.18 (g) Effective for services provided on or after January 1, 2021, all claims for payment
522.19 of clinic services provided by FQHCs and rural health clinics shall be paid by the
522.20 commissioner, according to an annual election by the FQHC or rural health clinic, under
522.21 the current prospective payment system described in paragraph (f) or the alternative payment
522.22 methodology described in paragraph (l).

522.23 (h) For purposes of this section, "nonprofit community clinic" is a clinic that:

522.24 (1) has nonprofit status as specified in chapter 317A;

522.25 (2) has tax exempt status as provided in Internal Revenue Code, section 501(c)(3);

522.26 (3) is established to provide health services to low-income population groups, uninsured,
522.27 high-risk and special needs populations, underserved and other special needs populations;

522.28 (4) employs professional staff at least one-half of which are familiar with the cultural
522.29 background of their clients;

522.30 (5) charges for services on a sliding fee scale designed to provide assistance to
522.31 low-income clients based on current poverty income guidelines and family size; and

523.1 (6) does not restrict access or services because of a client's financial limitations or public
523.2 assistance status and provides no-cost care as needed.

523.3 ~~(h)~~ (i) Effective for services provided on or after January 1, 2015, all claims for payment
523.4 of clinic services provided by ~~federally qualified health centers~~ FQHCs and rural health
523.5 clinics shall be paid by the commissioner. the commissioner shall determine the most feasible
523.6 method for paying claims from the following options:

523.7 (1) ~~federally qualified health centers~~ FQHCs and rural health clinics submit claims
523.8 directly to the commissioner for payment, and the commissioner provides claims information
523.9 for recipients enrolled in a managed care or county-based purchasing plan to the plan, on
523.10 a regular basis; or

523.11 (2) ~~federally qualified health centers~~ FQHCs and rural health clinics submit claims for
523.12 recipients enrolled in a managed care or county-based purchasing plan to the plan, and those
523.13 claims are submitted by the plan to the commissioner for payment to the clinic.

523.14 ~~(i)~~ (j) For clinic services provided prior to January 1, 2015, the commissioner shall
523.15 calculate and pay monthly the proposed managed care supplemental payments to clinics,
523.16 and clinics shall conduct a timely review of the payment calculation data in order to finalize
523.17 all supplemental payments in accordance with federal law. Any issues arising from a clinic's
523.18 review must be reported to the commissioner by January 1, 2017. Upon final agreement
523.19 between the commissioner and a clinic on issues identified under this subdivision, and in
523.20 accordance with United States Code, title 42, section 1396a(bb), no supplemental payments
523.21 for managed care plan or county-based purchasing plan claims for services provided prior
523.22 to January 1, 2015, shall be made after June 30, 2017. If the commissioner and clinics are
523.23 unable to resolve issues under this subdivision, the parties shall submit the dispute to the
523.24 arbitration process under section 14.57.

523.25 ~~(j)~~ (k) The commissioner shall seek a federal waiver, authorized under section 1115 of
523.26 the Social Security Act, to obtain federal financial participation at the 100 percent federal
523.27 matching percentage available to facilities of the Indian Health Service or tribal organization
523.28 in accordance with section 1905(b) of the Social Security Act for expenditures made to
523.29 organizations dually certified under Title V of the Indian Health Care Improvement Act,
523.30 Public Law 94-437, and as a federally qualified health center under paragraph (a) that
523.31 provides services to American Indian and Alaskan Native individuals eligible for services
523.32 under this subdivision.

524.1 (1) All claims for payment of clinic services provided by FQHCs and rural health clinics,
524.2 that have elected to be paid under this paragraph, shall be paid by the commissioner according
524.3 to the following requirements:

524.4 (1) the commissioner shall establish a single medical and single dental organization rate
524.5 for each FQHC and rural health clinic when applicable;

524.6 (2) each FQHC and rural health clinic is eligible for same day reimbursement of one
524.7 medical and one dental organization rate if eligible medical and dental visits are provided
524.8 on the same day;

524.9 (3) the commissioner shall reimburse FQHCs and rural health clinics, in accordance
524.10 with current applicable Medicare cost principles, their allowable costs, including direct
524.11 patient care costs and patient-related support services. Nonallowable costs include, but are
524.12 not limited to:

524.13 (i) general social service and administrative costs;

524.14 (ii) retail pharmacy;

524.15 (iii) patient incentives, food, housing assistance, and utility assistance;

524.16 (iv) external lab and x-ray;

524.17 (v) navigation services;

524.18 (vi) health care taxes;

524.19 (vii) advertising, public relations, and marketing;

524.20 (viii) office entertainment costs, food, alcohol, and gifts;

524.21 (ix) contributions and donations;

524.22 (x) bad debts or losses on awards or contracts;

524.23 (xi) fines, penalties, damages, or other settlements;

524.24 (xii) fund-raising, investment management, and associated administrative costs;

524.25 (xiii) research and associated administrative costs;

524.26 (xiv) nonpaid workers;

524.27 (xv) lobbying;

524.28 (xvi) scholarships and student aid; and

524.29 (xvii) nonmedical assistance covered services;

525.1 (4) the commissioner shall review the list of nonallowable costs in the years between
525.2 the rebasing process established in clause (5), in consultation with the Minnesota Association
525.3 of Community Health Centers, FQHCs, and rural health clinics. The commissioner shall
525.4 publish the list and any updates in the Minnesota health care programs provider manual;

525.5 (5) the initial applicable base year organization rates for FQHCs and rural health clinics
525.6 shall be computed for services delivered on or after January 1, 2021, and:

525.7 (i) must be determined using each FQHC's and rural health clinic's Medicare cost reports
525.8 from both 2017 and 2018;

525.9 (ii) must be according to current applicable Medicare cost principles as applicable to
525.10 FQHCs and rural health clinics without the application of productivity screens and upper
525.11 payment limits or the Medicare prospective payment system FQHC aggregate mean upper
525.12 payment limit;

525.13 (iii) must be subsequently rebased every two years thereafter using the Medicare cost
525.14 reports that are three and four years prior to the rebasing year;

525.15 (iv) must be inflated to the base year using the inflation factor described in clause (6);
525.16 and

525.17 (v) the commissioner must provide for a 60-day appeals process under section 14.57;

525.18 (6) the commissioner shall annually inflate the applicable organization rates for FQHCs
525.19 and rural health clinics from the base year payment rate to the effective date by using the
525.20 CMS FQHC Market Basket inflator established under United States Code, title 42, section
525.21 1395m(o), less productivity;

525.22 (7) FQHCs and rural health clinics that have elected the alternative payment methodology
525.23 under this paragraph shall submit all necessary documentation required by the commissioner
525.24 to compute the rebased organization rates no later than six months following the date the
525.25 applicable Medicare cost reports are due to the Centers for Medicare and Medicaid Services;

525.26 (8) the commissioner shall reimburse FQHCs and rural health clinics an additional
525.27 amount relative to their medical and dental organization rates that is attributable to the tax
525.28 required to be paid according to section 295.52, if applicable;

525.29 (9) FQHCs and rural health clinics may submit change of scope requests to the
525.30 commissioner if the change of scope would result in an increase or decrease of 2.5 percent
525.31 or higher in the medical or dental organization rate currently received by the FQHC or rural
525.32 health clinic;

526.1 (10) For FQHCs and rural health clinics seeking a change in scope with the commissioner
526.2 under clause (9) that requires the approval of the scope change by the federal Health
526.3 Resources Services Administration:

526.4 (i) FQHCs and rural health clinics shall submit the change of scope request, including
526.5 the start date of services, to the commissioner within seven business days of submission of
526.6 the scope change to the federal Health Resources Services Administration;

526.7 (ii) the commissioner shall establish the effective date of the payment change as the
526.8 federal Health Resources Services Administration date of approval of the FQHC's or rural
526.9 health clinic's scope change request, or the effective start date of services, whichever is
526.10 later; and

526.11 (iii) within 45 days of one year after the effective date established in item (ii), the
526.12 commissioner shall conduct a retroactive review to determine if the actual costs established
526.13 under clause (3) or encounters result in an increase or decrease of 2.5 percent or higher in
526.14 the medical or dental organization rate, and if this is the case, the commissioner shall revise
526.15 the rate accordingly and shall adjust payments retrospectively to the effective date established
526.16 in item (ii);

526.17 (11) for change of scope requests that do not require federal Health Resources Services
526.18 Administration approval, the FQHC and rural health clinic shall submit the request to the
526.19 commissioner before implementing the change, and the effective date of the change is the
526.20 date the commissioner received the FQHC's or rural health clinic's request, or the effective
526.21 start date of the service, whichever is later. The commissioner shall provide a response to
526.22 the FQHC's or rural health clinic's request within 45 days of submission and provide a final
526.23 approval within 120 days of submission. This timeline may be waived at the mutual
526.24 agreement of the commissioner and the FQHC or rural health clinic if more information is
526.25 needed to evaluate the request;

526.26 (12) the commissioner, when establishing organization rates for new FQHCs and rural
526.27 health clinics, shall consider the patient caseload of existing FQHCs and rural health clinics
526.28 in a 60-mile radius for organizations established outside of the seven-county metropolitan
526.29 area, and in a 30-mile radius for organizations in the seven-county metropolitan area. If this
526.30 information is not available, the commissioner may use Medicare cost reports or audited
526.31 financial statements to establish base rate;

526.32 (13) the commissioner shall establish a quality measures workgroup that includes
526.33 representatives from the Minnesota Association of Community Health Centers, FQHCs,
526.34 and rural health clinics, to evaluate clinical and nonclinical measures; and

527.1 (14) the commissioner shall not disallow or reduce costs that are related to an FQHC's
527.2 or rural health clinic's participation in health care educational programs to the extent that
527.3 the costs are not accounted for in the alternative payment methodology encounter rate
527.4 established in this paragraph.

527.5 Sec. 27. Minnesota Statutes 2018, section 256B.0625, subdivision 31, is amended to read:

527.6 Subd. 31. **Medical supplies and equipment.** (a) Medical assistance covers medical
527.7 supplies and equipment. Separate payment outside of the facility's payment rate shall be
527.8 made for wheelchairs and wheelchair accessories for recipients who are residents of
527.9 intermediate care facilities for the developmentally disabled. Reimbursement for wheelchairs
527.10 and wheelchair accessories for ICF/DD recipients shall be subject to the same conditions
527.11 and limitations as coverage for recipients who do not reside in institutions. A wheelchair
527.12 purchased outside of the facility's payment rate is the property of the recipient.

527.13 (b) Vendors of durable medical equipment, prosthetics, orthotics, or medical supplies
527.14 must enroll as a Medicare provider.

527.15 (c) When necessary to ensure access to durable medical equipment, prosthetics, orthotics,
527.16 or medical supplies, the commissioner may exempt a vendor from the Medicare enrollment
527.17 requirement if:

527.18 (1) the vendor supplies only one type of durable medical equipment, prosthetic, orthotic,
527.19 or medical supply;

527.20 (2) the vendor serves ten or fewer medical assistance recipients per year;

527.21 (3) the commissioner finds that other vendors are not available to provide same or similar
527.22 durable medical equipment, prosthetics, orthotics, or medical supplies; and

527.23 (4) the vendor complies with all screening requirements in this chapter and Code of
527.24 Federal Regulations, title 42, part 455. The commissioner may also exempt a vendor from
527.25 the Medicare enrollment requirement if the vendor is accredited by a Centers for Medicare
527.26 and Medicaid Services approved national accreditation organization as complying with the
527.27 Medicare program's supplier and quality standards and the vendor serves primarily pediatric
527.28 patients.

527.29 (d) Durable medical equipment means a device or equipment that:

527.30 (1) can withstand repeated use;

527.31 (2) is generally not useful in the absence of an illness, injury, or disability; and

528.1 (3) is provided to correct or accommodate a physiological disorder or physical condition
528.2 or is generally used primarily for a medical purpose.

528.3 (e) Electronic tablets may be considered durable medical equipment if the electronic
528.4 tablet will be used as an augmentative and alternative communication system as defined
528.5 under subdivision 31a, paragraph (a). To be covered by medical assistance, the device must
528.6 be locked in order to prevent use not related to communication.

528.7 (f) Notwithstanding the requirement in paragraph (e) that an electronic tablet must be
528.8 locked to prevent use not as an augmentative communication device, a recipient of waiver
528.9 services may use an electronic tablet for a use not related to communication when the
528.10 recipient has been authorized under the waiver to receive one or more additional applications
528.11 that can be loaded onto the electronic tablet, such that allowing the additional use prevents
528.12 the purchase of a separate electronic tablet with waiver funds.

528.13 (g) An order or prescription for medical supplies, equipment, or appliances must meet
528.14 the requirements in Code of Federal Regulations, title 42, part 440.70.

528.15 (h) Allergen-reducing products provided according to subdivision 66, paragraph (c),
528.16 shall be considered durable medical equipment.

528.17 **EFFECTIVE DATE.** This section is effective January 1, 2020, or upon federal approval,
528.18 whichever is later. The commissioner of human services shall notify the revisor of statutes
528.19 when federal approval is obtained.

528.20 Sec. 28. Minnesota Statutes 2018, section 256B.0625, subdivision 57, is amended to read:

528.21 Subd. 57. **Payment for Part B Medicare crossover claims.** (a) Effective for services
528.22 provided on or after January 1, 2012, medical assistance payment for an enrollee's
528.23 cost-sharing associated with Medicare Part B is limited to an amount up to the medical
528.24 assistance total allowed, when the medical assistance rate exceeds the amount paid by
528.25 Medicare.

528.26 (b) Excluded from this limitation are payments for mental health services and payments
528.27 for dialysis services provided to end-stage renal disease patients. The exclusion for mental
528.28 health services does not apply to payments for physician services provided by psychiatrists
528.29 and advanced practice nurses with a specialty in mental health.

528.30 (c) Excluded from this limitation are payments to federally qualified health centers,
528.31 Indian Health Services, and rural health clinics.

528.32 **EFFECTIVE DATE.** This section is effective the day following final enactment.

529.1 Sec. 29. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision
529.2 to read:

529.3 Subd. 66. **Enhanced asthma care services.** (a) Medical assistance covers enhanced
529.4 asthma care services and related products to be provided in the children's homes for children
529.5 with poorly controlled asthma. To be eligible for services and products under this subdivision,
529.6 a child must:

529.7 (1) be under the age of 21;

529.8 (2) have poorly controlled asthma defined by having received health care for the child's
529.9 asthma from a hospital emergency department at least one time in the past year or have
529.10 been hospitalized for the treatment of asthma at least one time in the past year; and

529.11 (3) receive a referral for services and products under this subdivision from a treating
529.12 health care provider.

529.13 (b) Covered services include home visits provided by a registered environmental health
529.14 specialist or lead risk assessor currently credentialed by the Department of Health or a
529.15 healthy homes specialist credentialed by the Building Performance Institute.

529.16 (c) Covered products include the following allergen-reducing products that are identified
529.17 as needed, and recommended for the child, by a registered environmental health specialist,
529.18 healthy homes specialist, lead risk assessor, certified asthma educator, public health nurse,
529.19 or other health care professional providing asthma care for the child, and proven to reduce
529.20 asthma triggers:

529.21 (1) allergen encasements for mattresses, box springs, and pillows;

529.22 (2) an allergen-rated vacuum cleaner, filters, and bags;

529.23 (3) a dehumidifier and filters;

529.24 (4) HEPA single-room air cleaners and filters;

529.25 (5) integrated pest management, including traps and starter packages of food storage
529.26 containers;

529.27 (6) a damp mopping system;

529.28 (7) if the child does not have access to a bed, a waterproof hospital-grade mattress; and

529.29 (8) for homeowners only, furnace filters.

529.30 The commissioner shall determine additional products that may be covered as new best
529.31 practices for asthma care are identified.

530.1 (d) A home assessment is a home visit to identify asthma triggers in the home and to
530.2 provide education on trigger-reducing products. A child is limited to two home assessments
530.3 except that a child may receive an additional home assessment if the child moves to a new
530.4 home; if a new asthma trigger, including tobacco smoke, enters the home; or if the child's
530.5 health care provider identifies a new allergy for the child, including an allergy to mold,
530.6 pests, pets, or dust mites. The commissioner shall determine the frequency with which a
530.7 child may receive a product listed in paragraph (c), based on the reasonable expected lifetime
530.8 of the product.

530.9 **EFFECTIVE DATE.** This section is effective January 1, 2020, or upon federal approval,
530.10 whichever is later. The commissioner of human services shall notify the revisor of statutes
530.11 when federal approval is obtained.

530.12 Sec. 30. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision
530.13 to read:

530.14 Subd. 67. **Provider tax rate increase.** (a) The commissioner shall increase the total
530.15 payments to managed care plans under section 256B.69 by an amount equal to the cost
530.16 increases to the managed care plans from the elimination of:

530.17 (1) the exemption from the taxes imposed under section 297I.05, subdivision 5, for
530.18 premiums paid by the state for medical assistance and the MinnesotaCare program; and

530.19 (2) the exemption of gross revenues subject to the taxes imposed under sections 295.50
530.20 to 295.57, for payments paid by the state for services provided under medical assistance
530.21 and the MinnesotaCare program. Any increase based on this clause must be reflected in
530.22 provider rates paid by the managed care plan unless the managed care plan is a staff model
530.23 health plan company.

530.24 (b) The commissioner shall increase by two percent the fee-for-service payments under
530.25 medical assistance and the MinnesotaCare program for services subject to the hospital,
530.26 surgical center, or health care provider taxes under sections 295.50 to 295.57.

530.27 Sec. 31. Minnesota Statutes 2018, section 256B.064, subdivision 1a, is amended to read:

530.28 Subd. 1a. **Grounds for sanctions against vendors.** (a) The commissioner may impose
530.29 sanctions against a vendor of medical care for any of the following: (1) fraud, theft, or abuse
530.30 in connection with the provision of medical care to recipients of public assistance; (2) a
530.31 pattern of presentment of false or duplicate claims or claims for services not medically
530.32 necessary; (3) a pattern of making false statements of material facts for the purpose of

531.1 obtaining greater compensation than that to which the vendor is legally entitled; (4)
531.2 suspension or termination as a Medicare vendor; (5) refusal to grant the state agency access
531.3 during regular business hours to examine all records necessary to disclose the extent of
531.4 services provided to program recipients and appropriateness of claims for payment; (6)
531.5 failure to repay an overpayment or a fine finally established under this section; (7) failure
531.6 to correct errors in the maintenance of health service or financial records for which a fine
531.7 was imposed or after issuance of a warning by the commissioner; and (8) any reason for
531.8 which a vendor could be excluded from participation in the Medicare program under section
531.9 1128, 1128A, or 1866(b)(2) of the Social Security Act.

531.10 (b) The commissioner may impose sanctions against a pharmacy provider for failure to
531.11 respond to a cost of dispensing survey under section 256B.0625, subdivision 13e, paragraph
531.12 (h).

531.13 **EFFECTIVE DATE.** This section is effective April 1, 2019.

531.14 Sec. 32. Minnesota Statutes 2018, section 256B.0659, subdivision 21, is amended to read:

531.15 Subd. 21. **Requirements for provider enrollment of personal care assistance provider**
531.16 **agencies.** (a) All personal care assistance provider agencies must provide, at the time of
531.17 enrollment, reenrollment, and revalidation as a personal care assistance provider agency in
531.18 a format determined by the commissioner, information and documentation that includes,
531.19 but is not limited to, the following:

531.20 (1) the personal care assistance provider agency's current contact information including
531.21 address, telephone number, and e-mail address;

531.22 (2) proof of surety bond coverage for each business location providing services. Upon
531.23 new enrollment, or if the provider's Medicaid revenue in the previous calendar year is up
531.24 to and including \$300,000, the provider agency must purchase a surety bond of \$50,000. If
531.25 the Medicaid revenue in the previous year is over \$300,000, the provider agency must
531.26 purchase a surety bond of \$100,000. The surety bond must be in a form approved by the
531.27 commissioner, must be renewed annually, and must allow for recovery of costs and fees in
531.28 pursuing a claim on the bond;

531.29 (3) proof of fidelity bond coverage in the amount of \$20,000 for each business location
531.30 providing service;

531.31 (4) proof of workers' compensation insurance coverage identifying the business location
531.32 where personal care assistance services are provided;

532.1 (5) proof of liability insurance coverage identifying the business location where personal
 532.2 care assistance services are provided and naming the department as a certificate holder;

532.3 ~~(6) a description of the personal care assistance provider agency's organization identifying~~
 532.4 ~~the names of all owners, managing employees, staff, board of directors, and the affiliations~~
 532.5 ~~of the directors, owners, or staff to other service providers;~~

532.6 ~~(7)~~ (6) a copy of the personal care assistance provider agency's written policies and
 532.7 procedures including: hiring of employees; training requirements; service delivery; and
 532.8 employee and consumer safety including process for notification and resolution of consumer
 532.9 grievances, identification and prevention of communicable diseases, and employee
 532.10 misconduct;

532.11 ~~(8)~~ (7) copies of all other forms the personal care assistance provider agency uses in the
 532.12 course of daily business including, but not limited to:

532.13 (i) a copy of the personal care assistance provider agency's time sheet if the time sheet
 532.14 varies from the standard time sheet for personal care assistance services approved by the
 532.15 commissioner, and a letter requesting approval of the personal care assistance provider
 532.16 agency's nonstandard time sheet;

532.17 (ii) the personal care assistance provider agency's template for the personal care assistance
 532.18 care plan; and

532.19 (iii) the personal care assistance provider agency's template for the written agreement
 532.20 in subdivision 20 for recipients using the personal care assistance choice option, if applicable;

532.21 ~~(9)~~ (8) a list of all training and classes that the personal care assistance provider agency
 532.22 requires of its staff providing personal care assistance services;

532.23 ~~(10)~~ (9) documentation that the personal care assistance provider agency and staff have
 532.24 successfully completed all the training required by this section;

532.25 ~~(11)~~ (10) documentation of the agency's marketing practices;

532.26 ~~(12)~~ (11) disclosure of ownership, leasing, or management of all residential properties
 532.27 that is used or could be used for providing home care services;

532.28 ~~(13)~~ (12) documentation that the agency will use the following percentages of revenue
 532.29 generated from the medical assistance rate paid for personal care assistance services for
 532.30 employee personal care assistant wages and benefits: 72.5 percent of revenue in the personal
 532.31 care assistance choice option and 72.5 percent of revenue from other personal care assistance

533.1 providers. The revenue generated by the qualified professional and the reasonable costs
533.2 associated with the qualified professional shall not be used in making this calculation; and
533.3 ~~(14)~~ (13) effective May 15, 2010, documentation that the agency does not burden
533.4 recipients' free exercise of their right to choose service providers by requiring personal care
533.5 assistants to sign an agreement not to work with any particular personal care assistance
533.6 recipient or for another personal care assistance provider agency after leaving the agency
533.7 and that the agency is not taking action on any such agreements or requirements regardless
533.8 of the date signed.

533.9 (b) Personal care assistance provider agencies shall provide the information specified
533.10 in paragraph (a) to the commissioner at the time the personal care assistance provider agency
533.11 enrolls as a vendor or upon request from the commissioner. The commissioner shall collect
533.12 the information specified in paragraph (a) from all personal care assistance providers
533.13 beginning July 1, 2009.

533.14 (c) All personal care assistance provider agencies shall require all employees in
533.15 management and supervisory positions and owners of the agency who are active in the
533.16 day-to-day management and operations of the agency to complete mandatory training as
533.17 determined by the commissioner before submitting an application for enrollment of the
533.18 agency as a provider. All personal care assistance provider agencies shall also require
533.19 qualified professionals to complete the training required by subdivision 13 before submitting
533.20 an application for enrollment of the agency as a provider. Employees in management and
533.21 supervisory positions and owners who are active in the day-to-day operations of an agency
533.22 who have completed the required training as an employee with a personal care assistance
533.23 provider agency do not need to repeat the required training if they are hired by another
533.24 agency, if they have completed the training within the past three years. By September 1,
533.25 2010, the required training must be available with meaningful access according to title VI
533.26 of the Civil Rights Act and federal regulations adopted under that law or any guidance from
533.27 the United States Health and Human Services Department. The required training must be
533.28 available online or by electronic remote connection. The required training must provide for
533.29 competency testing. Personal care assistance provider agency billing staff shall complete
533.30 training about personal care assistance program financial management. This training is
533.31 effective July 1, 2009. Any personal care assistance provider agency enrolled before that
533.32 date shall, if it has not already, complete the provider training within 18 months of July 1,
533.33 2009. Any new owners or employees in management and supervisory positions involved
533.34 in the day-to-day operations are required to complete mandatory training as a requisite of
533.35 working for the agency. Personal care assistance provider agencies certified for participation

534.1 in Medicare as home health agencies are exempt from the training required in this
534.2 subdivision. When available, Medicare-certified home health agency owners, supervisors,
534.3 or managers must successfully complete the competency test.

534.4 (d) All surety bonds, fidelity bonds, workers compensation insurance, and liability
534.5 insurance required by this subdivision must be maintained continuously. After initial
534.6 enrollment, a provider must submit proof of bonds and required coverages at any time at
534.7 the request of the commissioner. Services provided while there are lapses in coverage are
534.8 not eligible for payment. Lapses in coverage may result in sanctions, including termination.
534.9 The commissioner shall send instructions and a due date to submit the requested information
534.10 to the personal care assistance provider agency.

534.11 **EFFECTIVE DATE.** This section is effective the day following final enactment.

534.12 Sec. 33. **[256B.758] REIMBURSEMENT FOR DOULA SERVICES.**

534.13 Effective for services provided on or after July 1, 2019, payments for doula services
534.14 provided by a certified doula shall be \$47 per prenatal or postpartum visit and \$488 for
534.15 attending and providing doula services at a birth.

534.16 Sec. 34. Minnesota Statutes 2018, section 256B.766, is amended to read:

534.17 **256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.**

534.18 (a) Effective for services provided on or after July 1, 2009, total payments for basic care
534.19 services, shall be reduced by three percent, except that for the period July 1, 2009, through
534.20 June 30, 2011, total payments shall be reduced by 4.5 percent for the medical assistance
534.21 and general assistance medical care programs, prior to third-party liability and spenddown
534.22 calculation. Effective July 1, 2010, the commissioner shall classify physical therapy services,
534.23 occupational therapy services, and speech-language pathology and related services as basic
534.24 care services. The reduction in this paragraph shall apply to physical therapy services,
534.25 occupational therapy services, and speech-language pathology and related services provided
534.26 on or after July 1, 2010.

534.27 (b) Payments made to managed care plans and county-based purchasing plans shall be
534.28 reduced for services provided on or after October 1, 2009, to reflect the reduction effective
534.29 July 1, 2009, and payments made to the plans shall be reduced effective October 1, 2010,
534.30 to reflect the reduction effective July 1, 2010.

535.1 (c) Effective for services provided on or after September 1, 2011, through June 30, 2013,
535.2 total payments for outpatient hospital facility fees shall be reduced by five percent from the
535.3 rates in effect on August 31, 2011.

535.4 (d) Effective for services provided on or after September 1, 2011, through June 30, 2013,
535.5 total payments for ambulatory surgery centers facility fees, medical supplies and durable
535.6 medical equipment not subject to a volume purchase contract, prosthetics and orthotics,
535.7 renal dialysis services, laboratory services, public health nursing services, physical therapy
535.8 services, occupational therapy services, speech therapy services, eyeglasses not subject to
535.9 a volume purchase contract, hearing aids not subject to a volume purchase contract, and
535.10 anesthesia services shall be reduced by three percent from the rates in effect on August 31,
535.11 2011.

535.12 (e) Effective for services provided on or after September 1, 2014, payments for
535.13 ambulatory surgery centers facility fees, hospice services, renal dialysis services, laboratory
535.14 services, public health nursing services, eyeglasses not subject to a volume purchase contract,
535.15 and hearing aids not subject to a volume purchase contract shall be increased by three percent
535.16 and payments for outpatient hospital facility fees shall be increased by three percent.
535.17 Payments made to managed care plans and county-based purchasing plans shall not be
535.18 adjusted to reflect payments under this paragraph.

535.19 (f) Payments for medical supplies and durable medical equipment not subject to a volume
535.20 purchase contract, and prosthetics and orthotics, provided on or after July 1, 2014, through
535.21 June 30, 2015, shall be decreased by .33 percent. Payments for medical supplies and durable
535.22 medical equipment not subject to a volume purchase contract, and prosthetics and orthotics,
535.23 provided on or after July 1, 2015, shall be increased by three percent from the rates as
535.24 determined under paragraphs (i) and (j).

535.25 (g) Effective for services provided on or after July 1, 2015, payments for outpatient
535.26 hospital facility fees, medical supplies and durable medical equipment not subject to a
535.27 volume purchase contract, prosthetics, and orthotics to a hospital meeting the criteria specified
535.28 in section 62Q.19, subdivision 1, paragraph (a), clause (4), shall be increased by 90 percent
535.29 from the rates in effect on June 30, 2015. Payments made to managed care plans and
535.30 county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

535.31 (h) This section does not apply to physician and professional services, inpatient hospital
535.32 services, family planning services, mental health services, dental services, prescription
535.33 drugs, medical transportation, federally qualified health centers, rural health centers, Indian
535.34 health services, and Medicare cost-sharing.

536.1 (i) Effective for services provided on or after July 1, 2015, the following categories of
536.2 medical supplies and durable medical equipment shall be individually priced items: enteral
536.3 nutrition and supplies, customized and other specialized tracheostomy tubes and supplies,
536.4 electric patient lifts, and durable medical equipment repair and service. This paragraph does
536.5 not apply to medical supplies and durable medical equipment subject to a volume purchase
536.6 contract, products subject to the preferred diabetic testing supply program, and items provided
536.7 to dually eligible recipients when Medicare is the primary payer for the item. The
536.8 commissioner shall not apply any medical assistance rate reductions to durable medical
536.9 equipment as a result of Medicare competitive bidding.

536.10 (j) Effective for services provided on or after July 1, 2015, medical assistance payment
536.11 rates for durable medical equipment, prosthetics, orthotics, or supplies shall be increased
536.12 as follows:

536.13 (1) payment rates for durable medical equipment, prosthetics, orthotics, or supplies that
536.14 were subject to the Medicare competitive bid that took effect in January of 2009 shall be
536.15 increased by 9.5 percent; and

536.16 (2) payment rates for durable medical equipment, prosthetics, orthotics, or supplies on
536.17 the medical assistance fee schedule, whether or not subject to the Medicare competitive bid
536.18 that took effect in January of 2009, shall be increased by 2.94 percent, with this increase
536.19 being applied after calculation of any increased payment rate under clause (1).

536.20 This paragraph does not apply to medical supplies and durable medical equipment subject
536.21 to a volume purchase contract, products subject to the preferred diabetic testing supply
536.22 program, items provided to dually eligible recipients when Medicare is the primary payer
536.23 for the item, and individually priced items identified in paragraph (i). Payments made to
536.24 managed care plans and county-based purchasing plans shall not be adjusted to reflect the
536.25 rate increases in this paragraph.

536.26 (k) Effective for nonpressure support ventilators provided on or after January 1, 2016,
536.27 the rate shall be the lower of the submitted charge or the Medicare fee schedule rate. Effective
536.28 for pressure support ventilators provided on or after January 1, 2016, the rate shall be the
536.29 lower of the submitted charge or 47 percent above the Medicare fee schedule rate. For
536.30 payments made in accordance with this paragraph, if, and to the extent that, the commissioner
536.31 identifies that the state has received federal financial participation for ventilators in excess
536.32 of the amount allowed effective January 1, 2018, under United States Code, title 42, section
536.33 1396b(i)(27), the state shall repay the excess amount to the Centers for Medicare and
536.34 Medicaid Services with state funds and maintain the full payment rate under this paragraph.

537.1 (l) Payment rates for durable medical equipment, prosthetics, orthotics or supplies, that
537.2 are subject to the upper payment limit in accordance with section 1903(i)(27) of the Social
537.3 Security Act, shall be paid the Medicare rate. Rate increases provided in this chapter shall
537.4 not be applied to the items listed in this paragraph.

537.5 **EFFECTIVE DATE.** This section is effective July 1, 2019, subject to federal approval.
537.6 The commissioner shall notify the revisor of statutes when federal approval has been
537.7 obtained.

537.8 Sec. 35. Minnesota Statutes 2018, section 256L.11, subdivision 2, is amended to read:

537.9 Subd. 2. **Payment of certain providers.** Services provided by federally qualified health
537.10 centers, rural health clinics, and facilities of the Indian health service shall be paid for
537.11 according to the same rates and conditions applicable to the same service provided by
537.12 providers that are not federally qualified health centers, rural health clinics, or facilities of
537.13 the Indian health service. The alternative payment methodology described under section
537.14 256B.0625, subdivision 30, paragraph (l), shall not apply to services delivered under this
537.15 chapter by federally qualified health centers, rural health clinics, and facilities of the Indian
537.16 Health Services.

537.17 Sec. 36. Minnesota Statutes 2018, section 295.52, subdivision 8, is amended to read:

537.18 Subd. 8. **Contingent reduction in tax rate.** (a) By December 1 of each year, beginning
537.19 in 2011, the commissioner of management and budget shall determine the projected balance
537.20 in the health care access fund for the biennium.

537.21 (b) If the commissioner of management and budget determines that the projected balance
537.22 in the health care access fund for the biennium reflects a ratio of revenues to expenditures
537.23 and transfers greater than 125 percent, and if the actual cash balance in the fund is adequate,
537.24 as determined by the commissioner of management and budget, the commissioner, in
537.25 consultation with the commissioner of revenue, shall reduce the tax rates levied under
537.26 subdivisions 1, 1a, 2, 3, and 4, for the subsequent calendar year sufficient to reduce the
537.27 structural balance in the fund. The rate may be reduced to the extent that the projected
537.28 revenues for the biennium do not exceed 125 percent of expenditures and transfers. The
537.29 new rate shall be rounded to the nearest one-tenth of one percent. The rate reduction under
537.30 this paragraph expires at the end of each calendar year and is subject to an annual
537.31 redetermination by the commissioner of management and budget.

538.1 (c) For purposes of the analysis defined in paragraph (b), the commissioner of
 538.2 management and budget shall include projected revenues, ~~notwithstanding the repeal of the~~
 538.3 ~~tax imposed under this section effective January 1, 2020.~~

538.4 **EFFECTIVE DATE.** This section is effective the day following final enactment.

538.5 Sec. 37. Laws 2003, First Special Session chapter 14, article 13C, section 2, subdivision
 538.6 6, as amended by Laws 2004, chapter 272, article 2, section 4; Laws 2005, First Special
 538.7 Session chapter 4, article 5, section 18; and Laws 2005, First Special Session chapter 4,
 538.8 article 9, section 11, is amended to read:

538.9 **Subd. 6. Basic Health Care Grants**

538.10	Summary by Fund		
538.11	General	1,290,454,000	1,475,996,000
538.12	Health Care Access	254,121,000	282,689,000

538.13 **UPDATING FEDERAL POVERTY**

538.14 **GUIDELINES.** Annual updates to the federal
 538.15 poverty guidelines are effective each July 1,
 538.16 following publication by the United States
 538.17 Department of Health and Human Services
 538.18 for health care programs under Minnesota
 538.19 Statutes, chapters 256, 256B, 256D, and 256L.

538.20 The amounts that may be spent from this
 538.21 appropriation for each purpose are as follows:

538.22 (a) MinnesotaCare Grants

538.23	Health Care Access	253,371,000	281,939,000
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538.24 **MINNESOTACARE FEDERAL**

538.25 **RECEIPTS.** Receipts received as a result of
 538.26 federal participation pertaining to
 538.27 administrative costs of the Minnesota health
 538.28 care reform waiver shall be deposited as
 538.29 nondedicated revenue in the health care access
 538.30 fund. Receipts received as a result of federal
 538.31 participation pertaining to grants shall be
 538.32 deposited in the federal fund and shall offset

539.1 health care access funds for payments to
539.2 providers.

539.3 **MINNESOTACARE FUNDING.** The
539.4 commissioner may expend money
539.5 appropriated from the health care access fund
539.6 for MinnesotaCare in either fiscal year of the
539.7 biennium.

539.8 (b) MA Basic Health Care Grants - Families
539.9 and Children

539.10	General	427,769,000	489,545,000
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539.11 **SERVICES TO PREGNANT WOMEN.**
539.12 The commissioner shall use available federal
539.13 money for the State-Children's Health
539.14 Insurance Program for medical assistance
539.15 services provided to pregnant women who are
539.16 not otherwise eligible for federal financial
539.17 participation beginning in fiscal year 2003.
539.18 This federal money shall be deposited in the
539.19 federal fund and shall offset general funds for
539.20 payments to providers. Notwithstanding
539.21 section 14, this paragraph shall not expire.

539.22 **MANAGED CARE RATE INCREASE.** ~~(a)~~
539.23 ~~Effective January 1, 2004, the commissioner~~
539.24 ~~of human services shall increase the total~~
539.25 ~~payments to managed care plans under~~
539.26 ~~Minnesota Statutes, section 256B.69, by an~~
539.27 ~~amount equal to the cost increases to the~~
539.28 ~~managed care plans from by the elimination~~
539.29 ~~of: (1) the exemption from the taxes imposed~~
539.30 ~~under Minnesota Statutes, section 297I.05,~~
539.31 ~~subdivision 5, for premiums paid by the state~~
539.32 ~~for medical assistance, general assistance~~
539.33 ~~medical care, and the MinnesotaCare program;~~
539.34 ~~and (2) the exemption of gross revenues~~

540.1 ~~subject to the taxes imposed under Minnesota~~
 540.2 ~~Statutes, sections 295.50 to 295.57, for~~
 540.3 ~~payments paid by the state for services~~
 540.4 ~~provided under medical assistance, general~~
 540.5 ~~assistance medical care, and the~~
 540.6 ~~MinnesotaCare program. Any increase based~~
 540.7 ~~on clause (2) must be reflected in provider~~
 540.8 ~~rates paid by the managed care plan unless the~~
 540.9 ~~managed care plan is a staff model health plan~~
 540.10 ~~company.~~

540.11 ~~(b) The commissioner of human services shall~~
 540.12 ~~increase by the applicable tax rate in effect~~
 540.13 ~~under Minnesota Statutes, section 295.52, the~~
 540.14 ~~fee for service payments under medical~~
 540.15 ~~assistance, general assistance medical care,~~
 540.16 ~~and the MinnesotaCare program for services~~
 540.17 ~~subject to the hospital, surgical center, or~~
 540.18 ~~health care provider taxes under Minnesota~~
 540.19 ~~Statutes, sections 295.50 to 295.57, effective~~
 540.20 ~~for services rendered on or after January 1,~~
 540.21 ~~2004.~~

540.22 (c) The commissioner of finance shall transfer
 540.23 from the health care access fund to the general
 540.24 fund the following amounts in the fiscal years
 540.25 indicated: 2004, \$16,587,000; 2005,
 540.26 \$46,322,000; 2006, \$49,413,000; and 2007,
 540.27 \$58,695,000.

540.28 (d) Notwithstanding section 14, these
 540.29 provisions shall not expire.

540.30 (c) MA Basic Health Care Grants - Elderly
 540.31 and Disabled

540.32 General	610,518,000	743,858,000
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540.33 **DELAY MEDICAL ASSISTANCE**
 540.34 **FEE-FOR-SERVICE - ACUTE CARE.** The

541.1 following payments in fiscal year 2005 from
 541.2 the Medicaid Management Information
 541.3 System that would otherwise have been made
 541.4 to providers for medical assistance and general
 541.5 assistance medical care services shall be
 541.6 delayed and included in the first payment in
 541.7 fiscal year 2006:

- 541.8 (1) for hospitals, the last two payments; and
- 541.9 (2) for nonhospital providers, the last payment.

541.10 This payment delay shall not include payments
 541.11 to skilled nursing facilities, intermediate care
 541.12 facilities for mental retardation, prepaid health
 541.13 plans, home health agencies, personal care
 541.14 nursing providers, and providers of only
 541.15 waiver services. The provisions of Minnesota
 541.16 Statutes, section 16A.124, shall not apply to
 541.17 these delayed payments. Notwithstanding
 541.18 section 14, this provision shall not expire.

541.19 **DEAF AND HARD-OF-HEARING**
 541.20 **SERVICES.** If, after making reasonable
 541.21 efforts, the service provider for mental health
 541.22 services to persons who are deaf or hearing
 541.23 impaired is not able to earn \$227,000 through
 541.24 participation in medical assistance intensive
 541.25 rehabilitation services in fiscal year 2005, the
 541.26 commissioner shall transfer \$227,000 minus
 541.27 medical assistance earnings achieved by the
 541.28 grantee to deaf and hard-of-hearing grants to
 541.29 enable the provider to continue providing
 541.30 services to eligible persons.

541.31 (d) General Assistance Medical Care Grants

541.32 General	239,861,000	229,960,000
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541.33 (e) Health Care Grants - Other Assistance

542.1 General 3,067,000 3,407,000

542.2 Health Care Access 750,000 750,000

542.3 **MINNESOTA PRESCRIPTION DRUG**

542.4 **DEDICATED FUND.** Of the general fund
 542.5 appropriation, \$284,000 in fiscal year 2005 is
 542.6 appropriated to the commissioner for the
 542.7 prescription drug dedicated fund established
 542.8 under the prescription drug discount program.

542.9 **DENTAL ACCESS GRANTS**

542.10 **CARRYOVER AUTHORITY.** Any unspent
 542.11 portion of the appropriation from the health
 542.12 care access fund in fiscal years 2002 and 2003
 542.13 for dental access grants under Minnesota
 542.14 Statutes, section 256B.53, shall not cancel but
 542.15 shall be allowed to carry forward to be spent
 542.16 in the biennium beginning July 1, 2003, for
 542.17 these purposes.

542.18 **STOP-LOSS FUND ACCOUNT.** The
 542.19 appropriation to the purchasing alliance
 542.20 stop-loss fund account established under
 542.21 Minnesota Statutes, section 256.956,
 542.22 subdivision 2, for fiscal years 2004 and 2005
 542.23 shall only be available for claim
 542.24 reimbursements for qualifying enrollees who
 542.25 are members of purchasing alliances that meet
 542.26 the requirements described under Minnesota
 542.27 Statutes, section 256.956, subdivision 1,
 542.28 paragraph (f), clauses (1), (2), and (3).

542.29 (f) Prescription Drug Program

542.30 General 9,239,000 9,226,000

542.31 **PRESCRIPTION DRUG ASSISTANCE**

542.32 **PROGRAM.** Of the general fund
 542.33 appropriation, \$702,000 in fiscal year 2004
 542.34 and \$887,000 in fiscal year 2005 are for the

543.1 commissioner to establish and administer the
 543.2 prescription drug assistance program through
 543.3 the Minnesota board on aging.

543.4 **REBATE REVENUE RECAPTURE.** Any
 543.5 funds received by the state from a drug
 543.6 manufacturer due to errors in the
 543.7 pharmaceutical pricing used by the
 543.8 manufacturer in determining the prescription
 543.9 drug rebate are appropriated to the
 543.10 commissioner to augment funding of the
 543.11 prescription drug program established in
 543.12 Minnesota Statutes, section 256.955.

543.13 Sec. 38. **STUDY OF CLINIC COSTS.**

543.14 The commissioner of human services shall conduct a five-year comparative analysis of
 543.15 the actual change in aggregate federally qualified health center (FQHC) and rural health
 543.16 clinic costs versus the CMS FQHC Market Basket inflator using 2017 through 2022 finalized
 543.17 Medicare Cost Reports, CMS 2224-14, and report the findings to the chairs and ranking
 543.18 minority members of the legislative committees with jurisdiction over health and human
 543.19 services policy and finance, by July 1, 2025.

543.20 Sec. 39. **REPEALER.**

543.21 (a) Minnesota Statutes 2018, sections 256B.0625, subdivision 63; 256B.0659, subdivision
 543.22 22; and 256L.11, subdivision 2a, are repealed.

543.23 (b) Laws 2011, First Special Session chapter 9, article 6, section 97, subdivision 6, is
 543.24 repealed effective the day following final enactment.

543.25 **ARTICLE 9**

543.26 **ONECARE**

543.27 Section 1. Minnesota Statutes 2018, section 62J.497, subdivision 1, is amended to read:

543.28 Subdivision 1. **Definitions.** (a) For the purposes of this section, the following terms have
 543.29 the meanings given.

543.30 (b) "Backward compatible" means that the newer version of a data transmission standard
 543.31 would retain, at a minimum, the full functionality of the versions previously adopted, and

544.1 would permit the successful completion of the applicable transactions with entities that
544.2 continue to use the older versions.

544.3 (c) "Dispense" or "dispensing" has the meaning given in section 151.01, subdivision 30.
544.4 Dispensing does not include the direct administering of a controlled substance to a patient
544.5 by a licensed health care professional.

544.6 (d) "Dispenser" means a person authorized by law to dispense a controlled substance,
544.7 pursuant to a valid prescription.

544.8 (e) "Electronic media" has the meaning given under Code of Federal Regulations, title
544.9 45, part 160.103.

544.10 (f) "E-prescribing" means the transmission using electronic media of prescription or
544.11 prescription-related information between a prescriber, dispenser, pharmacy benefit manager,
544.12 or group purchaser, either directly or through an intermediary, including an e-prescribing
544.13 network. E-prescribing includes, but is not limited to, two-way transmissions between the
544.14 point of care and the dispenser and two-way transmissions related to eligibility, formulary,
544.15 and medication history information.

544.16 (g) "Electronic prescription drug program" means a program that provides for
544.17 e-prescribing.

544.18 (h) "Group purchaser" has the meaning given in section 62J.03, subdivision 6, excluding
544.19 state and federal health care programs under chapters 256B, 256L, and 256T.

544.20 (i) "HL7 messages" means a standard approved by the standards development
544.21 organization known as Health Level Seven.

544.22 (j) "National Provider Identifier" or "NPI" means the identifier described under Code
544.23 of Federal Regulations, title 45, part 162.406.

544.24 (k) "NCPDP" means the National Council for Prescription Drug Programs, Inc.

544.25 (l) "NCPDP Formulary and Benefits Standard" means the National Council for
544.26 Prescription Drug Programs Formulary and Benefits Standard, Implementation Guide,
544.27 Version 1, Release 0, October 2005.

544.28 (m) "NCPDP SCRIPT Standard" means the National Council for Prescription Drug
544.29 Programs Prescriber/Pharmacist Interface SCRIPT Standard, Implementation Guide Version
544.30 8, Release 1 (Version 8.1), October 2005, or the most recent standard adopted by the Centers
544.31 for Medicare and Medicaid Services for e-prescribing under Medicare Part D as required
544.32 by section 1860D-4(e)(4)(D) of the Social Security Act, and regulations adopted under it.

545.1 The standards shall be implemented according to the Centers for Medicare and Medicaid
545.2 Services schedule for compliance. Subsequently released versions of the NCPDP SCRIPT
545.3 Standard may be used, provided that the new version of the standard is backward compatible
545.4 to the current version adopted by the Centers for Medicare and Medicaid Services.

545.5 (n) "Pharmacy" has the meaning given in section 151.01, subdivision 2.

545.6 (o) "Prescriber" means a licensed health care practitioner, other than a veterinarian, as
545.7 defined in section 151.01, subdivision 23.

545.8 (p) "Prescription-related information" means information regarding eligibility for drug
545.9 benefits, medication history, or related health or drug information.

545.10 (q) "Provider" or "health care provider" has the meaning given in section 62J.03,
545.11 subdivision 8.

545.12 **EFFECTIVE DATE.** This section is effective January 1, 2022.

545.13 Sec. 2. **[62V.12] ADVANCED PAYMENT OF STATE-BASED HEALTH**
545.14 **INSURANCE PREMIUM TAX CREDIT.**

545.15 **Subdivision 1. Determination of eligibility for advanced payment of state-based**
545.16 **health insurance premium tax credit.** (a) The Board of Directors of MNsure shall assess
545.17 **an individual's eligibility for an advanced payment of the state-based health insurance tax**
545.18 **credit under section 290.0693 when an individual applies for an eligibility determination**
545.19 **through MNsure, basing the eligibility determination upon income for the relevant tax year**
545.20 **as projected by the individual. MNsure shall equally divide the value of the potential**
545.21 **state-based tax credit across the monthly premiums to be charged to the individual. If the**
545.22 **individual selects a plan through MNsure, MNsure shall notify the relevant health carrier**
545.23 **of the amount of the advanced payment of the state-based insurance premium tax credit**
545.24 **amount and direct the health carrier to deduct the amount from the eligible individual's**
545.25 **premiums.**

545.26 (b) An individual is eligible for an advanced payment of the state-based health insurance
545.27 premium tax credit if they are a Minnesota resident who:

545.28 (1) **had at least one month of coverage by a qualified health plan offered through MNsure**
545.29 **during the tax year;**

545.30 (2) **was not enrolled in public program coverage under section 256B.055 or 256L.04**
545.31 **during the months of coverage by the qualified health plan; and**

545.32 (3) **is eligible for the health insurance tax credit in section 290.0693.**

546.1 (c) To be eligible for an advanced payment of the state-based health insurance premium
546.2 tax credit, the individual must attest that the individual will file a state tax return in order
546.3 to reconcile any advanced payment of the credit and will file a joint tax return with their
546.4 spouse, if married.

546.5 (d) An individual is not eligible for an advanced payment of the state-based health
546.6 insurance premium tax credit for the taxable year if MNsure is notified by the commissioner
546.7 of revenue that the individual received an advanced payment in a prior tax year and has not
546.8 filed a tax return for the relevant tax year and has not fully paid any amount necessary to
546.9 reconcile the advanced payment.

546.10 Subd. 2. **Payments to health carriers.** The board shall make payments to health carriers
546.11 equal to the amount of the advance state-based health insurance premium tax credit amounts
546.12 provided to eligible individuals effectuating coverage for the months in which the individual
546.13 has paid the net premium amount to the health carrier.

546.14 Subd. 3. **Health carrier responsibilities.** A health carrier that receives notice from
546.15 MNsure that an individual enrolled in the health carrier's qualified health plan is eligible
546.16 for an advanced payment of the state-based health insurance premium tax credit shall:

546.17 (1) reduce the portion of the premium charged to the individual for the applicable months
546.18 by the amount of the state-based health insurance tax credit determined by MNsure;

546.19 (2) include the amount of advanced state-based health insurance premium tax credit
546.20 determined by MNsure on each billing statement for which an advanced state-based health
546.21 insurance tax credit has been applied; and

546.22 (3) reconcile advanced payments of state-based health insurance premium tax credits
546.23 with MNsure at least once a month.

546.24 Subd. 4. **Appeals.** MNsure appeals are available for Minnesota residents for initial
546.25 determinations and redeterminations made by MNsure of eligibility for and level of an
546.26 advanced payment of the state-based health insurance premium tax credit. The appeals must
546.27 follow the procedures enumerated in Minnesota Rules, chapter 7700.

546.28 Subd. 5. **Data practices.** The data classifications in section 62V.06, subdivision 3, apply
546.29 to data on individuals applying for or receiving a state-based health insurance tax credit
546.30 pursuant to this subdivision.

546.31 Subd. 6. **Data sharing.** Notwithstanding any law to the contrary, the board is permitted
546.32 to share or disseminate data in subdivision 5 as described in section 62V.06, subdivision 5.

547.1 Subd. 7. **Appropriations.** Beginning in fiscal year 2021 and each fiscal year thereafter,
547.2 an amount sufficient to make advanced payments of the state-based health insurance tax
547.3 credit is appropriated from the health care access fund to the board for payment of advanced
547.4 state-based health insurance premium tax credits under this section.

547.5 **EFFECTIVE DATE.** This section is effective for advanced payment of the state-based
547.6 health insurance premium tax credit applied to premiums for plan year 2021.

547.7 Sec. 3. **[62V.13] DEFINITIONS.**

547.8 Subdivision 1. **Scope.** For purposes of sections 62V.13 to 62V.133, the following terms
547.9 have the meanings given.

547.10 Subd. 2. **Board.** "Board" means the board of directors of MNsure specified in section
547.11 62V.04.

547.12 Subd. 3. **Eligible individual.** "Eligible individual" means a Minnesota resident who:

547.13 (1) is determined not eligible to receive an advance credit payment under Code of Federal
547.14 Regulations, title 26, section 1.36B-1(j), of the premium tax credit under Code of Federal
547.15 Regulations, title 26, section 1.36B-2, for a given month of coverage;

547.16 (2) is not enrolled in public program coverage under section 256B.055 or 256L.04; and

547.17 (3) purchased a qualified health plan through MNsure.

547.18 Subd. 4. **Gross premium.** "Gross premium" means the amount billed for a qualified
547.19 health plan purchased by an eligible individual prior to a premium subsidy or advanced
547.20 state-based tax credit being applied in a calendar year.

547.21 Subd. 5. **Health carrier.** "Health carrier" has the meaning given in section 62A.011,
547.22 subdivision 2.

547.23 Subd. 6. **MNsure.** "MNsure" means the state health benefit exchange as described in
547.24 section 1311 of the federal Patient Protection and Affordable Care Act, Public Law 111-148,
547.25 and chapter 62V.

547.26 Subd. 7. **Net premium.** "Net premium" means the gross premium less the premium
547.27 subsidy.

547.28 Subd. 8. **Premium subsidy.** "Premium subsidy":

547.29 (1) is a rebate payment to discount the cost of insurance for the promotion of general
547.30 welfare, and is not compensation for any services;

548.1 (2) is equal to 20 percent of the monthly gross premium otherwise paid by or on behalf
548.2 of the eligible individual for qualified health plan coverage purchased through MNsure that
548.3 covers the eligible individual and the eligible individual's covered spouse and covered
548.4 dependents; and

548.5 (3) is excluded from any calculation used to determine eligibility within any of the
548.6 Department of Human Services programs.

548.7 Subd. 9. **Qualified health plan.** "Qualified health plan" means a health plan that meets
548.8 the definition in section 1301(a) of the Affordable Care Act, Public Law 111-148, and has
548.9 been certified by the board in accordance with section 62V.05, subdivision 5, to be offered
548.10 through MNsure.

548.11 Sec. 4. **[62V.131] PAYMENT TO HEALTH CARRIERS ON BEHALF OF ELIGIBLE**
548.12 **INDIVIDUALS.**

548.13 Subdivision 1. **Program established.** The board shall establish and administer the
548.14 premium subsidy program authorized by this act to help eligible individuals pay for coverage
548.15 when purchasing qualified health plans through MNsure in plan year 2020 and in each
548.16 subsequent plan year for which an appropriation is approved.

548.17 Subd. 2. **Administration.** MNsure shall determine if an individual applying for coverage
548.18 through MNsure is an eligible individual. If so, MNsure shall calculate the proper amount
548.19 of the eligible individual's premium subsidy. MNsure shall notify the relevant health carrier
548.20 of the premium subsidy amount and direct the health carrier to deduct the premium subsidy
548.21 amount from the eligible individual's gross premium as a discount to the eligible individual's
548.22 qualified health plan premium.

548.23 Subd. 3. **Payments to health carriers.** (a) The board shall make payments to health
548.24 carriers equal to the amount of the premium subsidy discounts provided to eligible individuals
548.25 effectuating coverage for the months in which the individual has paid the net premium
548.26 amount to the health carrier. Payments to health carriers shall be based on the premium
548.27 subsidy provided on behalf of eligible individuals, regardless of the cost of coverage
548.28 purchased.

548.29 (b) Health carriers seeking reimbursement from the board must submit an invoice and
548.30 supporting information to the board using a format and method developed by the board in
548.31 order to be determined to be eligible for payment.

548.32 (c) The board shall consider health carriers as vendors under section 16A.124, subdivision
548.33 3, and each monthly invoice shall represent the completed delivery of the service.

549.1 Subd. 4. **Data practices.** The data classifications in section 62V.06, subdivision 3, apply
549.2 to data on individuals applying for or receiving a premium subsidy under this subdivision.

549.3 Subd. 5. **Data sharing.** Notwithstanding any law to the contrary, the board is permitted
549.4 to share or disseminate the data in subdivision 4 as described in section 62V.06, subdivision
549.5 5.

549.6 **Sec. 5. [62V.132] APPEALS.**

549.7 MNsure appeals are available for Minnesota residents for initial determinations and
549.8 redeterminations made by MNsure of eligibility for and level of premium subsidy and should
549.9 follow the procedures enumerated in Minnesota Rules, chapter 7700.

549.10 **Sec. 6. [62V.133] APPLICABILITY OF GROSS PREMIUM.**

549.11 Notwithstanding premium subsidies provided under section 62V.131, the premium base
549.12 for calculating the amount of any applicable premium taxes under chapter 297I, shall be
549.13 the gross premium for a qualified health plan purchased by eligible individuals through
549.14 MNsure.

549.15 **Sec. 7. [256B.0371] ADMINISTRATION OF DENTAL SERVICES.**

549.16 Subdivision 1. **Contract for dental administration services.** (a) Effective January 1,
549.17 2022, the commissioner shall contract with a dental administrator to administer dental
549.18 services for all recipients of medical assistance and MinnesotaCare.

549.19 (b) The dental administrator must provide administrative services including but not
549.20 limited to:

549.21 (1) provider recruitment, contracting, and assistance;

549.22 (2) recipient outreach and assistance;

549.23 (3) utilization management and review for medical necessity of dental services;

549.24 (4) dental claims processing;

549.25 (5) coordination with other services;

549.26 (6) management of fraud and abuse;

549.27 (7) monitoring of access to dental services;

549.28 (8) performance measurement;

549.29 (9) quality improvement and evaluation requirements; and

550.1 (10) management of third-party liability requirements.

550.2 (c) Payments to contracted dental providers must be at the rates established under section
550.3 256B.76.

550.4 **EFFECTIVE DATE.** This section is effective January 1, 2022.

550.5 Sec. 8. Minnesota Statutes 2018, section 256B.0644, is amended to read:

550.6 **256B.0644 REIMBURSEMENT UNDER OTHER STATE HEALTH CARE**
550.7 **PROGRAMS.**

550.8 (a) A vendor of medical care, as defined in section 256B.02, subdivision 7, and a health
550.9 maintenance organization, as defined in chapter 62D, must participate as a provider or
550.10 contractor in the medical assistance program and MinnesotaCare as a condition of
550.11 participating as a provider in health insurance plans and programs or contractor for state
550.12 employees established under section 43A.18, the public employees insurance program under
550.13 section 43A.316, for health insurance plans offered to local statutory or home rule charter
550.14 city, county, and school district employees, the workers' compensation system under section
550.15 176.135, and insurance plans provided through the Minnesota Comprehensive Health
550.16 Association under sections 62E.01 to 62E.19. The limitations on insurance plans offered to
550.17 local government employees shall not be applicable in geographic areas where provider
550.18 participation is limited by managed care contracts with the Department of Human Services.
550.19 This section does not apply to dental service providers providing dental services outside
550.20 the seven-county metropolitan area.

550.21 (b) For providers other than health maintenance organizations, participation in the medical
550.22 assistance program means that:

550.23 (1) the provider accepts new medical assistance and MinnesotaCare patients;

550.24 (2) for providers other than dental service providers, at least 20 percent of the provider's
550.25 patients are covered by medical assistance and MinnesotaCare as their primary source of
550.26 coverage; or

550.27 (3) for dental service providers providing dental services in the seven-county metropolitan
550.28 area, at least ten percent of the provider's patients are covered by medical assistance and
550.29 MinnesotaCare as their primary source of coverage, or the provider accepts new medical
550.30 assistance and MinnesotaCare patients who are children with special health care needs. For
550.31 purposes of this section, "children with special health care needs" means children up to age
550.32 18 who: (i) require health and related services beyond that required by children generally;
550.33 and (ii) have or are at risk for a chronic physical, developmental, behavioral, or emotional

551.1 condition, including: bleeding and coagulation disorders; immunodeficiency disorders;
 551.2 cancer; endocrinopathy; developmental disabilities; epilepsy, cerebral palsy, and other
 551.3 neurological diseases; visual impairment or deafness; Down syndrome and other genetic
 551.4 disorders; autism; fetal alcohol syndrome; and other conditions designated by the
 551.5 commissioner after consultation with representatives of pediatric dental providers and
 551.6 consumers.

551.7 (c) Patients seen on a volunteer basis by the provider at a location other than the provider's
 551.8 usual place of practice may be considered in meeting the participation requirement in this
 551.9 section. The commissioner shall establish participation requirements for health maintenance
 551.10 organizations. The commissioner shall provide lists of participating medical assistance
 551.11 providers on a quarterly basis to the commissioner of management and budget, the
 551.12 commissioner of labor and industry, and the commissioner of commerce. Each of the
 551.13 commissioners shall develop and implement procedures to exclude as participating providers
 551.14 in the program or programs under their jurisdiction those providers who do not participate
 551.15 in the medical assistance program. The commissioner of management and budget shall
 551.16 implement this section through contracts with participating health and dental carriers.

551.17 (d) A volunteer dentist who has signed a volunteer agreement under section 256B.0625,
 551.18 subdivision 9a, shall not be considered to be participating in medical assistance or
 551.19 MinnesotaCare for the purpose of this section.

551.20 (e) A vendor of medical care, as defined in section 256B.02, subdivision 7, that dispenses
 551.21 outpatient prescription drugs in accordance with chapter 151 must participate as a provider
 551.22 or contractor in the MinnesotaCare program as a condition of participating as a provider in
 551.23 the medical assistance program.

551.24 **EFFECTIVE DATE.** This section is effective January 1, 2022.

551.25 Sec. 9. Minnesota Statutes 2018, section 256B.69, subdivision 6d, is amended to read:

551.26 Subd. 6d. **Prescription drugs.** The commissioner ~~may~~ shall exclude or ~~modify~~ coverage
 551.27 for prescription drugs from the prepaid managed care contracts entered into under this
 551.28 section ~~in order to increase savings to the state by collecting additional prescription drug~~
 551.29 ~~rebates. The contracts must maintain incentives for the managed care plan to manage drug~~
 551.30 ~~costs and utilization and may require that the managed care plans maintain an open drug~~
 551.31 ~~formulary. In order to manage drug costs and utilization, the contracts may authorize the~~
 551.32 ~~managed care plans to use preferred drug lists and prior authorization. This subdivision is~~
 551.33 ~~contingent on federal approval of the managed care contract changes and the collection of~~
 551.34 ~~additional prescription drug rebates.~~

552.1 **EFFECTIVE DATE.** This section is effective January 1, 2022.

552.2 Sec. 10. Minnesota Statutes 2018, section 256B.69, subdivision 35, is amended to read:

552.3 Subd. 35. **Statewide procurement.** (a) For calendar year 2015, the commissioner may
552.4 extend a demonstration provider's contract under this section for a sixth year after the most
552.5 recent procurement. For calendar year 2015, section 16B.98, subdivision 5, paragraph (b),
552.6 and section 16C.05, subdivision 2, paragraph (b), shall not apply to contracts under this
552.7 section.

552.8 (b) For calendar year 2016 contracts under this section, the commissioner shall procure
552.9 through a statewide procurement, which includes all 87 counties, demonstration providers,
552.10 and participating entities as defined in section 256L.01, subdivision 7. The commissioner
552.11 shall publish a request for proposals by January 5, 2015. As part of the procurement process,
552.12 the commissioner shall:

552.13 (1) seek each individual county's input;

552.14 (2) organize counties into regional groups, and consider single counties for the largest
552.15 and most diverse counties; and

552.16 (3) seek regional and county input regarding the respondent's ability to fully and
552.17 adequately deliver required health care services, offer an adequate provider network, provide
552.18 care coordination with county services, and serve special populations, including enrollees
552.19 with language and cultural needs.

552.20 (c) For calendar year 2021, the commissioner may extend a demonstration provider's
552.21 contract under this section for a sixth year after the most recent procurement, for the provision
552.22 of services in the seven-county metropolitan area to families and children under medical
552.23 assistance and MinnesotaCare. For calendar year 2021, sections 16B.98, subdivision 5,
552.24 paragraph (b), and 16C.06, subdivision 3b, shall not apply to contracts under this section.
552.25 For calendar year 2022, the commissioner shall procure services in the seven-county
552.26 metropolitan area for families and children under medical assistance and MinnesotaCare,
552.27 from demonstration providers and participating entities as defined in section 256L.01,
552.28 subdivision 7.

552.29 Sec. 11. Minnesota Statutes 2018, section 256B.76, subdivision 2, is amended to read:

552.30 Subd. 2. **Dental reimbursement.** (a) Effective for services rendered on or after October
552.31 1, 1992, the commissioner shall make payments for dental services as follows:

553.1 (1) dental services shall be paid at the lower of (i) submitted charges, or (ii) 25 percent
553.2 above the rate in effect on June 30, 1992; and

553.3 (2) dental rates shall be converted from the 50th percentile of 1982 to the 50th percentile
553.4 of 1989, less the percent in aggregate necessary to equal the above increases.

553.5 (b) Beginning October 1, 1999, the payment for tooth sealants and fluoride treatments
553.6 shall be the lower of (1) submitted charge, or (2) 80 percent of median 1997 charges.

553.7 (c) Effective for services rendered on or after January 1, 2000, payment rates for dental
553.8 services shall be increased by three percent over the rates in effect on December 31, 1999.

553.9 (d) Effective for services provided on or after January 1, 2002, payment for diagnostic
553.10 examinations and dental x-rays provided to children under age 21 shall be the lower of (1)
553.11 the submitted charge, or (2) 85 percent of median 1999 charges.

553.12 (e) The increases listed in paragraphs (b) and (c) shall be implemented January 1, 2000,
553.13 for managed care.

553.14 (f) Effective for dental services rendered on or after October 1, 2010, by a state-operated
553.15 dental clinic, payment shall be paid on a reasonable cost basis that is based on the Medicare
553.16 principles of reimbursement. This payment shall be effective for services rendered on or
553.17 after January 1, 2011, to recipients enrolled in managed care plans or county-based
553.18 purchasing plans.

553.19 (g) Beginning in fiscal year 2011, if the payments to state-operated dental clinics in
553.20 paragraph (f), including state and federal shares, are less than \$1,850,000 per fiscal year, a
553.21 supplemental state payment equal to the difference between the total payments in paragraph
553.22 (f) and \$1,850,000 shall be paid from the general fund to state-operated services for the
553.23 operation of the dental clinics.

553.24 (h) If the cost-based payment system for state-operated dental clinics described in
553.25 paragraph (f) does not receive federal approval, then state-operated dental clinics shall be
553.26 designated as critical access dental providers under subdivision 4, paragraph (b), and shall
553.27 receive the critical access dental reimbursement rate as described under subdivision 4,
553.28 paragraph (a).

553.29 (i) Effective for services rendered on or after September 1, 2011, through June 30, 2013,
553.30 payment rates for dental services shall be reduced by three percent. This reduction does not
553.31 apply to state-operated dental clinics in paragraph (f).

553.32 (j) Effective for services rendered on or after January 1, 2014, payment rates for dental
553.33 services shall be increased by five percent from the rates in effect on December 31, 2013.

554.1 This increase does not apply to state-operated dental clinics in paragraph (f), federally
554.2 qualified health centers, rural health centers, and Indian health services. Effective January
554.3 1, 2014, payments made to managed care plans and county-based purchasing plans under
554.4 sections 256B.69, 256B.692, and 256L.12 shall reflect the payment increase described in
554.5 this paragraph.

554.6 (k) Effective for services rendered on or after July 1, 2015, through December 31, 2016,
554.7 the commissioner shall increase payment rates for services furnished by dental providers
554.8 located outside of the seven-county metropolitan area by the maximum percentage possible
554.9 above the rates in effect on June 30, 2015, while remaining within the limits of funding
554.10 appropriated for this purpose. This increase does not apply to state-operated dental clinics
554.11 in paragraph (f), federally qualified health centers, rural health centers, and Indian health
554.12 services. Effective January 1, 2016, through December 31, 2016, payments to managed care
554.13 plans and county-based purchasing plans under sections 256B.69 and 256B.692 shall reflect
554.14 the payment increase described in this paragraph. The commissioner shall require managed
554.15 care and county-based purchasing plans to pass on the full amount of the increase, in the
554.16 form of higher payment rates to dental providers located outside of the seven-county
554.17 metropolitan area.

554.18 (l) Effective for services provided on or after January 1, 2017, through December 31,
554.19 2021, the commissioner shall increase payment rates by 9.65 percent for dental services
554.20 provided outside of the seven-county metropolitan area. This increase does not apply to
554.21 state-operated dental clinics in paragraph (f), federally qualified health centers, rural health
554.22 centers, or Indian health services. Effective January 1, 2017, payments to managed care
554.23 plans and county-based purchasing plans under sections 256B.69 and 256B.692 shall reflect
554.24 the payment increase described in this paragraph.

554.25 (m) Effective for services provided on or after July 1, 2017, through December 31, 2021,
554.26 the commissioner shall increase payment rates by 23.8 percent for dental services provided
554.27 to enrollees under the age of 21. This rate increase does not apply to state-operated dental
554.28 clinics in paragraph (f), federally qualified health centers, rural health centers, or Indian
554.29 health centers. This rate increase does not apply to managed care plans and county-based
554.30 purchasing plans.

554.31 (n) Effective for dental services provided on or after January 1, 2022, the commissioner
554.32 shall increase payment rates by 54 percent. This rate increase does not apply to state-operated
554.33 dental clinics in paragraph (f), federally qualified health centers, rural health centers, or
554.34 Indian health centers.

555.1 Sec. 12. Minnesota Statutes 2018, section 256B.76, subdivision 4, is amended to read:

555.2 Subd. 4. **Critical access dental providers.** (a) The commissioner shall increase
555.3 reimbursements to dentists and dental clinics deemed by the commissioner to be critical
555.4 access dental providers. For dental services rendered on or after July 1, 2016, through
555.5 December 31, 2021, the commissioner shall increase reimbursement by 37.5 percent above
555.6 the reimbursement rate that would otherwise be paid to the critical access dental provider,
555.7 except as specified under paragraph (b). The commissioner shall pay the managed care
555.8 plans and county-based purchasing plans in amounts sufficient to reflect increased
555.9 reimbursements to critical access dental providers as approved by the commissioner.

555.10 (b) For dental services rendered on or after July 1, 2016, by a dental clinic or dental
555.11 group that meets the critical access dental provider designation under paragraph (d), clause
555.12 (4), and is owned and operated by a health maintenance organization licensed under chapter
555.13 62D, the commissioner shall increase reimbursement by 35 percent above the reimbursement
555.14 rate that would otherwise be paid to the critical access provider.

555.15 (c) Critical access dental payments made under paragraph (a) or (b) for dental services
555.16 provided by a critical access dental provider to an enrollee of a managed care plan or
555.17 county-based purchasing plan must not reflect any capitated payments or cost-based payments
555.18 from the managed care plan or county-based purchasing plan. The managed care plan or
555.19 county-based purchasing plan must base the additional critical access dental payment on
555.20 the amount that would have been paid for that service had the dental provider been paid
555.21 according to the managed care plan or county-based purchasing plan's fee schedule that
555.22 applies to dental providers that are not paid under a capitated payment or cost-based payment.

555.23 (d) The commissioner shall designate the following dentists and dental clinics as critical
555.24 access dental providers:

555.25 (1) nonprofit community clinics that:

555.26 (i) have nonprofit status in accordance with chapter 317A;

555.27 (ii) have tax exempt status in accordance with the Internal Revenue Code, section
555.28 501(c)(3);

555.29 (iii) are established to provide oral health services to patients who are low income,
555.30 uninsured, have special needs, and are underserved;

555.31 (iv) have professional staff familiar with the cultural background of the clinic's patients;

555.32 (v) charge for services on a sliding fee scale designed to provide assistance to low-income
555.33 patients based on current poverty income guidelines and family size;

556.1 (vi) do not restrict access or services because of a patient's financial limitations or public
556.2 assistance status; and

556.3 (vii) have free care available as needed;

556.4 (2) federally qualified health centers, rural health clinics, and public health clinics;

556.5 (3) hospital-based dental clinics owned and operated by a city, county, or former state
556.6 hospital as defined in section 62Q.19, subdivision 1, paragraph (a), clause (4);

556.7 (4) a dental clinic or dental group owned and operated by a nonprofit corporation in
556.8 accordance with chapter 317A with more than 10,000 patient encounters per year with
556.9 patients who are uninsured or covered by medical assistance or MinnesotaCare;

556.10 (5) a dental clinic owned and operated by the University of Minnesota or the Minnesota
556.11 State Colleges and Universities system; and

556.12 (6) private practicing dentists if:

556.13 (i) the dentist's office is located within the seven-county metropolitan area and more
556.14 than 50 percent of the dentist's patient encounters per year are with patients who are uninsured
556.15 or covered by medical assistance or MinnesotaCare; or

556.16 (ii) the dentist's office is located outside the seven-county metropolitan area and more
556.17 than 25 percent of the dentist's patient encounters per year are with patients who are uninsured
556.18 or covered by medical assistance or MinnesotaCare.

556.19 Sec. 13. Minnesota Statutes 2018, section 256L.03, is amended by adding a subdivision
556.20 to read:

556.21 Subd. 7. **Outpatient prescription drugs.** Outpatient prescription drugs are covered
556.22 according to section 256L.30. This subdivision applies to all individuals enrolled in the
556.23 MinnesotaCare program.

556.24 **EFFECTIVE DATE.** This section is effective January 1, 2022.

556.25 Sec. 14. Minnesota Statutes 2018, section 256L.07, subdivision 2, is amended to read:

556.26 Subd. 2. **Must not have access to employer-subsidized minimum essential**
556.27 **coverage.** (a) To be eligible, a family or individual must not have access to subsidized health
556.28 coverage that is affordable and provides minimum value as defined in Code of Federal
556.29 Regulations, title 26, section 1.36B-2.

557.1 (b) Notwithstanding paragraph (a), an individual who has access to subsidized health
557.2 coverage through a spouse's employer that is deemed minimum essential coverage under
557.3 Code of Federal Regulations, title 26, section 1.36B-2, is eligible for MinnesotaCare if the
557.4 portion of the annual premium the employee pays for employee and dependent coverage
557.5 exceeds the required contribution percentage as described in Code of Federal Regulations,
557.6 title 26, section 1.36B-2, and the individual meets all other eligibility requirements of this
557.7 chapter.

557.8 ~~(b)~~ (c) This subdivision does not apply to a family or individual who no longer has
557.9 employer-subsidized coverage due to the employer terminating health care coverage as an
557.10 employee benefit.

557.11 **EFFECTIVE DATE.** This section is effective January 1, 2020, or upon federal approval,
557.12 whichever is later. The commissioner of human services shall notify the revisor of statutes
557.13 when federal approval is obtained.

557.14 Sec. 15. Minnesota Statutes 2018, section 256L.07, is amended by adding a subdivision
557.15 to read:

557.16 Subd. 2b. **Federal waiver.** The commissioner of human services, in consultation with
557.17 the Board of Directors of MNsure, shall apply for a federal waiver to allow the state to
557.18 permit a person who has access to employer-sponsored health insurance through a spouse
557.19 or parent that is deemed minimum essential coverage under Code of Federal Regulations,
557.20 title 26, section 1.36B-2, and the portion of the annual premium the person pays for employee
557.21 and dependent coverage exceeds the required contribution percentage in Code of Federal
557.22 Regulations, title 26, section 1.36B-2, to:

557.23 (1) enroll in the MinnesotaCare program, if the person meets all eligibility requirements,
557.24 except for section 256L.07, subdivision 2, paragraph (a);

557.25 (2) qualify for advanced premium tax credits under Code of Federal Regulations, title
557.26 26, section 1.36B-2, and cost sharing reductions under Code of Federal Regulations, title
557.27 45, section 155.305(g), if the person meets all eligibility requirements, except for the
557.28 affordability requirement described in Code of Federal Regulations, title 26, section 1.36B-2
557.29 (c)(3)(v)(A)(2); and

557.30 (3) qualify to purchase coverage in the OneCare Buy-In pursuant to section 256T.03, if
557.31 the person meets all eligibility requirements.

557.32 **EFFECTIVE DATE.** This section is effective the day following final enactment.

558.1 Sec. 16. Minnesota Statutes 2018, section 256L.11, subdivision 7, is amended to read:

558.2 Subd. 7. **Critical access dental providers.** Effective for dental services provided to
558.3 MinnesotaCare enrollees on or after July 1, 2017, through December 31, 2021, the
558.4 commissioner shall increase payment rates to dentists and dental clinics deemed by the
558.5 commissioner to be critical access providers under section 256B.76, subdivision 4, by 20
558.6 percent above the payment rate that would otherwise be paid to the provider. The
558.7 commissioner shall pay the prepaid health plans under contract with the commissioner
558.8 amounts sufficient to reflect this rate increase. The prepaid health plan must pass this rate
558.9 increase to providers who have been identified by the commissioner as critical access dental
558.10 providers under section 256B.76, subdivision 4.

558.11 Sec. 17. **[256L.30] OUTPATIENT PRESCRIPTION DRUGS.**

558.12 Subdivision 1. Establishment of program. The commissioner shall administer and
558.13 oversee the outpatient prescription drug program for MinnesotaCare. The commissioner
558.14 shall not include the outpatient pharmacy benefit in a contract with a public or private entity.

558.15 Subd. 2. Covered outpatient prescription drugs. (a) In consultation with the Drug
558.16 Formulary Committee under section 256B.0625, subdivision 13d, the commissioner shall
558.17 establish an outpatient prescription drug formulary for MinnesotaCare that satisfies the
558.18 requirements for an essential health benefit under Code of Federal Regulations, title 45,
558.19 section 156.122. The commissioner may modify the formulary after consulting with the
558.20 Drug Formulary Committee and providing public notice and the opportunity for public
558.21 comment. The commissioner is exempt from the rulemaking requirements of chapter 14 to
558.22 establish the drug formulary, and section 14.386 does not apply. The commissioner shall
558.23 make the drug formulary available to the public on the agency website.

558.24 (b) The MinnesotaCare formulary must contain at least one drug in every United States
558.25 Pharmacopeia category and class or the same number of prescription drugs in each category
558.26 and class as the essential health benefit benchmark plan, whichever is greater.

558.27 (c) The commissioner may negotiate drug rebates or discounts directly with a drug
558.28 manufacturer to place a drug on the formulary. The commissioner may also negotiate drug
558.29 rebates, or discounts, with a drug manufacturer through a contract with a vendor. The
558.30 commissioner, beginning January 15, 2022, and each January 15 thereafter, shall notify the
558.31 chairs and ranking minority members of the legislative committees with jurisdiction over
558.32 health and human services policy and finance of the rebates and discounts negotiated, their
558.33 aggregate dollar value, and how the department applied these savings, including the extent
558.34 to which these savings were passed on to enrollees.

559.1 (d) Prior authorization may be required by the commissioner before certain formulary
559.2 drugs are eligible for payment. The Drug Formulary Committee may recommend drugs for
559.3 prior authorization directly to the commissioner. The commissioner may also request that
559.4 the Drug Formulary Committee review a drug for prior authorization.

559.5 (e) Before the commissioner requires prior authorization for a drug:

559.6 (1) the commissioner must provide the Drug Formulary Committee with information
559.7 on the impact that placing the drug on prior authorization may have on the quality of patient
559.8 care and on program costs and information regarding whether the drug is subject to clinical
559.9 abuse or misuse if such data is available; and

559.10 (2) the Drug Formulary Committee must hold a public forum and receive public comment
559.11 for an additional 15 days from the date of the public forum.

559.12 (f) Notwithstanding paragraph (e), the commissioner may automatically require prior
559.13 authorization for a period not to exceed 180 days for any drug that is approved by the United
559.14 States Food and Drug Administration after July 1, 2019. The 180-day period begins no later
559.15 than the first day that a drug is available for shipment to pharmacies within the state. The
559.16 Drug Formulary Committee shall recommend to the commissioner general criteria to use
559.17 for determining prior authorization of the drugs, but the Drug Formulary Committee is not
559.18 required to review each individual drug.

559.19 (g) The commissioner may also require prior authorization before nonformulary drugs
559.20 are eligible for payment.

559.21 (h) Prior authorization requests must be processed in accordance with Code of Federal
559.22 Regulations, title 45, section 156.122.

559.23 **Subd. 3. Pharmacy provider participation.** (a) A pharmacy enrolled to dispense
559.24 prescription drugs to medical assistance enrollees under section 256B.0625 must participate
559.25 as a provider in the MinnesotaCare outpatient prescription drug program.

559.26 (b) A pharmacy that is enrolled to dispense prescription drugs to MinnesotaCare enrollees
559.27 is not permitted to refuse service to an enrollee unless:

559.28 (1) the pharmacy does not have a prescription drug in stock and cannot obtain the drug
559.29 in time to treat the enrollee's medical condition;

559.30 (2) the enrollee is unable or unwilling to pay the enrollee's co-payment at the time the
559.31 drug is dispensed;

560.1 (3) after performing drug utilization review, the pharmacist identifies the prescription
560.2 drug as being a therapeutic duplication, having a drug-disease contraindication, having a
560.3 drug-drug interaction, having been prescribed for the incorrect dosage or duration of
560.4 treatment, having a drug-allergy interaction, or having issues related to clinical abuse or
560.5 misuse by the enrollee;

560.6 (4) the prescription drug is not covered by MinnesotaCare; or

560.7 (5) dispensing the drug would violate a provision of chapter 151.

560.8 Subd. 4. Covered outpatient prescription drug reimbursement rate. (a) The basis
560.9 for determining the amount of payment shall be the lowest of the National Average Drug
560.10 Acquisition Cost, plus a fixed dispensing fee; the maximum allowable cost established
560.11 under section 256B.0625, subdivision 13e, plus a fixed dispensing fee; or the usual and
560.12 customary price. The fixed dispensing fee shall be \$1.50 for covered outpatient prescription
560.13 drugs.

560.14 (b) The basis for determining the amount of payment for a pharmacy that acquires drugs
560.15 through the federal 340B Drug Pricing Program shall be the lowest of:

560.16 (1) the National Average Drug Acquisition Cost minus 30 percent;

560.17 (2) the maximum allowable cost established under section 256B.0625, subdivision 13e,
560.18 minus 30 percent, plus a fixed dispensing fee; or

560.19 (3) the usual and customary price. The fixed dispensing fee shall be \$1.50 for covered
560.20 outpatient prescription drugs.

560.21 (c) For purposes of this subdivision, the usual and customary price is the lowest price
560.22 charged by the provider to a patient who pays for the prescription by cash, check, or charge
560.23 account and includes the prices the pharmacy charges to customers enrolled in a prescription
560.24 savings club or prescription discount club administered by the pharmacy, pharmacy chain,
560.25 or contractor to the provider.

560.26 **EFFECTIVE DATE.** This section is effective January 1, 2022.

560.27 Sec. 18. **[256T.01] DEFINITIONS.**

560.28 Subdivision 1. **Application.** For purposes of this chapter, the terms in this section have
560.29 the meanings given.

560.30 Subd. 2. **Commissioner.** "Commissioner" means the commissioner of human services.

560.31 Subd. 3. **Department.** "Department" means the Department of Human Services.

561.1 Subd. 4. **Essential health benefits.** "Essential health benefits" has the meaning given
561.2 in section 62Q.81, subdivision 4.

561.3 Subd. 5. **Health plan.** "Health plan" has the meaning given in section 62A.011,
561.4 subdivision 3.

561.5 Subd. 6. **Individual market.** "Individual market" has the meaning given in section
561.6 62A.011, subdivision 5.

561.7 Subd. 7. **MNsure website.** "MNsure website" has the meaning given in section 62V.02,
561.8 subdivision 13.

561.9 Subd. 8. **Qualified health plan.** "Qualified health plan" has the meaning given in section
561.10 62A.011, subdivision 7.

561.11 **EFFECTIVE DATE.** This section is effective the day following final enactment.

561.12 Sec. 19. **[256T.02] ONECARE BUY-IN.**

561.13 Subdivision 1. **Establishment.** (a) The commissioner shall establish a program consistent
561.14 with this section to offer products developed for the OneCare Buy-In through the MNsure
561.15 website.

561.16 (b) The commissioner, in collaboration with the commissioner of commerce and the
561.17 MNsure Board, shall:

561.18 (1) establish a cost allocation methodology to reimburse MNsure operations in lieu of
561.19 the premium withhold for qualified health plans under section 62V.05;

561.20 (2) implement mechanisms to ensure the long-term financial sustainability of Minnesota's
561.21 public health care programs and mitigate any adverse financial impacts to the state and
561.22 MNsure. These mechanisms must minimize adverse selection, state financial risk and
561.23 contribution, and negative impacts to premiums in the individual and group health insurance
561.24 markets; and

561.25 (3) coordinate eligibility, coverage, and provider networks to ensure that persons, to the
561.26 extent possible, transitioning between medical assistance, MinnesotaCare, and the OneCare
561.27 Buy-In have continuity of care.

561.28 (c) The OneCare Buy-In shall be considered:

561.29 (1) a public health care program for purposes of chapter 62V; and

561.30 (2) the MinnesotaCare program for purposes of requirements for health maintenance
561.31 organizations under section 62D.04, subdivision 5, and providers under section 256B.0644.

562.1 (d) The Department of Human Services is deemed to meet and receive certification and
562.2 authority under section 62D.03 and be in compliance with sections 62D.01 to 62D.30. The
562.3 commissioner has the authority to accept and expend all federal funds made available under
562.4 this chapter upon federal approval.

562.5 (e) Unless otherwise specified under this chapter, health plans offered under the OneCare
562.6 Buy-In program must meet all requirements of chapters 62A, 62D, 62K, 62M, 62Q, and
562.7 62V determined to be applicable by the regulating authority.

562.8 Subd. 2. **Premium administration and payment.** (a) The commissioner shall establish
562.9 annually a per-enrollee monthly premium rate.

562.10 (b) OneCare Buy-In premium administration shall be consistent with requirements under
562.11 the federal Affordable Care Act for qualified health plan premium administration. Premium
562.12 rates shall be established in accordance with section 62A.65, subdivision 3.

562.13 Subd. 3. **Rates to providers.** The commissioner shall establish rates for provider
562.14 payments that are targeted to the current rates established under chapter 256L, plus the
562.15 aggregate difference between those rates and Medicare rates. The aggregate must not consider
562.16 services that receive a Medicare encounter payment.

562.17 Subd. 4. **Reserve and other financial requirements.** (a) A OneCare Buy-In reserve
562.18 account is established in the state treasury. Enrollee premiums collected under subdivision
562.19 2 shall be deposited into the reserve account. The reserve account shall be used to cover
562.20 expenditures related to operation of the OneCare Buy-In, including the payment of claims
562.21 and all other accrued liabilities. No other account within the state treasury shall be used to
562.22 finance the reserve account except as otherwise specified in state law.

562.23 (b) Beginning January 1, 2023, enrollee premiums shall be set at a level sufficient to
562.24 fund all ongoing claims costs and all ongoing costs necessary to manage the program and
562.25 support ongoing maintenance of information technology systems and operational and
562.26 administrative functions of the OneCare Buy-In program.

562.27 (c) The commissioner is prohibited from expending state dollars beyond what is
562.28 specifically appropriated in law, or transferring funds from other accounts, in order to fund
562.29 the reserve account, fund claims costs, or support ongoing administration and operation of
562.30 the program and its information technology systems.

562.31 Subd. 5. **Covered benefits.** Each health plan established under this chapter must include
562.32 the essential health benefits package required under section 1302(a) of the Affordable Care
562.33 Act and as described in section 62Q.81; dental services described in section 256B.0625,

563.1 subdivision 9, paragraphs (b) and (c); and vision services described in Minnesota Rules,
563.2 part 9505.0277, and may include other services under section 256L.03, subdivision 1.

563.3 Subd. 6. **Third-party administrator.** (a) The commissioner may enter into a contract
563.4 with a third-party administrator to perform the operational management of the OneCare
563.5 Buy-In. Duties of the third-party administrator include but are not limited to the following:

563.6 (1) development and distribution of plan materials for potential enrollees;

563.7 (2) receipt and processing of electronic enrollment files sent from the state;

563.8 (3) creation and distribution of plan enrollee materials including identification cards,
563.9 certificates of coverage, a plan formulary, a provider directory, and premium billing
563.10 statements;

563.11 (4) processing premium payments and sending termination notices for nonpayment to
563.12 enrollees and the state;

563.13 (5) payment and adjudication of claims;

563.14 (6) utilization management;

563.15 (7) coordination of benefits;

563.16 (8) grievance and appeals activities; and

563.17 (9) fraud, waste, and abuse prevention activities.

563.18 (b) Any solicitation of vendors to serve as the third-party administrator is subject to the
563.19 requirements under section 16C.06.

563.20 Subd. 7. **Eligibility.** (a) To be eligible for the OneCare Buy-In, a person must:

563.21 (1) be a resident of Minnesota; and

563.22 (2) not be enrolled in government-sponsored programs as defined in United States Code,
563.23 title 26, section 5000A(f)(1)(A). For purposes of this subdivision, an applicant who is
563.24 enrolled in Medicare Part A or enrolled in Medicare Part B coverage under title XVIII of
563.25 the Social Security Act, United States Code, title 42, sections 1395c to 1395w-152, is
563.26 considered enrolled in government-sponsored programs. An applicant shall not refuse to
563.27 apply for or enroll in Medicare coverage to establish eligibility for the OneCare Buy-In.

563.28 (b) A person who is determined eligible for enrollment in a qualified health plan with
563.29 or without advance payments of the premium tax credit and with or without cost-sharing
563.30 reductions according to Code of Federal Regulations, title 45, section 155.305, paragraphs

564.1 (a), (f), and (g), is eligible to purchase and enroll in the OneCare Buy-In instead of purchasing
564.2 a qualified health plan as defined under section 62V.02.

564.3 Subd. 8. **Enrollment.** (a) A person may apply for the OneCare Buy-In during the annual
564.4 open and special enrollment periods established for MNsure as defined in Code of Federal
564.5 Regulations, title 45, sections 155.410 and 155.420, through the MNsure website.

564.6 (b) A person must annually reenroll for the OneCare Buy-In during open and special
564.7 enrollment periods.

564.8 Subd. 9. **Premium tax credits, cost-sharing reductions, and subsidies.** A person who
564.9 is eligible under this chapter, and whose income is less than or equal to 400 percent of the
564.10 federal poverty guidelines, may qualify for advance premium tax credits and cost-sharing
564.11 reductions under Code of Federal Regulations, title 45, section 155.305, paragraphs (a), (f),
564.12 and (g), to purchase a health plan established under this chapter.

564.13 Subd. 10. **Covered benefits and payment rate modifications.** The commissioner, after
564.14 providing public notice and an opportunity for public comment, may modify the covered
564.15 benefits and payment rates to carry out this chapter.

564.16 Subd. 11. **Provider tax.** Section 295.582, subdivision 1, applies to health plans offered
564.17 under the OneCare Buy-In program.

564.18 Subd. 12. **Request for federal authority.** The commissioner shall seek all necessary
564.19 federal waivers to establish the OneCare Buy-In under this chapter.

564.20 **EFFECTIVE DATE.** (a) Subdivisions 1 to 11 are effective January 1, 2023.

564.21 (b) Subdivision 12 is effective the day following final enactment.

564.22 Sec. 20. **[256T.03] ONECARE BUY-IN PRODUCTS.**

564.23 Subdivision 1. **Platinum product.** The commissioner of human services shall establish
564.24 a OneCare Buy-In coverage option that provides platinum level of coverage in accordance
564.25 with the Affordable Care Act and benefits that are actuarially equivalent to 90 percent of
564.26 the full actuarial value of the benefits provided under the OneCare Buy-In coverage option.
564.27 This product must be made available in all rating areas in the state.

564.28 Subd. 2. **Silver and gold products.** (a) If any rating area lacks an affordable or
564.29 comprehensive health care coverage option according to standards developed by the
564.30 commissioner of health, the following year the commissioner of human services shall offer
564.31 silver and gold products established under paragraph (b) in the rating area for a five-year
564.32 period.

565.1 (b) The commissioner shall establish the following OneCare Buy-In coverage options:
565.2 one coverage option shall provide silver level of coverage in accordance with the Affordable
565.3 Care Act and benefits that are actuarially equivalent to 70 percent of the full actuarial value
565.4 of the benefits provided under the OneCare Buy-In coverage option, and one coverage
565.5 option shall provide gold level of coverage in accordance with the Affordable Care Act and
565.6 benefits that are actuarially equivalent to 80 percent of the full actuarial value of the benefits
565.7 provided under the OneCare Buy-In coverage option.

565.8 Subd. 3. **Qualified health plan rules.** (a) The coverage options developed under this
565.9 section are subject to the process under section 62K.06. The coverage options developed
565.10 under this section shall meet requirements of chapters 62A, 62K, and 62V that apply to
565.11 qualified health plans.

565.12 (b) The Department of Human Services is not an insurance company for purposes of
565.13 this chapter.

565.14 Subd. 4. **Actuarial value.** Determination of the actuarial value of coverage options under
565.15 this section must be calculated in accordance with Code of Federal Regulations, title 45,
565.16 section 156.135.

565.17 **EFFECTIVE DATE.** This section is effective January 1, 2023.

565.18 Sec. 21. **[256T.04] OUTPATIENT PRESCRIPTION DRUGS.**

565.19 Subdivision 1. **Establishment of program.** The commissioner shall administer and
565.20 oversee the outpatient prescription drug program for the OneCare Buy-In program. The
565.21 commissioner shall not include the outpatient pharmacy benefit in a contract with a public
565.22 or private entity.

565.23 Subd. 2. **Covered outpatient prescription drugs.** Outpatient prescription drugs are
565.24 covered in accordance with chapter 256L.

565.25 Subd. 3. **Pharmacy provider participation.** Pharmacy provider participation shall be
565.26 governed by section 256L.30, subdivision 3.

565.27 Subd. 4. **Reimbursement rate.** The commissioner shall establish outpatient prescription
565.28 drug reimbursement rates according to chapter 256L.

565.29 **EFFECTIVE DATE.** This section is effective January 1, 2023.

566.1 Sec. 22. Minnesota Statutes 2018, section 270B.12, is amended by adding a subdivision
566.2 to read:

566.3 Subd. 15. **Board of Directors of MNsure.** The commissioner may disclose return
566.4 information to the extent necessary to the Board of Directors of MNsure to determine
566.5 eligibility under section 62V.12, subdivision 1.

566.6 **EFFECTIVE DATE.** This section is effective for taxable years beginning after December
566.7 31, 2020.

566.8 Sec. 23. Minnesota Statutes 2018, section 290.0131, is amended by adding a subdivision
566.9 to read:

566.10 Subd. 15. **Health insurance premiums.** The amount of health insurance premiums
566.11 deducted on the taxpayer's federal return, to the extent used to calculate the credit under
566.12 section 290.0693, is an addition.

566.13 **EFFECTIVE DATE.** This section is effective for taxable years beginning after December
566.14 31, 2020.

566.15 Sec. 24. **[290.0693] HEALTH INSURANCE PREMIUM CREDIT.**

566.16 Subdivision 1. **Credit allowed.** (a) An individual who is a resident of Minnesota is
566.17 allowed a credit against the tax due under this chapter if the individual would be allowed a
566.18 credit under section 36B of the Internal Revenue Code, except that the individual's household
566.19 income, as defined in section 36B(d)(2) of the Internal Revenue Code, exceeds 400 percent
566.20 of the poverty line for the individual's family size as defined in section 36B(d)(3) of the
566.21 Internal Revenue Code.

566.22 (b) In the determination of "coverage month" under section 36B(c)(2) of the Internal
566.23 Revenue Code, section 36B(c)(2)(B) and (C) must not apply.

566.24 (c) The credit is equal to what the credit would have been under section 36B of the
566.25 Internal Revenue Code, except the applicable percentage for purposes of section
566.26 36B(b)(2)(B)(ii) of the Internal Revenue Code is the highest premium percentage in section
566.27 36B(b)(3)(A) of the Internal Revenue Code.

566.28 (d) The amount of monthly premiums taken into account under section 36B(b)(2)(A) of
566.29 the Internal Revenue Code must be reduced by the amount of premium subsidy made by
566.30 MNsure and applied to the gross premium.

567.1 Subd. 2. **Advanced payment of credit.** (a) An individual may claim the credit on the
567.2 individual's tax return or have the credit paid in advance pursuant to section 62V.12.

567.3 (b) If an individual elects to have the credit paid in advance, the credit claimed under
567.4 subdivision 1 must be reduced by the amount of the advanced payments. If the amount of
567.5 the advance payments exceeds the amount of credit the individual is eligible for, the tax
567.6 imposed by this chapter for the taxable year must be increased by the amount of the excess.

567.7 (c) If the amount of credit that the individual is allowed under subdivision 1, after
567.8 subtracting any advanced payments, exceeds the individual's tax liability under this chapter,
567.9 the commissioner shall refund the excess to the individual.

567.10 (d) By January 31 of each year, the Board of Directors of MNsure must provide to each
567.11 individual who applied for assistance and enrolled in a qualified health plan and to the
567.12 commissioner a statement containing information on the preceding year necessary to reconcile
567.13 the credit with the advance payments. The Board of Directors of MNsure and the
567.14 commissioner must consult to develop the form and manner of the report.

567.15 (e) Each year, 60 days prior to MNsure's open enrollment, the commissioner shall provide
567.16 information to MNsure about which individuals received an advanced payment of the
567.17 state-based health insurance tax credit under section 62V.12 in a prior taxable year and did
567.18 not file a return and reconcile the payments for that taxable year.

567.19 Subd. 3. **Reporting requirements.** (a) If the individual has a change in eligibility status
567.20 determination by MNsure, after the taxable year is complete, the individual and MNsure
567.21 must notify the commissioner of the change in eligibility within six months of the change.

567.22 (b) Notwithstanding any law to the contrary, the commissioner may recompute the tax
567.23 due based on the determination of eligibility.

567.24 Subd. 4. **Appropriation.** An amount sufficient to pay the refunds required by this section
567.25 is appropriated to the commissioner from the health care access fund.

567.26 **EFFECTIVE DATE.** This section is effective for taxable years beginning after December
567.27 31, 2020.

567.28 Sec. 25. Minnesota Statutes 2018, section 295.51, subdivision 1a, is amended to read:

567.29 Subd. 1a. **Nexus in Minnesota.** (a) To the extent allowed by the United States
567.30 Constitution and the laws of the United States, a person who is a wholesale drug distributor
567.31 has nexus in Minnesota if its contacts with or presence in Minnesota is sufficient to satisfy
567.32 the requirements of the United States Constitution., a person who receives legend drugs for

568.1 resale or use in Minnesota other than from a wholesale drug distributor that is subject to
568.2 tax, or a person who sells or repairs hearing aids and related equipment or prescription
568.3 eyewear is subject to the taxes imposed by this chapter if the person:

568.4 (1) has or maintains within this state, directly or by a subsidiary or an affiliate, an office,
568.5 place of distribution, sales, storage, or sample room or place, warehouse, or other place of
568.6 business, including the employment of a resident of this state who works from a home office
568.7 in this state;

568.8 (2) has a representative, including but not limited to an employee, affiliate, agent,
568.9 salesperson, canvasser, solicitor, independent contractor, or other third party operating in
568.10 this state under the person's authority or the authority of the person's subsidiary, for any
568.11 purpose, including the repairing, selling, delivering, installing, facilitating sales, processing
568.12 sales, or soliciting of orders for the person's goods or services, or the leasing of tangible
568.13 personal property located in this state, whether the place of business or the agent,
568.14 representative, affiliate, salesperson, canvasser, or solicitor is located in the state permanently
568.15 or temporarily, or whether or not the person, subsidiary, or affiliate is authorized to do
568.16 business in this state;

568.17 (3) owns or leases real property that is located in this state; or

568.18 (4) owns or leases tangible personal property that is present in this state, including but
568.19 not limited to mobile property.

568.20 (b) To the extent allowed by the United States Constitution and the laws of the United
568.21 States, a person who is a wholesale drug distributor, or a person who receives legend drugs
568.22 for resale or use in Minnesota other than from a wholesale drug distributor that is subject
568.23 to tax, is subject to the taxes imposed by this chapter if the person:

568.24 (1) conducts a trade or business not described in paragraph (a) and sells, delivers, or
568.25 distributes legend drugs from outside this state to a destination within this state by common
568.26 carrier or otherwise; and

568.27 (2) meets one of the following thresholds:

568.28 (i) makes 100 or more sales, deliveries, or distributions described in clause (1) during
568.29 any taxable year;

568.30 (ii) the gross revenues of a wholesale drug distributor that sells or distributes legend
568.31 drugs as described in clause (1) totals more than \$100,000 during any taxable year; or

569.1 (iii) the price paid by a person who receives legend drugs for resale or use in Minnesota
569.2 other than from a wholesale drug distributor that is subject to tax for legend drugs as
569.3 described in clause (1) totals more than \$100,000 during any taxable year.

569.4 (c) To the extent allowed by the United States Constitution and the laws of the United
569.5 States, a person who sells or repairs hearing aids and related equipment or prescription
569.6 eyewear is subject to the taxes imposed by this chapter if the person:

569.7 (1) conducts a trade or business not described in paragraph (a) and:

569.8 (i) sells, delivers, or distributes hearing aids or prescription eyewear from outside of this
569.9 state to a destination within this state by common carrier or otherwise; or

569.10 (ii) repairs hearing aids or prescription eyewear outside of this state and delivers or
569.11 distributes the hearing aids or prescription eyewear to a destination within this state by
569.12 common carrier or otherwise; and

569.13 (2) meets one of the following thresholds:

569.14 (i) makes 100 or more sales, deliveries, distributions, or repairs described in clause (1)
569.15 during any taxable year; or

569.16 (ii) the gross revenues of the person who sells, delivers, distributes, or repairs hearing
569.17 aids or prescription eyewear described in clause (1) totals more than \$100,000 during any
569.18 taxable year.

569.19 (d) Once a taxpayer has established nexus with Minnesota under paragraph (b) or (c),
569.20 the taxpayer must continue to file an annual return and remit taxes for subsequent years. A
569.21 taxpayer who has established nexus under paragraph (b) or (c) is no longer required to file
569.22 an annual return and remit taxes if the taxpayer:

569.23 (1) ceases to engage in the activities, or no longer meets any of the applicable thresholds,
569.24 in paragraph (b) or (c) for an entire taxable year; and

569.25 (2) notifies the commissioner by March 15 of the following calendar year, in a manner
569.26 prescribed by the commissioner, that the taxpayer no longer engages in any of the activities,
569.27 or no longer meets any of the applicable thresholds, in paragraph (b) or (c).

569.28 (e) If, after notifying the commissioner pursuant to paragraph (d), the taxpayer
569.29 subsequently engages in any of the activities, and meets any of the applicable thresholds,
569.30 in paragraph (b) or (c), the taxpayer shall again comply with the applicable requirements
569.31 of paragraphs (b), (c), and (d).

570.1 **EFFECTIVE DATE; APPLICATION.** (a) This section is effective the day following
 570.2 final enactment.

570.3 (b) In enacting this section, the legislature confirms that the United States Supreme Court
 570.4 decision in South Dakota v. Wayfair, Inc. et al., Dkt. No. 17-494 (June 21, 2018); 138 S.
 570.5 Ct. 2080 (2018), applied upon the date of that decision to provide Minnesota with jurisdiction
 570.6 over persons described in paragraphs (b) and (c) for purposes of imposing tax under chapter
 570.7 295 to the extent allowed by the United States Constitution and the laws of the United States.

570.8 Sec. 26. Minnesota Statutes 2018, section 295.57, subdivision 3, is amended to read:

570.9 Subd. 3. **Interest on overpayments.** Interest must be paid on an overpayment refunded
 570.10 or credited to the taxpayer ~~from the date of payment of the tax until the date the refund is~~
 570.11 ~~paid or credited. For purposes of this subdivision, the date of payment is the due date of the~~
 570.12 ~~return or the date of actual payment of the tax, whichever is later~~ in the manner provided
 570.13 in section 289A.56, subdivision 2.

570.14 **EFFECTIVE DATE.** This section is effective for overpayments made on or after
 570.15 January 1, 2020.

570.16 Sec. 27. Minnesota Statutes 2018, section 295.582, subdivision 1, is amended to read:

570.17 Subdivision 1. **Tax expense transfer.** (a) A hospital, surgical center, or health care
 570.18 provider that is subject to a tax under section 295.52, or a pharmacy that has paid additional
 570.19 expense transferred under this section by a wholesale drug distributor, may transfer additional
 570.20 expense generated by section 295.52 obligations on to all third-party contracts for the
 570.21 purchase of health care services on behalf of a patient or consumer. Nothing shall prohibit
 570.22 a pharmacy from transferring the additional expense generated under section 295.52 to a
 570.23 pharmacy benefits manager. The additional expense transferred to the third-party purchaser
 570.24 or a pharmacy benefits manager must not exceed the tax percentage specified in section
 570.25 295.52 multiplied against the gross revenues received under the third-party contract, and
 570.26 the tax percentage specified in section 295.52 multiplied against co-payments and deductibles
 570.27 paid by the individual patient or consumer. The expense must not be generated on revenues
 570.28 derived from payments that are excluded from the tax under section 295.53. All third-party
 570.29 purchasers of health care services including, but not limited to, third-party purchasers
 570.30 regulated under chapter 60A, 62A, 62C, 62D, 62H, 62N, 64B, 65A, 65B, 79, ~~or 79A,~~ or
 570.31 256T, or under section 471.61 or 471.617, and pharmacy benefits managers must pay the
 570.32 transferred expense in addition to any payments due under existing contracts with the
 570.33 hospital, surgical center, pharmacy, or health care provider, to the extent allowed under

571.1 federal law. A third-party purchaser of health care services includes, but is not limited to,
571.2 a health carrier or community integrated service network that pays for health care services
571.3 on behalf of patients or that reimburses, indemnifies, compensates, or otherwise insures
571.4 patients for health care services. For purposes of this section, a pharmacy benefits manager
571.5 means an entity that performs pharmacy benefits management. A third-party purchaser or
571.6 pharmacy benefits manager shall comply with this section regardless of whether the
571.7 third-party purchaser or pharmacy benefits manager is a for-profit, not-for-profit, or nonprofit
571.8 entity. A wholesale drug distributor may transfer additional expense generated by section
571.9 295.52 obligations to entities that purchase from the wholesaler, and the entities must pay
571.10 the additional expense. Nothing in this section limits the ability of a hospital, surgical center,
571.11 pharmacy, wholesale drug distributor, or health care provider to recover all or part of the
571.12 section 295.52 obligation by other methods, including increasing fees or charges.

571.13 (b) Any hospital, surgical center, or health care provider subject to a tax under section
571.14 295.52 or a pharmacy that has paid additional expense transferred under this section by a
571.15 wholesale drug distributor may file a complaint with the commissioner responsible for
571.16 regulating the third-party purchaser if at any time the third-party purchaser fails to comply
571.17 with paragraph (a).

571.18 (c) If the commissioner responsible for regulating the third-party purchaser finds at any
571.19 time that the third-party purchaser has not complied with paragraph (a), the commissioner
571.20 may take enforcement action against a third-party purchaser which is subject to the
571.21 commissioner's regulatory jurisdiction and which does not allow a hospital, surgical center,
571.22 pharmacy, or provider to pass-through the tax. The commissioner may by order fine or
571.23 censure the third-party purchaser or revoke or suspend the certificate of authority or license
571.24 of the third-party purchaser to do business in this state if the commissioner finds that the
571.25 third-party purchaser has not complied with this section. The third-party purchaser may
571.26 appeal the commissioner's order through a contested case hearing in accordance with chapter
571.27 14.

571.28 **Sec. 28. DIRECTION TO COMMISSIONER; STATE-BASED RISK ADJUSTMENT**
571.29 **ANALYSIS.**

571.30 The commissioner of commerce, in consultation with the commissioner of health, shall
571.31 conduct a study on the design and implementation of a state-based risk adjustment program.
571.32 The commissioner shall report on the findings of the study and any recommendations to
571.33 the chairs and ranking minority members of the legislative committees with jurisdiction
571.34 over the individual health insurance market by February 15, 2021.

572.1 **Sec. 29. STUDY OF COST OF PROVIDING DENTAL SERVICES.**

572.2 The commissioner of human services shall contract with a vendor to conduct a survey
572.3 of the cost to Minnesota dental providers of delivering dental services to medical assistance
572.4 and MinnesotaCare enrollees under both fee-for-service and managed care. The commissioner
572.5 of human services shall ensure that the vendor has prior experience in conducting surveys
572.6 of the cost of providing health care services. Each dental provider enrolled with the
572.7 department must respond to the cost of service survey. The commissioner of human services
572.8 may sanction a dental provider under Minnesota Statutes, section 256B.064, for failure to
572.9 respond. The commissioner of human services shall require the vendor to measure statewide
572.10 and regional costs for both fee-for-service and managed care, by major dental service
572.11 category and for the most common dental services. The commissioner of human services
572.12 shall post a copy of the final survey report on the department's website. The initial survey
572.13 must be completed no later than January 1, 2021, and the survey must be repeated every
572.14 three years. The commissioner of human services shall provide a summary of the results of
572.15 each cost of dental services survey and provide recommendations for any changes to dental
572.16 payment rates to the chairs and ranking members of the legislative committees with
572.17 jurisdiction over health and human services policy and finance.

572.18 **Sec. 30. OUTPATIENT PHARMACY BENEFIT FOR ENROLLEES OF HEALTH**
572.19 **PLAN COMPANIES.**

572.20 (a) The commissioner of human services shall develop a plan for an outpatient pharmacy
572.21 benefit to be administered by the commissioner of human services for enrollees of health
572.22 plan companies. The plan must:

572.23 (1) provide prescription drug coverage, beginning January 1, 2022, to the enrollees of
572.24 health plan companies that choose to participate in the pharmacy benefit program;

572.25 (2) provide coverage and reimbursement for outpatient prescription drugs in accordance
572.26 with Minnesota Statutes, chapter 256L;

572.27 (3) require the commissioner to annually determine and publish the monthly premium
572.28 per enrollee for prescription drug coverage by August 1 of each year, for coverage taking
572.29 effect the following January 1;

572.30 (4) establish different co-payments for each of the following categories: preferred generic
572.31 drugs; preferred branded drugs; nonpreferred generic drugs; nonpreferred branded drugs;
572.32 and specialty drugs; and

573.1 (5) require a health plan company that enters into a contract with the commissioner to
 573.2 participate in the program to pay the commissioner for all costs incurred in providing a
 573.3 prescription drug benefit, including costs related to benefit administration and the purchasing
 573.4 of prescription drugs.

573.5 (b) The commissioner shall present the plan to the chairs and ranking minority members
 573.6 of the legislative committees with jurisdiction over health and human services policy and
 573.7 finance and health insurance by December 15, 2019.

573.8 Sec. 31. **BENEFIT AND COST ANALYSIS OF A UNIFIED HEALTH CARE**
 573.9 **FINANCING SYSTEM.**

573.10 Subdivision 1. **Contract for analysis of proposal.** The commissioner of health shall
 573.11 contract with the University of Minnesota School of Public Health to conduct an analysis
 573.12 of the current health care financing environment and evaluate whether a unified health care
 573.13 financing system would provide better access to care, reduce or slow the rate of increase in
 573.14 total health care spending, and provide other benefits to individuals, businesses, and the
 573.15 state economy, relative to the current health care financing environment.

573.16 Subd. 2. **Proposal.** The analysis shall include recommendations for a framework for a
 573.17 unified health care financing system designed to:

573.18 (1) ensure all Minnesotans have access to all necessary primary and specialty care,
 573.19 including dental, vision and hearing, mental health, chemical dependency treatment,
 573.20 prescription drugs, medical equipment and supplies, long-term, and home care;

573.21 (2) maximize the ability for patients to choose doctors, hospitals, and other providers;
 573.22 and

573.23 (3) incentivize a focus on preventative care and public health, including social
 573.24 determinants of health and care coordination.

573.25 Subd. 3. **Proposal analysis.** (a) The analysis must forecast over a ten-year or longer
 573.26 period determined to be sufficient to capture all benefits and costs of the unified health care
 573.27 financing system. The analysis must compare and contrast the impact of the proposed health
 573.28 care financing system and the current health care financing environment on:

573.29 (1) the number of people covered versus the number of people who continue to lack
 573.30 access to health care because of financial or other barriers, if any;

574.1 (2) the completeness of the coverage and the number of people lacking coverage for
574.2 dental, long-term care, medical equipment or supplies, vision and hearing, or other health
574.3 services that are not covered, if any;

574.4 (3) the adequacy of the coverage, the level of underinsured in the state, and whether
574.5 people with coverage can afford the care they need or whether cost prevents them from
574.6 accessing care;

574.7 (4) the timeliness and appropriateness of the care received and whether people turn to
574.8 less appropriate care such as emergency rooms because of a lack of proper care in accordance
574.9 with clinical guidelines; and

574.10 (5) total public and private health care spending in Minnesota under the current health
574.11 care financing environment versus a unified health care financing system, including all
574.12 spending by individuals, businesses, and government. "Total public and private health care
574.13 spending" means spending on all medical care including but not limited to dental, vision
574.14 and hearing, mental health, chemical dependency treatment, prescription drugs, medical
574.15 equipment and supplies, long-term care, and home care, whether paid through premiums,
574.16 co-pays and deductibles, other out-of-pocket payments, or other funding from government,
574.17 employers, or other sources. Total public and private health care spending also includes the
574.18 costs associated with administering, delivering, and paying for the care. The costs of
574.19 administering, delivering, and paying for the care includes all expenses by insurers, providers,
574.20 employers, individuals, and government to select, negotiate, purchase, and administer
574.21 insurance and care including but not limited to coverage for health care, dental, prescription
574.22 drugs, medical expense portions of workers compensation and automobile insurance, and
574.23 the cost of administering and paying for all health care products and services that are not
574.24 covered by insurance. The analysis of total health care spending shall examine, to the extent
574.25 possible given available data and resources, whether there are savings or additional costs
574.26 under the proposed health care financing system compared to the existing health care
574.27 financing environment due to:

574.28 (i) reduced insurance, billing, underwriting, marketing, evaluation, and other
574.29 administrative functions including savings from global budgeting for hospitals and
574.30 institutional care instead of billing for individual services provided;

574.31 (ii) reduced prices on medical services and products including pharmaceuticals due to
574.32 price negotiations, if applicable under the proposal;

574.33 (iii) shortages or excess capacity of medical facilities and equipment;

575.1 (iv) changes in utilization, better health outcomes, and reduced time away from work
 575.2 due to prevention, early intervention, and health-promoting activities; and

575.3 (v) the impact on state, local, and federal government non-health-care expenditures,
 575.4 such as reduced demand for public services and reduced out-of-home placement costs due
 575.5 to increased access to mental health and chemical dependency services.

575.6 (b) The analysis shall assume that operation of the unified health care financing system
 575.7 is not preempted by federal law.

575.8 (c) The commissioner shall issue a final report by January 15, 2021, and may provide
 575.9 interim reports and status updates to the governor and the chairs and ranking minority
 575.10 members of the legislative committees with jurisdiction over health and human services
 575.11 policy and finance.

575.12 Sec. 32. **REPEALER.**

575.13 Minnesota Statutes 2018, section 256L.11, subdivision 6a, is repealed.

575.14 **EFFECTIVE DATE.** This section is effective January 1, 2022.

575.15 **ARTICLE 10**

575.16 **PRESCRIPTION DRUGS**

575.17 Section 1. Minnesota Statutes 2018, section 8.31, subdivision 1, is amended to read:

575.18 Subdivision 1. **Investigate offenses against provisions of certain designated sections;**
 575.19 **assist in enforcement.** The attorney general shall investigate violations of the law of this
 575.20 state respecting unfair, discriminatory, and other unlawful practices in business, commerce,
 575.21 or trade, and specifically, but not exclusively, the Prohibition Against Charging
 575.22 Unconscionable Prices for Prescription Drugs (section 151.462), the Nonprofit Corporation
 575.23 Act (sections 317A.001 to 317A.909), the Act Against Unfair Discrimination and
 575.24 Competition (sections 325D.01 to 325D.07), the Unlawful Trade Practices Act (sections
 575.25 325D.09 to 325D.16), the Antitrust Act (sections 325D.49 to 325D.66), section 325F.67
 575.26 and other laws against false or fraudulent advertising, the antidiscrimination acts contained
 575.27 in section 325D.67, the act against monopolization of food products (section 325D.68), the
 575.28 act regulating telephone advertising services (section 325E.39), the Prevention of Consumer
 575.29 Fraud Act (sections 325F.68 to 325F.70), and chapter 53A regulating currency exchanges
 575.30 and assist in the enforcement of those laws as in this section provided.

576.1 Sec. 2. **[62Q.528] DRUG COVERAGE IN EMERGENCY SITUATIONS.**

576.2 A health plan that provides prescription drug coverage must provide coverage for a
576.3 prescription drug dispensed by a pharmacist under section 151.211, subdivision 3, under
576.4 the terms of coverage that would apply had the prescription drug been dispensed according
576.5 to a prescription.

576.6 Sec. 3. **[62Q.83] PRESCRIPTIONS FOR SPECIALTY DRUGS.**

576.7 Subdivision 1. Definitions. (a) For purposes of this section, the following terms have
576.8 the meaning given them.

576.9 (b) "Health plan company" has the meaning given in section 62Q.01, subdivision 4, but
576.10 also includes a county-based purchasing plan participating in a public program under chapter
576.11 256B or 256L, and in integrated health partnership under section 256B.0755.

576.12 (c) "Mail order pharmacy" means a pharmacy whose primary business is to receive
576.13 prescriptions by mail, fax, or through electronic submissions, dispense prescription drugs
576.14 to enrollees through the use of United States mail or other common carrier services, and
576.15 provide consultation with patients by telephone or electronically rather than face-to-face.

576.16 (d) "Pharmacy benefit manager" has the meaning provided in section 151.71, subdivision
576.17 1, paragraph (c).

576.18 (e) "Retail pharmacy" means a chain pharmacy, a supermarket pharmacy, an independent
576.19 pharmacy, or a network of independent pharmacies, licensed under chapter 151, that
576.20 dispenses prescription drugs to the public.

576.21 (f) "Specialty drug" means a prescription drug that:

576.22 (1) is not routinely made available to enrollees of a health plan company or its contracted
576.23 pharmacy benefit manager through dispensing by a retail pharmacy, regardless if the drug
576.24 is meant to be self-administered;

576.25 (2) must usually be obtained from specialty or mail order pharmacies; and

576.26 (3) has special storage, handling, or distribution requirements that typically cannot be
576.27 met by a retail pharmacy.

576.28 Subd. 2. Prompt filling of specialty drug prescriptions. A health plan company or its
576.29 contracted pharmacy benefit manager that requires or provides financial incentives for
576.30 enrollees to use a mail order pharmacy to fill a prescription for a specialty drug must ensure
576.31 through contract and other means that the mail order pharmacy dispenses the prescription
576.32 drug to the enrollee in a timely manner, such that the enrollee receives the filled prescription

577.1 within five business days of the date of transmittal to the mail order pharmacy. The health
577.2 plan company or contracted pharmacy benefit manager may grant an exemption from this
577.3 requirement if the mail order pharmacy can document that the specialty drug was out of
577.4 stock due to a delay in shipment by the specialty drug manufacturer or prescription drug
577.5 wholesaler. If an exemption is granted, the health plan company or pharmacy benefit manager
577.6 shall notify the enrollee within 24 hours of granting the exemption and, if medically
577.7 necessary, shall provide the enrollee with an emergency supply of the specialty drug.

577.8 **EFFECTIVE DATE.** This section is effective January 1, 2020, and applies to health
577.9 plans offered, issued, or renewed on or after that date.

577.10 Sec. 4. **[62Q.84] PRESCRIPTION DRUG BENEFIT TRANSPARENCY AND**
577.11 **MANAGEMENT.**

577.12 Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have
577.13 the meanings given them.

577.14 (b) "Drug" has the meaning given in section 151.01, subdivision 5.

577.15 (c) "Enrollee contract term" means the 12-month term during which benefits associated
577.16 with health plan company products are in effect. For managed care plans and county-based
577.17 purchasing plans under section 256B.69 and chapter 256L, it means a single calendar quarter.

577.18 (d) "Formulary" means a list of prescription drugs that have been developed by clinical
577.19 and pharmacy experts and represents the health plan company's medically appropriate and
577.20 cost-effective prescription drugs approved for use.

577.21 (e) "Health plan company" has the meaning given in section 62Q.01, subdivision 4, and
577.22 includes an entity that performs pharmacy benefits management for the health plan company.
577.23 For purposes of this definition, "pharmacy benefits management" means the administration
577.24 or management of prescription drug benefits provided by the health plan company for the
577.25 benefit of its enrollees and may include but is not limited to procurement of prescription
577.26 drugs, clinical formulary development and management services, claims processing, and
577.27 rebate contracting and administration.

577.28 (f) "Prescription" has the meaning given in section 151.01, subdivision 16a.

577.29 Subd. 2. **Prescription drug benefit disclosure.** (a) A health plan company that provides
577.30 prescription drug benefit coverage and uses a formulary must make its formulary and related
577.31 benefit information available by electronic means and, upon request, in writing, at least 30
577.32 days prior to annual renewal dates.

578.1 (b) Formularies must be organized and disclosed consistent with the most recent version
578.2 of the United States Pharmacopeia's (USP) Model Guidelines.

578.3 (c) For each item or category of items on the formulary, the specific enrollee benefit
578.4 terms must be identified, including enrollee cost-sharing and expected out-of-pocket costs.

578.5 Subd. 3. **Formulary changes.** (a) Once a formulary has been established, a health plan
578.6 company may, at any time during the enrollee's contract term:

578.7 (1) expand its formulary by adding drugs to the formulary;

578.8 (2) reduce co-payments or coinsurance; or

578.9 (3) move a drug to a benefit category that reduces an enrollee's cost.

578.10 (b) A health plan company may remove a brand name drug from its formulary or place
578.11 a brand name drug in a benefit category that increases an enrollee's cost only upon the
578.12 addition to the formulary of a generic or multisource brand name drug rated as therapeutically
578.13 equivalent according to the FDA Orange Book or a biologic drug rated as interchangeable
578.14 according to the FDA Purple Book at a lower cost to the enrollee, and upon at least a 60-day
578.15 notice to prescribers, pharmacists, and affected enrollees.

578.16 (c) A health plan company may change utilization review requirements or move drugs
578.17 to a benefit category that increases an enrollee's cost during the enrollee's contract term
578.18 upon at least a 60-day notice to prescribers, pharmacists, and affected enrollees, provided
578.19 that these changes do not apply to enrollees who are currently taking the drugs affected by
578.20 these changes for the duration of the enrollee's contract term.

578.21 (d) A health plan company may remove any drugs from its formulary that have been
578.22 deemed unsafe by the Food and Drug Administration, that have been withdrawn by either
578.23 the Food and Drug Administration or the product manufacturer, or when an independent
578.24 source of research, clinical guidelines, or evidence-based standards has issued drug-specific
578.25 warnings or recommended changes in drug usage.

578.26 Sec. 5. **[62W.01] CITATION.**

578.27 This chapter may be cited as the "Minnesota Pharmacy Benefit Manager Licensure and
578.28 Regulation Act."

578.29 Sec. 6. **[62W.02] DEFINITIONS.**

578.30 Subdivision 1. **Scope.** For purposes of this chapter, the following terms have the meanings
578.31 given.

579.1 Subd. 2. **Aggregate retained rebate.** "Aggregate retained rebate" means the percentage
579.2 of all rebates received by a pharmacy benefit manager from a drug manufacturer for drug
579.3 utilization that is not passed on to the pharmacy benefit manager's health carrier's clients.

579.4 Subd. 3. **Claims processing service.** "Claims processing service" means the
579.5 administrative services performed in connection with the processing and adjudicating of
579.6 claims relating to pharmacy services that includes:

579.7 (1) receiving payments for pharmacy services;

579.8 (2) making payments to pharmacists or pharmacies for pharmacy services; or

579.9 (3) both clause (1) and clause (2).

579.10 Subd. 4. **Commissioner.** "Commissioner" means the commissioner of commerce.

579.11 Subd. 5. **Enrollee.** "Enrollee" means a natural person covered by a health plan and
579.12 includes an insured, policyholder, subscriber, contract holder, member, covered person, or
579.13 certificate holder.

579.14 Subd. 6. **Health carrier.** "Health carrier" has the meaning given in section 62A.011,
579.15 subdivision 2.

579.16 Subd. 7. **Health plan.** "Health plan" means a policy, contract, certificate, or agreement
579.17 defined in section 62A.011, subdivision 3.

579.18 Subd. 8. **Mail order pharmacy.** "Mail order pharmacy" means a pharmacy whose
579.19 primary business is to receive prescriptions by mail, fax, or through electronic submissions,
579.20 dispense prescription drugs to enrollees through the use of the United States mail or other
579.21 common carrier services, and provide consultation with patients electronically rather than
579.22 face-to-face.

579.23 Subd. 9. **Maximum allowable cost price.** "Maximum allowable cost price" means the
579.24 maximum amount that a pharmacy benefit manager will reimburse a pharmacy for a group
579.25 of therapeutically and pharmaceutically equivalent multiple source drugs. The maximum
579.26 allowable cost price does not include a dispensing or professional fee.

579.27 Subd. 10. **Multiple source drugs.** "Multiple source drugs" means a therapeutically
579.28 equivalent drug that is available from at least two manufacturers.

579.29 Subd. 11. **Network pharmacy.** "Network pharmacy" means a retail or other licensed
579.30 pharmacy provider that directly contracts with a pharmacy benefit manager.

580.1 Subd. 12. **Other prescription drug or device services.** "Other prescription drug or
580.2 device services" means services other than claims processing services, provided directly or
580.3 indirectly, whether in connection with or separate from claims processing services, including:

580.4 (1) negotiating rebates, discounts, or other financial incentives and arrangements with
580.5 drug manufacturers;

580.6 (2) disbursing or distributing rebates;

580.7 (3) managing or participating in incentive programs or arrangements for pharmacy
580.8 services;

580.9 (4) negotiating or entering into contractual arrangements with pharmacists or pharmacies,
580.10 or both;

580.11 (5) developing prescription drug formularies;

580.12 (6) designing prescription benefit programs; or

580.13 (7) advertising or promoting services.

580.14 Subd. 13. **Pharmacist.** "Pharmacist" means an individual with a valid license issued by
580.15 the Board of Pharmacy under chapter 151.

580.16 Subd. 14. **Pharmacy.** "Pharmacy" or "pharmacy provider" means a place of business
580.17 licensed by the Board of Pharmacy under chapter 151 in which prescription drugs are
580.18 prepared, compounded, or dispensed, or under the supervision of a pharmacist.

580.19 Subd. 15. **Pharmacy benefit manager.** (a) "Pharmacy benefit manager" means a person,
580.20 business, or other entity that contracts with a plan sponsor to perform pharmacy benefits
580.21 management, including but not limited to:

580.22 (1) contracting directly or indirectly with pharmacies to provide prescription drugs to
580.23 enrollees or other covered individuals;

580.24 (2) administering a prescription drug benefit;

580.25 (3) processing or paying pharmacy claims;

580.26 (4) creating or updating prescription drug formularies;

580.27 (5) making or assisting in making prior authorization determinations on prescription
580.28 drugs;

580.29 (6) administering rebates on prescription drugs; or

580.30 (7) establishing a pharmacy network.

581.1 (b) "Pharmacy benefit manager" does not include the Department of Human Services.

581.2 Subd. 16. **Plan sponsor.** "Plan sponsor" means a group purchaser as defined under
581.3 section 62J.03; an employer in the case of an employee health benefit plan established or
581.4 maintained by a single employer; or an employee organization in the case of a health plan
581.5 established or maintained by an employee organization, an association, joint board trustees,
581.6 a committee, or other similar group that establishes or maintains the health plan. This term
581.7 includes a person or entity acting for a pharmacy benefit manager in a contractual or
581.8 employment relationship in the performance of pharmacy benefits management. Plan sponsor
581.9 does not include the Department of Human Services.

581.10 Subd. 17. **Specialty drug.** "Specialty drug" means a prescription drug that:

581.11 (1) cannot be routinely dispensed at a majority of retail pharmacies;

581.12 (2) is used to treat chronic and complex, or rare, medical conditions; and

581.13 (3) meets a majority of the following criteria:

581.14 (i) requires special handling or storage;

581.15 (ii) requires complex and extended patient education or counseling;

581.16 (iii) requires intensive monitoring;

581.17 (iv) requires clinical oversight; and

581.18 (v) requires product support services.

581.19 Subd. 18. **Retail pharmacy.** "Retail pharmacy" means a chain pharmacy, a supermarket
581.20 pharmacy, an independent pharmacy, or a network of independent pharmacies, licensed
581.21 under chapter 151, that dispenses prescription drugs to the public.

581.22 Subd. 19. **Rebates.** "Rebates" means all price concessions paid by a drug manufacturer
581.23 to a pharmacy benefit manager or plan sponsor, including discounts and other price
581.24 concessions that are based on the actual or estimated utilization of a prescription drug.
581.25 Rebates also include price concessions based on the effectiveness of a prescription drug as
581.26 in a value-based or performance-based contract.

581.27 Sec. 7. **[62W.03] LICENSE TO DO BUSINESS.**

581.28 Subdivision 1. **General.** (a) Beginning January 1, 2020, no person shall perform, act,
581.29 or do business in this state as a pharmacy benefits manager unless the person has a valid
581.30 license issued under this chapter by the commissioner of commerce.

581.31 (b) A license issued in accordance with this chapter is nontransferable.

582.1 Subd. 2. **Application.** (a) A pharmacy benefit manager seeking a license shall apply to
582.2 the commissioner of commerce on a form prescribed by the commissioner. The application
582.3 form must include at a minimum the following information:

582.4 (1) the name, address, and telephone number of the pharmacy benefit manager;

582.5 (2) the name and address of the pharmacy benefit manager agent for service of process
582.6 in this state;

582.7 (3) the name, address, official position, and professional qualifications of each person
582.8 responsible for the conduct of affairs of the pharmacy benefit manager, including all members
582.9 of the board of directors, board of trustees, executive committee, or other governing board
582.10 or committee; the principal officers in the case of a corporation; or the partners or members
582.11 in the case of a partnership or association; and

582.12 (4) a statement reasonably describing the geographic area or areas to be served and the
582.13 type or types of enrollees to be served.

582.14 (b) Each application for licensure must be accompanied by a nonrefundable fee of \$8,500
582.15 and evidence of financial responsibility in the amount of \$1,000,000 to be maintained at all
582.16 times by the pharmacy benefit manager during its licensure period. The fees collected under
582.17 this subdivision shall be deposited in the general fund.

582.18 (c) Within 30 days of receiving an application, the commissioner may require additional
582.19 information or submissions from an applicant and may obtain any document or information
582.20 reasonably necessary to verify the information contained in the application. Within 90 days
582.21 after receipt of a completed application, evidence of financial responsibility, the network
582.22 adequacy report required under section 62W.05, and the applicable license fee, the
582.23 commissioner shall review the application and issue a license if the applicant is deemed
582.24 qualified under this section. If the commissioner determines the applicant is not qualified,
582.25 the commissioner shall notify the applicant and shall specify the reason or reasons for the
582.26 denial.

582.27 Subd. 3. **Renewal.** (a) A license issued under this chapter is valid for a period of one
582.28 year. To renew a license, an applicant must submit a completed renewal application on a
582.29 form prescribed by the commissioner, the network adequacy report required under section
582.30 62W.05, and a renewal fee of \$8,500. The commissioner may request a renewal applicant
582.31 to submit additional information to clarify any new information presented in the renewal
582.32 application. The fees collected under this paragraph shall be deposited in the general fund.

583.1 (b) A renewal application submitted after the renewal deadline date must be accompanied
583.2 by a nonrefundable late fee of \$500. The fees collected under this paragraph shall be
583.3 deposited in the general fund.

583.4 (c) The commissioner shall deny the renewal of a license for any of the following reasons:

583.5 (1) the pharmacy benefit manager is operating in a financially hazardous condition
583.6 relative to its financial condition and the services it administers for health carriers;

583.7 (2) the pharmacy benefit manager has been determined by the commissioner to be in
583.8 violation or noncompliance with the requirements of state law or the rules promulgated
583.9 under this chapter; or

583.10 (3) the pharmacy benefit manager has failed to timely submit a renewal application and
583.11 the information required under paragraph (a).

583.12 In lieu of a denial of a renewal application, the commissioner may permit the pharmacy
583.13 benefit manager to submit to the commissioner a corrective action plan to cure or correct
583.14 deficiencies.

583.15 Subd. 4. **Oversight.** (a) The commissioner may suspend, revoke, or place on probation
583.16 a pharmacy benefit manager license issued under this chapter for any of the following
583.17 circumstances:

583.18 (1) the pharmacy benefit manager has engaged in fraudulent activity that constitutes a
583.19 violation of state or federal law;

583.20 (2) the commissioner has received consumer complaints that justify an action under this
583.21 subdivision to protect the safety and interests of consumers;

583.22 (3) the pharmacy benefit manager fails to pay an application license or renewal fee; and

583.23 (4) the pharmacy benefit manager fails to comply with a requirement set forth in this
583.24 chapter.

583.25 (b) The commissioner may issue a license subject to restrictions or limitations, including
583.26 the types of services that may be supplied or the activities in which the pharmacy benefit
583.27 manager may be engaged.

583.28 Subd. 5. **Penalty.** If a pharmacy benefit manager acts without a license, the pharmacy
583.29 benefit manager may be subject to a fine of \$5,000 per day for the period the pharmacy
583.30 benefit manager is found to be in violation. Any penalties collected under this subdivision
583.31 shall be deposited in the general fund.

583.32 Subd. 6. **Rulemaking.** The commissioner may adopt rules to implement this section.

584.1 Subd. 7. **Enforcement.** The commissioner shall enforce this chapter under the provisions
584.2 of chapter 45.

584.3 Sec. 8. **[62W.04] PHARMACY BENEFIT MANAGER GENERAL BUSINESS**
584.4 **PRACTICES.**

584.5 (a) A pharmacy benefit manager has a fiduciary duty to a health carrier and must
584.6 discharge that duty in accordance with the provisions of state and federal law.

584.7 (b) A pharmacy benefit manager must perform its duties with care, skill, prudence,
584.8 diligence, and professionalism. A pharmacy benefit manager must exercise good faith and
584.9 fair dealing in the performance of its contractual duties. A provision in a contract between
584.10 a pharmacy benefit manager and a health carrier or a network pharmacy that attempts to
584.11 waive or limit this obligation is void.

584.12 (c) A pharmacy benefit manager must notify a health carrier in writing of any activity,
584.13 policy, or practice of the pharmacy benefit manager that directly or indirectly presents a
584.14 conflict of interest with the duties imposed in this section.

584.15 Sec. 9. **[62W.05] PHARMACY BENEFIT MANAGER NETWORK ADEQUACY.**

584.16 (a) A pharmacy benefit manager must provide an adequate and accessible pharmacy
584.17 network for the provision of prescription drugs as defined under section 62K.10. Mail order
584.18 pharmacies must not be included in the calculations of determining the adequacy of the
584.19 pharmacy benefit manager's pharmacy network under section 62K.10.

584.20 (b) A pharmacy benefit manager must submit to the commissioner a pharmacy network
584.21 adequacy report describing the pharmacy network and pharmacy accessibility in this state,
584.22 with the pharmacy benefit manager's license application and renewal, in a manner prescribed
584.23 by the commissioner.

584.24 (c) A pharmacy benefit manager may apply for a waiver of the requirements in paragraph
584.25 (a) if it is unable to meet the statutory requirements. A waiver application must be submitted
584.26 on a form provided by the commissioner and must (1) demonstrate with specific data that
584.27 the requirement of paragraph (a) is not feasible in a particular service area or part of a service
584.28 area, and (2) include information as to the steps that were and will be taken to address the
584.29 network inadequacy. The waiver shall automatically expire after three years. If a renewal
584.30 of the waiver is sought, the commissioner shall take into consideration steps that have been
584.31 taken to address network adequacy.

585.1 (d) The pharmacy benefit manager must establish a pharmacy network service area
585.2 consistent with the requirements under section 62K.13 for every pharmacy network subject
585.3 to review under this section.

585.4 Sec. 10. **[62W.06] PHARMACY BENEFIT MANAGER TRANSPARENCY.**

585.5 Subdivision 1. Transparency to plan sponsors. (a) Beginning in the second quarter
585.6 after the effective date of a contract between a pharmacy benefit manager and a plan sponsor,
585.7 the pharmacy benefit manager must disclose, upon the request of the plan sponsor, the
585.8 following information with respect to prescription drug benefits specific to the plan sponsor:

585.9 (1) the aggregate wholesale acquisition costs from a drug manufacturer or wholesale
585.10 drug distributor for each therapeutic category of prescription drugs;

585.11 (2) the aggregate amount of rebates received by the pharmacy benefit manager by
585.12 therapeutic category of prescription drugs. The aggregate amount of rebates must include
585.13 any utilization discounts the pharmacy benefit manager receives from a drug manufacturer
585.14 or wholesale drug distributor;

585.15 (3) any other fees received from a drug manufacturer or wholesale drug distributor;

585.16 (4) whether the pharmacy benefit manager has a contract, agreement, or other arrangement
585.17 with a drug manufacturer to exclusively dispense or provide a drug to a plan sponsor's
585.18 employees or enrollees, and the application of all consideration or economic benefits collected
585.19 or received pursuant to the arrangement;

585.20 (5) prescription drug utilization information for the plan sponsor's employees or enrollees
585.21 that is not specific to any individual employee or enrollee;

585.22 (6) de-identified claims level information in electronic format that allows the plan sponsor
585.23 to sort and analyze the following information for each claim:

585.24 (i) the drug and quantity for each prescription;

585.25 (ii) whether the claim required prior authorization;

585.26 (iii) patient cost-sharing paid on each prescription;

585.27 (iv) the amount paid to the pharmacy for each prescription, net of the aggregate amount
585.28 of fees or other assessments imposed on the pharmacy, including point-of-sale and retroactive
585.29 charges;

585.30 (v) any spread between the net amount paid to the pharmacy in item (iv) and the amount
585.31 charged to the plan sponsor;

- 586.1 (vi) identity of the pharmacy for each prescription;
- 586.2 (vii) whether the pharmacy is, or is not, under common control or ownership with the
586.3 pharmacy benefit manager;
- 586.4 (viii) whether the pharmacy is, or is not, a preferred pharmacy under the plan;
- 586.5 (ix) whether the pharmacy is, or is not, a mail order pharmacy; and
- 586.6 (x) whether enrollees are required by the plan to use the pharmacy;
- 586.7 (7) the aggregate amount of payments made by the pharmacy benefit manager to
586.8 pharmacies owned or controlled by the pharmacy benefit manager;
- 586.9 (8) the aggregate amount of payments made by the pharmacy benefit manager to
586.10 pharmacies not owned or controlled by the pharmacy benefit manager; and
- 586.11 (9) the aggregate amount of the fees imposed on, or collected from, network pharmacies
586.12 or other assessments against network pharmacies, including point-of-sale fees and retroactive
586.13 charges, and the application of those amounts collected pursuant to the contract with the
586.14 plan sponsor.
- 586.15 **Subd. 2. Transparency report to the commissioner.** (a) Beginning June 1, 2020, and
586.16 annually thereafter, each pharmacy benefit manager must submit to the commissioner of
586.17 commerce a transparency report containing data from the prior calendar year. The report
586.18 must contain the following information:
- 586.19 (1) the aggregate wholesale acquisition costs from a drug manufacturer or wholesale
586.20 drug distributor for each therapeutic category of prescription drugs for all of the pharmacy
586.21 benefit manager's health carrier clients and for each health carrier client, and these costs net
586.22 of all rebates and other fees and payments, direct or indirect, from all sources;
- 586.23 (2) the aggregate amount of all rebates that the pharmacy benefit manager received from
586.24 all drug manufacturers for all of the pharmacy benefit manager's health carrier clients and
586.25 for each health carrier client. The aggregate amount of rebates must include any utilization
586.26 discounts the pharmacy benefit manager receives from a drug manufacturer or wholesale
586.27 drug distributor;
- 586.28 (3) the aggregate of all fees from all sources, direct or indirect, that the pharmacy benefit
586.29 manager received for all of the pharmacy benefit manager's health carrier clients, and the
586.30 amount of these fees for each health carrier client separately;

587.1 (4) the aggregate retained rebates and other fees, as listed in clause (3), that the pharmacy
587.2 benefit manager received from all sources, direct or indirect, that were not passed through
587.3 to the health carrier;

587.4 (5) the aggregate retained rebate and fees percentage;

587.5 (6) the highest, lowest, and mean aggregate retained rebate and fees percentage for all
587.6 of the pharmacy benefit manager's health carrier clients and for each health carrier client;
587.7 and

587.8 (7) de-identified claims level information in electronic format that allows the
587.9 commissioner to sort and analyze the following information for each claim:

587.10 (i) the drug and quantity for each prescription;

587.11 (ii) whether the claim required prior authorization;

587.12 (iii) patient cost-sharing paid on each prescription;

587.13 (iv) the amount paid to the pharmacy for each prescription, net of the aggregate amount
587.14 of fees or other assessments imposed on the pharmacy, including point-of-sale and retroactive
587.15 charges;

587.16 (v) any spread between the net amount paid to the pharmacy in item (iv) and the amount
587.17 charged to the plan sponsor;

587.18 (vi) identity of the pharmacy for each prescription;

587.19 (vii) whether the pharmacy is, or is not, under common control or ownership with the
587.20 pharmacy benefit manager;

587.21 (viii) whether the pharmacy is, or is not, a preferred pharmacy under the plan;

587.22 (ix) whether the pharmacy is, or is not, a mail order pharmacy; and

587.23 (x) whether enrollees are required by the plan to use the pharmacy.

587.24 (b) Within 60 days upon receipt of the transparency report, the commissioner shall
587.25 publish the report from each pharmacy benefit manager on the Department of Commerce's
587.26 website, with the exception of data considered trade secret information under section 13.37.

587.27 (c) For purposes of this subdivision, the aggregate retained rebate and fee percentage
587.28 must be calculated for each health carrier for rebates and fees in the previous calendar year
587.29 as follows:

588.1 (1) the sum total dollar amount of rebates and fees from all drug manufacturers for all
588.2 utilization of enrollees of a health carrier that was not passed through to the health carrier;
588.3 and

588.4 (2) divided by the sum total dollar amount of all rebates and fees received from all
588.5 sources, direct or indirect, for all enrollees of a health carrier.

588.6 Subd. 3. **Penalty.** The commissioner may impose civil penalties of not more than \$1,000
588.7 per day per violation of this section.

588.8 Sec. 11. **[62W.07] PHARMACY OWNERSHIP INTEREST; SPECIALTY**
588.9 **PHARMACY SERVICES; NONDISCRIMINATION.**

588.10 (a) A pharmacy benefit manager that has an ownership interest either directly or indirectly,
588.11 or through an affiliate or subsidiary, in a pharmacy must disclose to a plan sponsor that
588.12 contracts with the pharmacy benefit manager any difference between the amount paid to a
588.13 pharmacy and the amount charged to the plan sponsor.

588.14 (b) A pharmacy benefit manager or a pharmacy benefit manager's affiliates or subsidiaries
588.15 must not own or have an ownership interest in a patient assistance program or a mail order
588.16 specialty pharmacy, unless the pharmacy benefit manager, affiliate, or subsidiary agrees to
588.17 fair competition, no self-dealing, and no interference with prospective economic advantage,
588.18 and establishes a firewall between the administrative functions and the mail order pharmacy.

588.19 (c) A pharmacy benefit manager or health carrier is prohibited from penalizing, requiring,
588.20 or providing financial incentives, including variations in premiums, deductibles, co-payments,
588.21 or coinsurance, to an enrollee as an incentive to use a retail pharmacy, mail order pharmacy,
588.22 specialty pharmacy, or other network pharmacy provider in which a pharmacy benefit
588.23 manager has an ownership interest or that has an ownership interest in a pharmacy benefit
588.24 manager.

588.25 (d) A pharmacy benefit manager or health carrier is prohibited from imposing limits,
588.26 including quantity limits or refill frequency limits, on a patient's access to medication that
588.27 differ based solely on whether the health carrier or pharmacy benefit manager has an
588.28 ownership interest in a pharmacy or the pharmacy has an ownership in the pharmacy benefit
588.29 manager.

588.30 (e) A pharmacy benefit manager must not require pharmacy accreditation standards or
588.31 recertification requirements to participate in a network that are inconsistent with, more
588.32 stringent than, or in addition to federal and state requirements for licensure as a pharmacy
588.33 in this state.

589.1 (f) A pharmacy benefit manager must not discriminate against a pharmacy participating
589.2 in a health plan as an entity authorized to participate under section 340B of the Public Health
589.3 Service Act, United States Code, title 42, chapter 6A, or any pharmacy under contract with
589.4 such an entity to provide prescriptions.

589.5 Sec. 12. **[62W.08] MAXIMUM ALLOWABLE COST PRICING.**

589.6 (a) With respect to each contract and contract renewal between a pharmacy benefit
589.7 manager and a pharmacy, the pharmacy benefits manager must:

589.8 (1) provide to the pharmacy, at the beginning of each contract and contract renewal, the
589.9 sources utilized to determine the maximum allowable cost pricing of the pharmacy benefit
589.10 manager;

589.11 (2) update any maximum allowable cost price list at least every seven business days,
589.12 noting any price changes from the previous list, and provide a means by which network
589.13 pharmacies may promptly review current prices in an electronic, print, or telephonic format
589.14 within one business day at no cost to the pharmacy;

589.15 (3) maintain a procedure to eliminate products from the list of drugs subject to maximum
589.16 allowable cost pricing in a timely manner in order to remain consistent with changes in the
589.17 marketplace;

589.18 (4) ensure that the maximum allowable cost prices are not set below sources utilized by
589.19 the pharmacy benefits manager; and

589.20 (5) upon request of a network pharmacy, disclose the sources utilized for setting
589.21 maximum allowable cost price rates on each maximum allowable cost price list included
589.22 under the contract and identify each maximum allowable cost price list that applies to the
589.23 network pharmacy. A pharmacy benefit manager must make the list of the maximum
589.24 allowable costs available to a contracted pharmacy in a format that is readily accessible and
589.25 usable to the network pharmacy.

589.26 (b) A pharmacy benefit manager must not place a prescription drug on a maximum
589.27 allowable cost list unless the drug is available for purchase by pharmacies in this state from
589.28 a national or regional drug wholesaler and is not obsolete.

589.29 (c) Each contract between a pharmacy benefit manager and a pharmacy must include a
589.30 process to appeal, investigate, and resolve disputes regarding maximum allowable cost
589.31 pricing that includes:

589.32 (1) a 15-business-day limit on the right to appeal following the initial claim;

590.1 (2) a requirement that the appeal be investigated and resolved within seven business
590.2 days after the appeal is received; and

590.3 (3) a requirement that a pharmacy benefit manager provide a reason for any appeal denial
590.4 and identify the national drug code of a drug that may be purchased by the pharmacy at a
590.5 price at or below the maximum allowable cost price as determined by the pharmacy benefit
590.6 manager.

590.7 (d) If an appeal is upheld, the pharmacy benefit manager must make an adjustment to
590.8 the maximum allowable cost price no later than one business day after the date of
590.9 determination. The pharmacy benefit manager must make the price adjustment applicable
590.10 to all similarly situated network pharmacy providers as defined by the plan sponsor.

590.11 Sec. 13. **[62W.09] PHARMACY AUDITS.**

590.12 Subdivision 1. Procedure and process for conducting and reporting an audit. (a)
590.13 Unless otherwise prohibited by federal requirements or regulations, any entity conducting
590.14 a pharmacy audit must follow the following procedures:

590.15 (1) a pharmacy must be given notice 14 days before an initial on-site audit is conducted;

590.16 (2) an audit that involves clinical or professional judgment must be conducted by or in
590.17 consultation with a licensed pharmacist; and

590.18 (3) each pharmacy shall be audited under the same standards and parameters as other
590.19 similarly situated pharmacies.

590.20 (b) Unless otherwise prohibited by federal requirements or regulations, for any entity
590.21 conducting a pharmacy audit the following items apply:

590.22 (1) the period covered by the audit may not exceed 24 months from the date that the
590.23 claim was submitted to or adjudicated by the entity, unless a longer period is required under
590.24 state or federal law;

590.25 (2) if an entity uses random sampling as a method for selecting a set of claims for
590.26 examination, the sample size must be appropriate for a statistically reliable sample.

590.27 Notwithstanding section 151.69, the auditing entity shall provide the pharmacy a masked
590.28 list that provides a prescription number or date range that the auditing entity is seeking to
590.29 audit;

590.30 (3) an on-site audit may not take place during the first five business days of the month
590.31 unless consented to by the pharmacy;

591.1 (4) auditors may not enter the pharmacy area unless escorted where patient-specific
591.2 information is available and to the extent possible must be out of sight and hearing range
591.3 of the pharmacy customers;

591.4 (5) any recoupment will not be deducted against future remittances until after the appeals
591.5 process and both parties have received the results of the final audit;

591.6 (6) a pharmacy benefit manager may not require information to be written on a
591.7 prescription unless the information is required to be written on the prescription by state or
591.8 federal law. Recoupment may be assessed for items not written on the prescription if:

591.9 (i) additional information is required in the provider manual; or

591.10 (ii) the information is required by the Food and Drug Administration (FDA); or

591.11 (iii) the information is required by the drug manufacturer's product safety program; and

591.12 (iv) the information in item (i), (ii), or (iii) is not readily available for the auditor at the
591.13 time of the audit; and

591.14 (7) the auditing company or agent may not receive payment based on a percentage of
591.15 the amount recovered. This section does not prevent the entity conducting the audit from
591.16 charging or assessing the responsible party, directly or indirectly, based on amounts recouped
591.17 if both of the following conditions are met:

591.18 (i) the plan sponsor and the entity conducting the audit have a contract that explicitly
591.19 states the percentage charge or assessment to the plan sponsor; and

591.20 (ii) a commission to an agent or employee of the entity conducting the audit is not based,
591.21 directly or indirectly, on amounts recouped.

591.22 (c) An amendment to pharmacy audit terms in a contract between a pharmacy benefit
591.23 manager and a pharmacy must be disclosed to the pharmacy at least 60 days prior to the
591.24 effective date of the proposed change.

591.25 Subd. 2. Requirement for recoupment or chargeback. For recoupment or chargeback,
591.26 the following criteria apply:

591.27 (1) audit parameters must consider consumer-oriented parameters based on manufacturer
591.28 listings;

591.29 (2) a pharmacy's usual and customary price for compounded medications is considered
591.30 the reimbursable cost unless the pricing methodology is outlined in the pharmacy provider
591.31 contract;

592.1 (3) a finding of overpayment or underpayment must be based on the actual overpayment
592.2 or underpayment and not a projection based on the number of patients served having a
592.3 similar diagnosis or on the number of similar orders or refills for similar drugs;

592.4 (4) the entity conducting the audit shall not use extrapolation in calculating the
592.5 recoupment or penalties for audits unless required by state or federal law or regulations;

592.6 (5) calculations of overpayments must not include dispensing fees unless a prescription
592.7 was not actually dispensed, the prescriber denied authorization, the prescription dispensed
592.8 was a medication error by the pharmacy, or the identified overpayment is solely based on
592.9 an extra dispensing fee;

592.10 (6) an entity may not consider any clerical or record-keeping error, such as a typographical
592.11 error, scrivener's error, or computer error regarding a required document or record as fraud,
592.12 however such errors may be subject to recoupment;

592.13 (7) in the case of errors that have no actual financial harm to the patient or plan, the
592.14 pharmacy benefit manager must not assess any chargebacks. Errors that are a result of the
592.15 pharmacy failing to comply with a formal corrective action plan may be subject to recovery;
592.16 and

592.17 (8) interest may not accrue during the audit period for either party, beginning with the
592.18 notice of the audit and ending with the final audit report.

592.19 Subd. 3. **Documentation.** (a) To validate the pharmacy record and delivery, the pharmacy
592.20 may use authentic and verifiable statements or records including medication administration
592.21 records of a nursing home, assisted living facility, hospital, physician, or other authorized
592.22 practitioner or additional audit documentation parameters located in the provider manual.

592.23 (b) Any legal prescription that meets the requirements in this chapter may be used to
592.24 validate claims in connection with prescriptions, refills, or changes in prescriptions, including
592.25 medication administration records, faxes, e-prescriptions, or documented telephone calls
592.26 from the prescriber or the prescriber's agents.

592.27 Subd. 4. **Appeals process.** The entity conducting the audit must establish a written
592.28 appeals process which must include appeals of preliminary reports and final reports.

592.29 Subd. 5. **Audit information and reports.** (a) A preliminary audit report must be delivered
592.30 to the pharmacy within 60 days after the conclusion of the audit.

592.31 (b) A pharmacy must be allowed at least 45 days following receipt of the preliminary
592.32 audit to provide documentation to address any discrepancy found in the audit.

593.1 (c) A final audit report must be delivered to the pharmacy within 120 days after receipt
593.2 of the preliminary audit report or final appeal, whichever is later.

593.3 (d) An entity shall remit any money due to a pharmacy or pharmacist as a result of an
593.4 underpayment of a claim within 45 days after the appeals process has been exhausted and
593.5 the final audit report has been issued.

593.6 Subd. 6. **Disclosure to plan sponsor.** Where contractually required, an auditing entity
593.7 must provide a copy to the plan sponsor of its claims that were included in the audit, and
593.8 any recouped money shall be returned to the plan sponsor.

593.9 Subd. 7. **Applicability of other laws and regulations.** This section does not apply to
593.10 any investigative audit that involves suspected fraud, willful misrepresentation, abuse, or
593.11 any audit completed by Minnesota health care programs.

593.12 Subd. 8. **Definitions.** For purposes of this section, "entity" means a pharmacy benefits
593.13 manager or any person or organization that represents these companies, groups, or
593.14 organizations.

593.15 **Sec. 14. [62W.10] SYNCHRONIZATION.**

593.16 (a) For purposes of this section, "synchronization" means the coordination of prescription
593.17 drug refills for a patient taking two or more medications for one or more chronic conditions,
593.18 to allow the patient's medications to be refilled on the same schedule for a given period of
593.19 time.

593.20 (b) A contract between a pharmacy benefit manager and a pharmacy must allow for
593.21 synchronization of prescription drug refills for a patient on at least one occasion per year,
593.22 if the following criteria are met:

593.23 (1) the prescription drugs are covered under the patient's health plan or have been
593.24 approved by a formulary exceptions process;

593.25 (2) the prescription drugs are maintenance medications as defined by the health plan
593.26 and have one or more refills available at the time of synchronization;

593.27 (3) the prescription drugs are not Schedule II, III, or IV controlled substances;

593.28 (4) the patient meets all utilization management criteria relevant to the prescription drug
593.29 at the time of synchronization;

593.30 (5) the prescription drugs are of a formulation that can be safely split into short-fill
593.31 periods to achieve synchronization; and

594.1 (6) the prescription drugs do not have special handling or sourcing needs that require a
594.2 single, designated pharmacy to fill or refill the prescription.

594.3 (c) When necessary to permit synchronization, the pharmacy benefit manager must apply
594.4 a prorated, daily patient cost-sharing rate to any prescription drug dispensed by a pharmacy
594.5 under this section. The dispensing fee must not be prorated, and all dispensing fees shall
594.6 be based on the number of prescriptions filled or refilled.

594.7 (d) Synchronization may be requested by the patient or by the patient's parent or legal
594.8 guardian. For purposes of this paragraph, "legal guardian" includes but is not limited to a
594.9 guardian of an incapacitated person appointed pursuant to chapter 524.

594.10 **Sec. 15. [62W.11] GAG CLAUSE PROHIBITION.**

594.11 (a) No contract between a pharmacy benefit manager or health carrier and a pharmacy
594.12 or pharmacist shall prohibit, restrict, or penalize a pharmacy or pharmacist from disclosing
594.13 to an enrollee any health care information that the pharmacy or pharmacist deems appropriate
594.14 regarding the nature of treatment; the risks or alternatives; the availability of alternative
594.15 therapies, consultations, or tests; the decision of utilization reviewers or similar persons to
594.16 authorize or deny services; the process that is used to authorize or deny health care services
594.17 or benefits; or information on financial incentives and structures used by the health carrier
594.18 or pharmacy benefit manager.

594.19 (b) A pharmacy or pharmacist must provide to an enrollee information regarding the
594.20 enrollee's total cost for each prescription drug dispensed where part or all of the cost of the
594.21 prescription is being paid or reimbursed by the employer-sponsored plan or by a health
594.22 carrier or pharmacy benefit manager, in accordance with section 151.214, subdivision 1.

594.23 (c) A pharmacy benefit manager or health carrier must not prohibit a pharmacist or
594.24 pharmacy from discussing information regarding the total cost for pharmacy services for a
594.25 prescription drug, including the patient's co-payment amount, the pharmacy's own usual
594.26 and customary price of the prescription, and the net amount the pharmacy will receive from
594.27 all sources for dispensing the prescription drug, once the claim has been completed by the
594.28 pharmacy benefit manager or the patient's health carrier.

594.29 (d) A pharmacy benefit manager or health carrier must not prohibit a pharmacist or
594.30 pharmacy from discussing the availability of any therapeutically equivalent alternative
594.31 prescription drugs or alternative methods for purchasing the prescription drug, including
594.32 but not limited to paying out-of-pocket the pharmacy's usual and customary price when that

595.1 amount is less expensive to the enrollee than the amount the enrollee is required to pay for
 595.2 the prescription drug under the enrollee's health plan.

595.3 Sec. 16. **[62W.12] POINT OF SALE.**

595.4 No pharmacy benefit manager or health carrier shall require an enrollee to make a
 595.5 payment at the point of sale for a covered prescription drug in an amount greater than the
 595.6 lesser of:

595.7 (1) the applicable co-payment for the prescription drug;

595.8 (2) the allowable claim amount for the prescription drug;

595.9 (3) the amount an enrollee would pay for the prescription drug if the enrollee purchased
 595.10 the prescription drug without using a health plan or any other source of prescription drug
 595.11 benefits or discounts; or

595.12 (4) the amount the pharmacy will be reimbursed for the prescription drug from the
 595.13 pharmacy benefit manager or health carrier.

595.14 Sec. 17. **[62W.13] RETROACTIVE ADJUSTMENTS.**

595.15 No pharmacy benefit manager shall retroactively adjust a claim for reimbursement
 595.16 submitted by a pharmacy for a prescription drug, unless the adjustment is a result of a:

595.17 (1) pharmacy audit conducted in accordance with section 62W.09; or

595.18 (2) technical billing error.

595.19 Sec. 18. Minnesota Statutes 2018, section 147.37, is amended to read:

595.20 **147.37 INFORMATION PROVISION; PHARMACEUTICAL ASSISTANCE**
 595.21 **PROGRAMS.**

595.22 At least annually, the board shall encourage licensees who are authorized to prescribe
 595.23 drugs to make available to patients information on ~~free and discounted prescription drug~~
 595.24 ~~programs offered by pharmaceutical manufacturers when the information is provided to the~~
 595.25 ~~licensees at no cost~~ sources of lower cost prescription drugs and shall provide these licensees
 595.26 with the address for the website established by the Board of Pharmacy pursuant to section
 595.27 151.06, subdivision 6.

596.1 Sec. 19. [148.192] INFORMATION PROVISION; PHARMACEUTICAL
596.2 ASSISTANCE PROGRAMS.

596.3 At least annually, the board shall encourage licensees who are authorized to prescribe
596.4 drugs to make available to patients information on sources of lower cost prescription drugs
596.5 and shall provide these licensees with the address for the website established by the Board
596.6 of Pharmacy pursuant to section 151.06, subdivision 6.

596.7 Sec. 20. Minnesota Statutes 2018, section 151.01, subdivision 23, is amended to read:

596.8 Subd. 23. **Practitioner.** "Practitioner" means a licensed doctor of medicine, licensed
596.9 doctor of osteopathic medicine duly licensed to practice medicine, licensed doctor of
596.10 dentistry, licensed doctor of optometry, licensed podiatrist, licensed veterinarian, or licensed
596.11 advanced practice registered nurse. For purposes of sections 151.15, subdivision 4; 151.211,
596.12 subdivision 3; 151.252, subdivision 3; 151.37, subdivision 2, paragraphs (b), (e), and (f);
596.13 and 151.461, "practitioner" also means a physician assistant authorized to prescribe, dispense,
596.14 and administer under chapter 147A. For purposes of sections 151.15, subdivision 4; 151.211,
596.15 subdivision 3; 151.252, subdivision 3; 151.37, subdivision 2, paragraph (b); and 151.461,
596.16 "practitioner" also means a dental therapist authorized to dispense and administer under
596.17 chapter 150A.

596.18 Sec. 21. Minnesota Statutes 2018, section 151.06, is amended by adding a subdivision to
596.19 read:

596.20 Subd. 6. **Information provision; sources of lower cost prescription drugs.** (a) The
596.21 board shall publish a page on its website that provides regularly updated information
596.22 concerning:

596.23 (1) pharmaceutical manufacturer patient assistance programs;

596.24 (2) the prescription drug assistance program established by the Minnesota Board of
596.25 Aging under section 256.975, subdivision 9;

596.26 (3) the emergency insulin assistance program established under section 256.937;

596.27 (4) the websites through which individuals can access information concerning eligibility
596.28 for and enrollment in Medicare, medical assistance, MinnesotaCare, and other
596.29 government-funded programs that help pay for the cost of health care;

596.30 (5) the program established under section 340b of the federal Public Health Services
596.31 Act, United States Code, title 42, section 256b; and

597.1 (6) any other resource that the board deems useful to individuals who are attempting to
597.2 purchase prescription drugs at lower costs.

597.3 (b) The board shall prepare educational documents and materials, including brochures
597.4 and posters, based on the information it provides on its website under paragraph (a). The
597.5 documents and materials shall be in a form that can be downloaded from the board's website
597.6 and used for patient education by pharmacists and by practitioners who are licensed to
597.7 prescribe. The board is not required to provide printed copies of these documents and
597.8 materials.

597.9 (c) At least annually, the board shall encourage licensed pharmacists and pharmacies to
597.10 make available to patients information on sources of lower cost prescription drugs and shall
597.11 provide these licensees with the address for the website established under paragraph (a).

597.12 Sec. 22. Minnesota Statutes 2018, section 151.071, subdivision 1, is amended to read:

597.13 Subdivision 1. **Forms of disciplinary action.** When the board finds that a licensee,
597.14 registrant, or applicant has engaged in conduct prohibited under subdivision 2, it may do
597.15 one or more of the following:

597.16 (1) deny the issuance of a license or registration;

597.17 (2) refuse to renew a license or registration;

597.18 (3) revoke the license or registration;

597.19 (4) suspend the license or registration;

597.20 (5) impose limitations, conditions, or both on the license or registration, including but
597.21 not limited to: the limitation of practice to designated settings; the limitation of the scope
597.22 of practice within designated settings; the imposition of retraining or rehabilitation
597.23 requirements; the requirement of practice under supervision; the requirement of participation
597.24 in a diversion program such as that established pursuant to section 214.31 or the conditioning
597.25 of continued practice on demonstration of knowledge or skills by appropriate examination
597.26 or other review of skill and competence;

597.27 (6) impose a civil penalty not exceeding \$10,000 for each separate violation, except that
597.28 a civil penalty not exceeding \$25,000 may be imposed for each separate violation of section
597.29 151.462, the amount of the civil penalty to be fixed so as to deprive a licensee or registrant
597.30 of any economic advantage gained by reason of the violation, to discourage similar violations
597.31 by the licensee or registrant or any other licensee or registrant, or to reimburse the board
597.32 for the cost of the investigation and proceeding, including but not limited to, fees paid for

598.1 services provided by the Office of Administrative Hearings, legal and investigative services
598.2 provided by the Office of the Attorney General, court reporters, witnesses, reproduction of
598.3 records, board members' per diem compensation, board staff time, and travel costs and
598.4 expenses incurred by board staff and board members; and

598.5 (7) reprimand the licensee or registrant.

598.6 Sec. 23. Minnesota Statutes 2018, section 151.071, subdivision 2, is amended to read:

598.7 Subd. 2. **Grounds for disciplinary action.** The following conduct is prohibited and is
598.8 grounds for disciplinary action:

598.9 (1) failure to demonstrate the qualifications or satisfy the requirements for a license or
598.10 registration contained in this chapter or the rules of the board. The burden of proof is on
598.11 the applicant to demonstrate such qualifications or satisfaction of such requirements;

598.12 (2) obtaining a license by fraud or by misleading the board in any way during the
598.13 application process or obtaining a license by cheating, or attempting to subvert the licensing
598.14 examination process. Conduct that subverts or attempts to subvert the licensing examination
598.15 process includes, but is not limited to: (i) conduct that violates the security of the examination
598.16 materials, such as removing examination materials from the examination room or having
598.17 unauthorized possession of any portion of a future, current, or previously administered
598.18 licensing examination; (ii) conduct that violates the standard of test administration, such as
598.19 communicating with another examinee during administration of the examination, copying
598.20 another examinee's answers, permitting another examinee to copy one's answers, or
598.21 possessing unauthorized materials; or (iii) impersonating an examinee or permitting an
598.22 impersonator to take the examination on one's own behalf;

598.23 (3) for a pharmacist, pharmacy technician, pharmacist intern, applicant for a pharmacist
598.24 or pharmacy license, or applicant for a pharmacy technician or pharmacist intern registration,
598.25 conviction of a felony reasonably related to the practice of pharmacy. Conviction as used
598.26 in this subdivision includes a conviction of an offense that if committed in this state would
598.27 be deemed a felony without regard to its designation elsewhere, or a criminal proceeding
598.28 where a finding or verdict of guilt is made or returned but the adjudication of guilt is either
598.29 withheld or not entered thereon. The board may delay the issuance of a new license or
598.30 registration if the applicant has been charged with a felony until the matter has been
598.31 adjudicated;

598.32 (4) for a facility, other than a pharmacy, licensed or registered by the board, if an owner
598.33 or applicant is convicted of a felony reasonably related to the operation of the facility. The

599.1 board may delay the issuance of a new license or registration if the owner or applicant has
599.2 been charged with a felony until the matter has been adjudicated;

599.3 (5) for a controlled substance researcher, conviction of a felony reasonably related to
599.4 controlled substances or to the practice of the researcher's profession. The board may delay
599.5 the issuance of a registration if the applicant has been charged with a felony until the matter
599.6 has been adjudicated;

599.7 (6) disciplinary action taken by another state or by one of this state's health licensing
599.8 agencies:

599.9 (i) revocation, suspension, restriction, limitation, or other disciplinary action against a
599.10 license or registration in another state or jurisdiction, failure to report to the board that
599.11 charges or allegations regarding the person's license or registration have been brought in
599.12 another state or jurisdiction, or having been refused a license or registration by any other
599.13 state or jurisdiction. The board may delay the issuance of a new license or registration if an
599.14 investigation or disciplinary action is pending in another state or jurisdiction until the
599.15 investigation or action has been dismissed or otherwise resolved; and

599.16 (ii) revocation, suspension, restriction, limitation, or other disciplinary action against a
599.17 license or registration issued by another of this state's health licensing agencies, failure to
599.18 report to the board that charges regarding the person's license or registration have been
599.19 brought by another of this state's health licensing agencies, or having been refused a license
599.20 or registration by another of this state's health licensing agencies. The board may delay the
599.21 issuance of a new license or registration if a disciplinary action is pending before another
599.22 of this state's health licensing agencies until the action has been dismissed or otherwise
599.23 resolved;

599.24 (7) for a pharmacist, pharmacy, pharmacy technician, or pharmacist intern, violation of
599.25 any order of the board, of any of the provisions of this chapter or any rules of the board or
599.26 violation of any federal, state, or local law or rule reasonably pertaining to the practice of
599.27 pharmacy;

599.28 (8) for a facility, other than a pharmacy, licensed by the board, violations of any order
599.29 of the board, of any of the provisions of this chapter or the rules of the board or violation
599.30 of any federal, state, or local law relating to the operation of the facility;

599.31 (9) engaging in any unethical conduct; conduct likely to deceive, defraud, or harm the
599.32 public, or demonstrating a willful or careless disregard for the health, welfare, or safety of
599.33 a patient; or pharmacy practice that is professionally incompetent, in that it may create

600.1 unnecessary danger to any patient's life, health, or safety, in any of which cases, proof of
600.2 actual injury need not be established;

600.3 (10) aiding or abetting an unlicensed person in the practice of pharmacy, except that it
600.4 is not a violation of this clause for a pharmacist to supervise a properly registered pharmacy
600.5 technician or pharmacist intern if that person is performing duties allowed by this chapter
600.6 or the rules of the board;

600.7 (11) for an individual licensed or registered by the board, adjudication as mentally ill
600.8 or developmentally disabled, or as a chemically dependent person, a person dangerous to
600.9 the public, a sexually dangerous person, or a person who has a sexual psychopathic
600.10 personality, by a court of competent jurisdiction, within or without this state. Such
600.11 adjudication shall automatically suspend a license for the duration thereof unless the board
600.12 orders otherwise;

600.13 (12) for a pharmacist or pharmacy intern, engaging in unprofessional conduct as specified
600.14 in the board's rules. In the case of a pharmacy technician, engaging in conduct specified in
600.15 board rules that would be unprofessional if it were engaged in by a pharmacist or pharmacist
600.16 intern or performing duties specifically reserved for pharmacists under this chapter or the
600.17 rules of the board;

600.18 (13) for a pharmacy, operation of the pharmacy without a pharmacist present and on
600.19 duty except as allowed by a variance approved by the board;

600.20 (14) for a pharmacist, the inability to practice pharmacy with reasonable skill and safety
600.21 to patients by reason of illness, drunkenness, use of drugs, narcotics, chemicals, or any other
600.22 type of material or as a result of any mental or physical condition, including deterioration
600.23 through the aging process or loss of motor skills. In the case of registered pharmacy
600.24 technicians, pharmacist interns, or controlled substance researchers, the inability to carry
600.25 out duties allowed under this chapter or the rules of the board with reasonable skill and
600.26 safety to patients by reason of illness, drunkenness, use of drugs, narcotics, chemicals, or
600.27 any other type of material or as a result of any mental or physical condition, including
600.28 deterioration through the aging process or loss of motor skills;

600.29 (15) for a pharmacist, pharmacy, pharmacist intern, pharmacy technician, medical gas
600.30 distributor, or controlled substance researcher, revealing a privileged communication from
600.31 or relating to a patient except when otherwise required or permitted by law;

600.32 (16) for a pharmacist or pharmacy, improper management of patient records, including
600.33 failure to maintain adequate patient records, to comply with a patient's request made pursuant
600.34 to sections 144.291 to 144.298, or to furnish a patient record or report required by law;

601.1 (17) fee splitting, including without limitation:

601.2 (i) paying, offering to pay, receiving, or agreeing to receive, a commission, rebate,
601.3 kickback, or other form of remuneration, directly or indirectly, for the referral of patients;
601.4 and

601.5 (ii) referring a patient to any health care provider as defined in sections 144.291 to
601.6 144.298 in which the licensee or registrant has a financial or economic interest as defined
601.7 in section 144.6521, subdivision 3, unless the licensee or registrant has disclosed the
601.8 licensee's or registrant's financial or economic interest in accordance with section 144.6521;

601.9 (18) engaging in abusive or fraudulent billing practices, including violations of the
601.10 federal Medicare and Medicaid laws or state medical assistance laws or rules;

601.11 (19) engaging in conduct with a patient that is sexual or may reasonably be interpreted
601.12 by the patient as sexual, or in any verbal behavior that is seductive or sexually demeaning
601.13 to a patient;

601.14 (20) failure to make reports as required by section 151.072 or to cooperate with an
601.15 investigation of the board as required by section 151.074;

601.16 (21) knowingly providing false or misleading information that is directly related to the
601.17 care of a patient unless done for an accepted therapeutic purpose such as the dispensing and
601.18 administration of a placebo;

601.19 (22) aiding suicide or aiding attempted suicide in violation of section 609.215 as
601.20 established by any of the following:

601.21 (i) a copy of the record of criminal conviction or plea of guilty for a felony in violation
601.22 of section 609.215, subdivision 1 or 2;

601.23 (ii) a copy of the record of a judgment of contempt of court for violating an injunction
601.24 issued under section 609.215, subdivision 4;

601.25 (iii) a copy of the record of a judgment assessing damages under section 609.215,
601.26 subdivision 5; or

601.27 (iv) a finding by the board that the person violated section 609.215, subdivision 1 or 2.
601.28 The board shall investigate any complaint of a violation of section 609.215, subdivision 1
601.29 or 2;

601.30 (23) for a pharmacist, practice of pharmacy under a lapsed or nonrenewed license. For
601.31 a pharmacist intern, pharmacy technician, or controlled substance researcher, performing
601.32 duties permitted to such individuals by this chapter or the rules of the board under a lapsed

602.1 or nonrenewed registration. For a facility required to be licensed under this chapter, operation
 602.2 of the facility under a lapsed or nonrenewed license or registration; ~~and~~

602.3 (24) for a pharmacist, pharmacist intern, or pharmacy technician, termination or discharge
 602.4 from the health professionals services program for reasons other than the satisfactory
 602.5 completion of the program; and

602.6 (25) for a manufacturer or wholesale drug distributor, a violation of section 151.462.

602.7 Sec. 24. Minnesota Statutes 2018, section 151.21, subdivision 7, is amended to read:

602.8 Subd. 7. **Drug formulary.** ~~This section~~ Subdivision 3 does not apply when a pharmacist
 602.9 is dispensing a prescribed drug to persons covered under a managed health care plan that
 602.10 maintains a mandatory or closed drug formulary.

602.11 Sec. 25. Minnesota Statutes 2018, section 151.21, is amended by adding a subdivision to
 602.12 read:

602.13 Subd. 7a. Coverage by substitution. (a) When a pharmacist receives a prescription
 602.14 order by paper or hard copy, by electronic transmission, or by oral instruction from the
 602.15 prescriber, in which the prescriber has not expressly indicated that the prescription is to be
 602.16 dispensed as communicated and the drug prescribed is not covered under the purchaser's
 602.17 health plan or prescription drug plan, the pharmacist may dispense a therapeutically
 602.18 equivalent and interchangeable prescribed drug or biological product that is covered under
 602.19 the purchaser's plan, if the pharmacist has a written protocol with the prescriber that outlines
 602.20 the class of drugs of the same generation and designed for the same indication that can be
 602.21 substituted and the required communication between the pharmacist and the prescriber.

602.22 (b) The pharmacist must inform the purchaser if the pharmacist is dispensing a drug or
 602.23 biological product other than the specific drug or biological product prescribed and the
 602.24 reason for the substitution.

602.25 (c) The pharmacist must communicate to the prescriber the name and manufacturer of
 602.26 the substituted drug that was dispensed and the reason for the substitution, in accordance
 602.27 with the written protocol.

602.28 Sec. 26. Minnesota Statutes 2018, section 151.211, subdivision 2, is amended to read:

602.29 Subd. 2. **Refill requirements.** Except as provided in subdivision 3, a prescription drug
 602.30 order may be refilled only with the written, electronic, or verbal consent of the prescriber
 602.31 and in accordance with the requirements of this chapter, the rules of the board, and where

603.1 applicable, section 152.11. The date of such refill must be recorded and initialed upon the
603.2 original prescription drug order, or within the electronically maintained record of the original
603.3 prescription drug order, by the pharmacist, pharmacist intern, or practitioner who refills the
603.4 prescription.

603.5 Sec. 27. Minnesota Statutes 2018, section 151.211, is amended by adding a subdivision
603.6 to read:

603.7 Subd. 3. **Emergency prescription refills.** (a) A pharmacist may, using sound professional
603.8 judgment and in accordance with accepted standards of practice, dispense a legend drug
603.9 without a current prescription drug order from a licensed practitioner if all of the following
603.10 conditions are met:

603.11 (1) the patient has been compliant with taking the medication and has consistently had
603.12 the drug filled or refilled as demonstrated by records maintained by the pharmacy;

603.13 (2) the pharmacy from which the legend drug is dispensed has record of a prescription
603.14 drug order for the drug in the name of the patient who is requesting it, but the prescription
603.15 drug order does not provide for a refill, or the time during which the refills were valid has
603.16 elapsed;

603.17 (3) the pharmacist has tried but is unable to contact the practitioner who issued the
603.18 prescription drug order, or another practitioner responsible for the patient's care, to obtain
603.19 authorization to refill the prescription;

603.20 (4) the drug is essential to sustain the life of the patient or to continue therapy for a
603.21 chronic condition;

603.22 (5) failure to dispense the drug to the patient would result in harm to the health of the
603.23 patient; and

603.24 (6) the drug is not a controlled substance listed in section 152.02, subdivisions 3 to 6,
603.25 except for a controlled substance that has been specifically prescribed to treat a seizure
603.26 disorder, in which case the pharmacist may dispense up to a 72-hour supply.

603.27 (b) If the conditions in paragraph (a) are met, the amount of the drug dispensed by the
603.28 pharmacist to the patient must not exceed a 30-day supply, or the quantity originally
603.29 prescribed, whichever is less, except as provided for controlled substances in paragraph (a),
603.30 clause (6). If the standard unit of dispensing for the drug exceeds a 30-day supply, the
603.31 amount of the drug dispensed or sold must not exceed the standard unit of dispensing.

604.1 (c) A pharmacist shall not dispense or sell the same drug to the same patient, as provided
604.2 in this section, more than one time in any 12-month period.

604.3 (d) A pharmacist must notify the practitioner who issued the prescription drug order not
604.4 later than 72 hours after the drug is sold or dispensed. The pharmacist must request and
604.5 receive authorization before any additional refills may be dispensed. If the practitioner
604.6 declines to provide authorization for additional refills, the pharmacist must inform the patient
604.7 of that fact.

604.8 (e) The record of a drug sold or dispensed under this section shall be maintained in the
604.9 same manner required for prescription drug orders under this section.

604.10 Sec. 28. Minnesota Statutes 2018, section 151.252, subdivision 1, is amended to read:

604.11 Subdivision 1. **Requirements.** (a) No person shall act as a drug manufacturer without
604.12 first obtaining a license from the board and paying any applicable fee specified in section
604.13 151.065.

604.14 (b) In addition to the license required under paragraph (a), a manufacturer of insulin
604.15 must pay the applicable insulin registration fee in section 151.254, by June 1 of each year,
604.16 beginning June 1, 2020. In the event of a change of ownership of the manufacturer, the new
604.17 owner must pay the registration fee in section 151.254 that the original owner would have
604.18 been assessed had it retained ownership. The board may assess a late fee of ten percent per
604.19 month for any portion of a month that the registration fee is paid after the due date. The
604.20 registration fee collected under this paragraph, including any late fees, shall be deposited
604.21 in the insulin assistance account established under section 256.938.

604.22 ~~(b)~~ (c) Application for a drug manufacturer license under this section shall be made in
604.23 a manner specified by the board.

604.24 ~~(e)~~ (d) No license shall be issued or renewed for a drug manufacturer unless the applicant
604.25 agrees to operate in a manner prescribed by federal and state law and according to Minnesota
604.26 Rules.

604.27 ~~(d)~~ (e) No license shall be issued or renewed for a drug manufacturer that is required to
604.28 be registered pursuant to United States Code, title 21, section 360, unless the applicant
604.29 supplies the board with proof of registration. The board may establish by rule the standards
604.30 for licensure of drug manufacturers that are not required to be registered under United States
604.31 Code, title 21, section 360.

604.32 ~~(e)~~ (f) No license shall be issued or renewed for a drug manufacturer that is required to
604.33 be licensed or registered by the state in which it is physically located unless the applicant

605.1 supplies the board with proof of licensure or registration. The board may establish, by rule,
605.2 standards for the licensure of a drug manufacturer that is not required to be licensed or
605.3 registered by the state in which it is physically located.

605.4 ~~(f)~~ (g) The board shall require a separate license for each facility located within the state
605.5 at which drug manufacturing occurs and for each facility located outside of the state at
605.6 which drugs that are shipped into the state are manufactured.

605.7 ~~(g)~~ (h) The board shall not issue an initial or renewed license for a drug manufacturing
605.8 facility unless the facility passes an inspection conducted by an authorized representative
605.9 of the board. In the case of a drug manufacturing facility located outside of the state, the
605.10 board may require the applicant to pay the cost of the inspection, in addition to the license
605.11 fee in section 151.065, unless the applicant furnishes the board with a report, issued by the
605.12 appropriate regulatory agency of the state in which the facility is located or by the United
605.13 States Food and Drug Administration, of an inspection that has occurred within the 24
605.14 months immediately preceding receipt of the license application by the board. The board
605.15 may deny licensure unless the applicant submits documentation satisfactory to the board
605.16 that any deficiencies noted in an inspection report have been corrected.

605.17 Sec. 29. [151.254] INSULIN REGISTRATION FEE.

605.18 Subdivision 1. Definition. (a) For purposes of this section, the following terms have the
605.19 meanings given them.

605.20 (b) "Manufacturer" means a manufacturer licensed under section 151.252 engaged in
605.21 the manufacturing of insulin.

605.22 (c) "Wholesaler" means a wholesale drug distributor licensed under section 151.47 and
605.23 engaged in the wholesale drug distribution of insulin.

605.24 Subd. 2. Reporting requirements. (a) Effective March 1 of each year, beginning March
605.25 1, 2020, each manufacturer and each wholesaler must report to the Board of Pharmacy every
605.26 sale, delivery, or other distribution within or into the state of insulin that was made to any
605.27 practitioner, pharmacy, hospital, or other person who is permitted by section 151.37 to
605.28 possess insulin for administration or was dispensed to human patients during the previous
605.29 calendar year. Reporting must be in a manner specified by the board. If the manufacturer
605.30 or wholesaler fails to provide information required under this paragraph on a timely basis,
605.31 the board may assess an administrative penalty of \$100 per day. This penalty shall not be
605.32 considered a form of disciplinary action. Any penalty assessed under this section shall be
605.33 deposited in the insulin assistance account established under section 256.938.

606.1 (b) By March 1 of each year, beginning March 1, 2020, each owner of a pharmacy with
606.2 at least one location within this state must report to the board any intracompany delivery
606.3 or distribution of insulin into this state, to the extent that those deliveries and distributions
606.4 are not reported to the board by a licensed wholesaler owned by, under contract to, or
606.5 otherwise operating on behalf of the owner of the pharmacy. Reporting must be in the
606.6 manner and format specified by the board for deliveries and distributions that occurred
606.7 during the previous calendar year. The report must include the name of the manufacturer
606.8 or wholesaler from which the owner of the pharmacy ultimately purchased the insulin and
606.9 the amount and date the purchase occurred.

606.10 Subd. 3. **Determination of manufacturer's registration fee.** (a) The board shall annually
606.11 assess manufacturers a registration fee that in aggregate equals the total cost of the insulin
606.12 assistance program established under section 256.937 for the previous fiscal year, including
606.13 any administration costs incurred by the commissioner of human services or the board in
606.14 collecting the fee. The board shall determine each manufacturer's annual insulin registration
606.15 fee that is prorated and based on the manufacturer's percentage of the total number of units
606.16 reported to the board under subdivision 2. For the first assessment, the commissioner shall
606.17 estimate the cost of the program for the first fiscal year and notify the board of the estimated
606.18 cost by March 1, 2020. The board shall determine each manufacturer's initial registration
606.19 fee based on the estimated cost.

606.20 (b) By April 1 of each year, beginning April 1, 2020, the board shall notify each
606.21 manufacturer of the annual amount of the manufacturer's insulin registration fee to be paid
606.22 in accordance with section 151.252, subdivision 1, paragraph (b).

606.23 (c) A manufacturer may dispute the fee assessed under this section as determined by the
606.24 board no later than 30 days after the date of notification. However, the manufacturer must
606.25 still remit the registration fee required by section 151.252, subdivision 1, paragraph (b).
606.26 The dispute must be filed with the board in the manner and using the forms specified by
606.27 the board. A manufacturer must submit, with the required forms, data satisfactory to the
606.28 board that demonstrates that the fee was incorrect or otherwise unwarranted. The board
606.29 must make a decision concerning a dispute no later than 60 days after receiving the required
606.30 dispute forms. If the board determines that the manufacturer has satisfactorily demonstrated
606.31 that the original fee was incorrect, the board must: (1) adjust the manufacturer's fee; (2)
606.32 adjust the manufacturer's fee due the next year by the amount in excess of the correct fee
606.33 that should have been paid; or (3) refund the amount paid in error.

607.1 Sec. 30. [151.462] PROHIBITION AGAINST CHARGING UNCONSCIONABLE
607.2 PRICES FOR PRESCRIPTION DRUGS.

607.3 Subdivision 1. Purpose. The purpose of this section is to promote public health in
607.4 Minnesota by preventing unconscionable price gouging with respect to the price of essential
607.5 prescription drugs sold in Minnesota. Essential prescription drugs are a necessity. These
607.6 drugs, which are made available in this state by drug manufacturers and wholesale
607.7 distributors, provide critically important benefits to the health and well-being of Minnesota
607.8 citizens. Abuses in the pricing of various essential prescription drugs are well-documented,
607.9 jeopardize the health and welfare of the public, and have caused the death of patients who
607.10 could not afford to pay an unconscionable price for these drugs. For example, these price
607.11 gouging practices have created a public health catastrophe in Minnesota regarding the sale
607.12 of insulin, an essential prescription drug for the treatment of more than 320,000 people
607.13 residing in Minnesota who are diabetic. This section is intended to address such abuses, but
607.14 allow drug manufacturers and wholesale drug distributors a fair rate of return with respect
607.15 to their sale of essential prescription drugs in the state of Minnesota.

607.16 Subd. 2. Definitions. (a) For purposes of this section, the following definitions apply.

607.17 (b) "Essential prescription drug" means a patented (including an exclusivity-protected
607.18 drug), off-patent, or generic drug prescribed in Minnesota by a practitioner:

607.19 (1) that either:

607.20 (i) is covered under the medical assistance program or by any Medicare Part D plan
607.21 offered in the state of Minnesota; or

607.22 (ii) has been designated by the commissioner of human services under subdivision 4 as
607.23 an essential medicine due to its efficacy in treating a life-threatening health condition or a
607.24 chronic health condition that substantially impairs an individual's ability to engage in
607.25 activities of daily living; and

607.26 (2) for which:

607.27 (i) a 30-day supply of the maximum recommended dosage of the drug for any indication,
607.28 according to the label for the drug approved under the Federal Food, Drug, and Cosmetic
607.29 Act, would cost more than \$80 at the drug's wholesale acquisition cost;

607.30 (ii) a full course of treatment with the drug, according to the label for the drug approved
607.31 under the Federal Food, Drug, and Cosmetic Act, would cost more than \$80 at the drug's
607.32 wholesale acquisition cost; or

608.1 (iii) if the drug is made available to consumers only in quantities that do not correspond
608.2 to a 30-day supply, a full course of treatment, or a single dose, it would cost more than \$80
608.3 at the drug's wholesale acquisition cost to obtain a 30-day supply or a full course of treatment.
608.4 Essential prescription drug also includes a patented or off-patent drug-device combination
608.5 product, whose wholesale acquisition cost is more than \$80, and which is used at least in
608.6 part for delivery of a drug described in this paragraph.

608.7 (c) "Health plan company" has the meaning provided in section 62Q.01, subdivision 4.

608.8 (d) "Unconscionable price" means a price that:

608.9 (1) is not reasonably justified by the actual cost of inventing, producing, selling, and
608.10 distributing the essential prescription drug, and any actual cost of an appropriate expansion
608.11 of access to the drug to promote public health; and

608.12 (2) applies to an essential prescription drug sold to:

608.13 (i) consumers in Minnesota;

608.14 (ii) the commissioner of human services for use in a Minnesota public health care
608.15 program; or

608.16 (iii) a health plan company providing medical care to Minnesota consumers; and the
608.17 consumer, commissioner, or health plan company has no meaningful choice about whether
608.18 to purchase the drug, because there is no other comparable drug sold in Minnesota at a price
608.19 that is reasonably justified by the actual cost of inventing, producing, selling, and distributing
608.20 the comparable drug, and any actual cost of an appropriate expansion of access to the drug
608.21 to promote public health.

608.22 (e) "Wholesale acquisition cost" has the meaning given in United States Code, title 42,
608.23 section 1395w-3a.

608.24 Subd. 3. **Prohibition.** No drug manufacturer or wholesale drug distributor shall charge
608.25 or cause to be charged in Minnesota an unconscionable price for an essential prescription
608.26 drug sold in Minnesota. It is not a violation of this section for a wholesale drug distributor
608.27 to charge a price for an essential prescription drug to be sold in Minnesota that is directly
608.28 and substantially attributable to the cost of the drug charged by the manufacturer.

608.29 Subd. 4. **Commissioner of human services; list of essential prescription drugs.** The
608.30 commissioner of human services, in consultation with the Formulary Committee established
608.31 under section 256B.0625, subdivision 13c, may designate essential medicines in accordance
608.32 with subdivision 2, paragraph (b), clause (1), item (ii), and shall maintain a list of all essential

609.1 prescription drugs on the agency website. The commissioner is exempt from the rulemaking
609.2 requirements of chapter 14 in making the essential medicine designation and compiling the
609.3 list of all essential prescription drugs under this subdivision.

609.4 Subd. 5. **Notification of attorney general.** The Minnesota Board of Pharmacy, the
609.5 commissioner of human services, and health plan companies providing health coverage to
609.6 Minnesota consumers, shall notify the attorney general of any increase of 15 percent or
609.7 more during a one-year period in the price of any essential prescription drug sold in
609.8 Minnesota.

609.9 Subd. 6. **Attorney general's office to confer with drug manufacturer or distributor.** In
609.10 order for the attorney general to bring an action for an alleged violation of subdivision 3
609.11 against a drug manufacturer or wholesale distributor, the attorney general must have provided
609.12 the manufacturer or wholesale distributor an opportunity to meet with the attorney general
609.13 to present any justification for the price of the essential prescription drug. This meeting
609.14 shall be in addition to any response or responses that the drug manufacturer or wholesale
609.15 distributor may make to prelitigation investigation or discovery conducted by the attorney
609.16 general pursuant to section 8.31.

609.17 Subd. 7. **Private right of action.** Any action brought pursuant to section 8.31, subdivision
609.18 3a, by a person injured by a violation of this section is for the benefit of the public.

609.19 Subd. 8. **Severability.** In accordance with section 645.20, it is the intent of the legislature
609.20 that the provisions, or any part of a provision, of this section or its effective date are severable
609.21 in the event any provision, or any part of a provision, of this section or its effective date is
609.22 found by a court to be unconstitutional.

609.23 **EFFECTIVE DATE.** This section is effective the day following final enactment and,
609.24 notwithstanding any statutory or common law to the contrary, applies retroactively to any
609.25 prices charged by a drug manufacturer or drug wholesaler for essential prescription drugs
609.26 sold or distributed in Minnesota on or after July 1, 2014.

609.27 Sec. 31. **[151.555] PRESCRIPTION DRUG REPOSITORY PROGRAM.**

609.28 Subdivision 1. **Definitions.** (a) For the purposes of this section, the terms defined in this
609.29 subdivision have the meanings given.

609.30 (b) "Central repository" means a wholesale distributor that meets the requirements under
609.31 subdivision 3 and enters into a contract with the Board of Pharmacy in accordance with this
609.32 section.

609.33 (c) "Distribute" means to deliver, other than by administering or dispensing.

610.1 (d) "Donor" means:

610.2 (1) a health care facility as defined in this subdivision;

610.3 (2) a skilled nursing facility licensed under chapter 144A;

610.4 (3) an assisted living facility registered under chapter 144D where there is centralized
610.5 storage of drugs and 24-hour on-site licensed nursing coverage provided seven days a week;

610.6 (4) a pharmacy licensed under section 151.19, and located either in the state or outside
610.7 the state;

610.8 (5) a drug wholesaler licensed under section 151.47;

610.9 (6) a drug manufacturer licensed under section 151.252; or

610.10 (7) an individual at least 18 years of age, provided that the drug or medical supply that
610.11 is donated was obtained legally and meets the requirements of this section for donation.

610.12 (e) "Drug" means any prescription drug that has been approved for medical use in the
610.13 United States, is listed in the United States Pharmacopoeia or National Formulary, and
610.14 meets the criteria established under this section for donation. This definition includes cancer
610.15 drugs and antirejection drugs, but does not include controlled substances, as defined in
610.16 section 152.01, subdivision 4, or a prescription drug that can only be dispensed to a patient
610.17 registered with the drug's manufacturer in accordance with federal Food and Drug
610.18 Administration requirements.

610.19 (f) "Health care facility" means:

610.20 (1) a physician's office or health care clinic where licensed practitioners provide health
610.21 care to patients;

610.22 (2) a hospital licensed under section 144.50;

610.23 (3) a pharmacy licensed under section 151.19 and located in Minnesota; or

610.24 (4) a nonprofit community clinic, including a federally qualified health center; a rural
610.25 health clinic; public health clinic; or other community clinic that provides health care utilizing
610.26 a sliding fee scale to patients who are low-income, uninsured, or underinsured.

610.27 (g) "Local repository" means a health care facility that elects to accept donated drugs
610.28 and medical supplies and meets the requirements of subdivision 4.

610.29 (h) "Medical supplies" or "supplies" means any prescription and nonprescription medical
610.30 supply needed to administer a prescription drug.

611.1 (i) "Original, sealed, unopened, tamper-evident packaging" means packaging that is
611.2 sealed, unopened, and tamper-evident, including a manufacturer's original unit dose or
611.3 unit-of-use container, a repackager's original unit dose or unit-of-use container, or unit-dose
611.4 packaging prepared by a licensed pharmacy according to the standards of Minnesota Rules,
611.5 part 6800.3750.

611.6 (j) "Practitioner" has the meaning given in section 151.01, subdivision 23, except that
611.7 it does not include a veterinarian.

611.8 Subd. 2. **Establishment.** By January 1, 2020, the Board of Pharmacy shall establish a
611.9 drug repository program, through which donors may donate a drug or medical supply for
611.10 use by an individual who meets the eligibility criteria specified under subdivision 5. The
611.11 board shall contract with a central repository that meets the requirements of subdivision 3
611.12 to implement and administer the prescription drug repository program.

611.13 Subd. 3. **Central repository requirements.** (a) The board shall publish a request for
611.14 proposal for participants who meet the requirements of this subdivision and are interested
611.15 in acting as the central repository for the drug repository program. The board shall follow
611.16 all applicable state procurement procedures in the selection process.

611.17 (b) To be eligible to act as the central repository, the participant must be a wholesale
611.18 drug distributor located in Minnesota, licensed pursuant to section 151.47, and in compliance
611.19 with all applicable federal and state statutes, rules, and regulations.

611.20 (c) The central repository shall be subject to inspection by the board pursuant to section
611.21 151.06, subdivision 1.

611.22 (d) The central repository shall comply with all applicable federal and state laws, rules,
611.23 and regulations pertaining to the drug repository program, drug storage, and dispensing.
611.24 The facility must maintain in good standing any state license or registration that applies to
611.25 the facility.

611.26 Subd. 4. **Local repository requirements.** (a) To be eligible for participation in the drug
611.27 repository program, a health care facility must agree to comply with all applicable federal
611.28 and state laws, rules, and regulations pertaining to the drug repository program, drug storage,
611.29 and dispensing. The facility must also agree to maintain in good standing any required state
611.30 license or registration that may apply to the facility.

611.31 (b) A local repository may elect to participate in the program by submitting the following
611.32 information to the central repository on a form developed by the board and made available
611.33 on the board's website:

612.1 (1) the name, street address, and telephone number of the health care facility and any
612.2 state-issued license or registration number issued to the facility, including the issuing state
612.3 agency;

612.4 (2) the name and telephone number of a responsible pharmacist or practitioner who is
612.5 employed by or under contract with the health care facility; and

612.6 (3) a statement signed and dated by the responsible pharmacist or practitioner indicating
612.7 that the health care facility meets the eligibility requirements under this section and agrees
612.8 to comply with this section.

612.9 (c) Participation in the drug repository program is voluntary. A local repository may
612.10 withdraw from participation in the drug repository program at any time by providing written
612.11 notice to the central repository on a form developed by the board and made available on
612.12 the board's website. The central repository shall provide the board with a copy of the
612.13 withdrawal notice within ten business days from the date of receipt of the withdrawal notice.

612.14 Subd. 5. **Individual eligibility and application requirements.** (a) To be eligible for
612.15 the drug repository program, an individual must submit to a local repository an intake
612.16 application form that is signed by the individual and attests that the individual:

612.17 (1) is a resident of Minnesota;

612.18 (2) is uninsured and is not enrolled in the medical assistance program under chapter
612.19 256B or the MinnesotaCare program under chapter 256L, has no prescription drug coverage,
612.20 or is underinsured;

612.21 (3) acknowledges that the drugs or medical supplies to be received through the program
612.22 may have been donated; and

612.23 (4) consents to a waiver of the child-resistant packaging requirements of the federal
612.24 Poison Prevention Packaging Act.

612.25 (b) Upon determining that an individual is eligible for the program, the local repository
612.26 shall furnish the individual with an identification card. The card shall be valid for one year
612.27 from the date of issuance and may be used at any local repository. A new identification card
612.28 may be issued upon expiration once the individual submits a new application form.

612.29 (c) The local repository shall send a copy of the intake application form to the central
612.30 repository by regular mail, facsimile, or secured e-mail within ten days from the date the
612.31 application is approved by the local repository.

613.1 (d) The board shall develop and make available on the board's website an application
613.2 form and the format for the identification card.

613.3 **Subd. 6. Standards and procedures for accepting donations of drugs and supplies. (a)**
613.4 A donor may donate prescription drugs or medical supplies to the central repository or a
613.5 local repository if the drug or supply meets the requirements of this section as determined
613.6 by a pharmacist or practitioner who is employed by or under contract with the central
613.7 repository or a local repository.

613.8 (b) A prescription drug is eligible for donation under the drug repository program if the
613.9 following requirements are met:

613.10 (1) the donation is accompanied by a drug repository donor form described under
613.11 paragraph (d) that is signed by an individual who is authorized by the donor to attest to the
613.12 donor's knowledge in accordance with paragraph (d);

613.13 (2) the drug's expiration date is at least six months after the date the drug was donated.
613.14 If a donated drug bears an expiration date that is less than six months from the donation
613.15 date, the drug may be accepted and distributed if the drug is in high demand and can be
613.16 dispensed for use by a patient before the drug's expiration date;

613.17 (3) the drug is in its original, sealed, unopened, tamper-evident packaging that includes
613.18 the expiration date. Single-unit-dose drugs may be accepted if the single-unit-dose packaging
613.19 is unopened;

613.20 (4) the drug or the packaging does not have any physical signs of tampering, misbranding,
613.21 deterioration, compromised integrity, or adulteration;

613.22 (5) the drug does not require storage temperatures other than normal room temperature
613.23 as specified by the manufacturer or United States Pharmacopoeia, unless the drug is being
613.24 donated directly by its manufacturer, a wholesale drug distributor, or a pharmacy located
613.25 in Minnesota; and

613.26 (6) the prescription drug is not a controlled substance.

613.27 (c) A medical supply is eligible for donation under the drug repository program if the
613.28 following requirements are met:

613.29 (1) the supply has no physical signs of tampering, misbranding, or alteration and there
613.30 is no reason to believe it has been adulterated, tampered with, or misbranded;

613.31 (2) the supply is in its original, unopened, sealed packaging;

614.1 (3) the donation is accompanied by a drug repository donor form described under
614.2 paragraph (d) that is signed by an individual who is authorized by the donor to attest to the
614.3 donor's knowledge in accordance with paragraph (d); and

614.4 (4) if the supply bears an expiration date, the date is at least six months later than the
614.5 date the supply was donated. If the donated supply bears an expiration date that is less than
614.6 six months from the date the supply was donated, the supply may be accepted and distributed
614.7 if the supply is in high demand and can be dispensed for use by a patient before the supply's
614.8 expiration date.

614.9 (d) The board shall develop the drug repository donor form and make it available on the
614.10 board's website. The form must state that to the best of the donor's knowledge the donated
614.11 drug or supply has been properly stored under appropriate temperature and humidity
614.12 conditions, and that the drug or supply has never been opened, used, tampered with,
614.13 adulterated, or misbranded.

614.14 (e) Donated drugs and supplies may be shipped or delivered to the premises of the central
614.15 repository or a local repository, and shall be inspected by a pharmacist or an authorized
614.16 practitioner who is employed by or under contract with the repository and who has been
614.17 designated by the repository to accept donations. A drop box must not be used to deliver
614.18 or accept donations.

614.19 (f) The central repository and local repository shall inventory all drugs and supplies
614.20 donated to the repository. For each drug, the inventory must include the drug's name, strength,
614.21 quantity, manufacturer, expiration date, and the date the drug was donated. For each medical
614.22 supply, the inventory must include a description of the supply, its manufacturer, the date
614.23 the supply was donated, and, if applicable, the supply's brand name and expiration date.

614.24 **Subd. 7. Standards and procedures for inspecting and storing donated prescription**
614.25 **drugs and supplies.** (a) A pharmacist or authorized practitioner who is employed by or
614.26 under contract with the central repository or a local repository shall inspect all donated
614.27 prescription drugs and supplies before the drug or supply is dispensed to determine, to the
614.28 extent reasonably possible in the professional judgment of the pharmacist or practitioner,
614.29 that the drug or supply is not adulterated or misbranded, has not been tampered with, is safe
614.30 and suitable for dispensing, has not been subject to a recall, and meets the requirements for
614.31 donation. The pharmacist or practitioner who inspects the drugs or supplies shall sign an
614.32 inspection record stating that the requirements for donation have been met. If a local
614.33 repository receives drugs and supplies from the central repository, the local repository does
614.34 not need to reinspect the drugs and supplies.

615.1 (b) The central repository and local repositories shall store donated drugs and supplies
615.2 in a secure storage area under environmental conditions appropriate for the drug or supply
615.3 being stored. Donated drugs and supplies may not be stored with nondonated inventory. If
615.4 donated drugs or supplies are not inspected immediately upon receipt, a repository must
615.5 quarantine the donated drugs or supplies separately from all dispensing stock until the
615.6 donated drugs or supplies have been inspected and (1) approved for dispensing under the
615.7 program; (2) disposed of pursuant to paragraph (c); or (3) returned to the donor pursuant to
615.8 paragraph (d).

615.9 (c) The central repository and local repositories shall dispose of all prescription drugs
615.10 and medical supplies that are not suitable for donation in compliance with applicable federal
615.11 and state statutes, regulations, and rules concerning hazardous waste.

615.12 (d) In the event that controlled substances or prescription drugs that can only be dispensed
615.13 to a patient registered with the drug's manufacturer are shipped or delivered to a central or
615.14 local repository for donation, the shipment delivery must be documented by the repository
615.15 and returned immediately to the donor or the donor's representative that provided the drugs.

615.16 (e) Each repository must develop drug and medical supply recall policies and procedures.
615.17 If a repository receives a recall notification, the repository shall destroy all of the drug or
615.18 medical supply in its inventory that is the subject of the recall and complete a record of
615.19 destruction form in accordance with paragraph (f). If a drug or medical supply that is the
615.20 subject of a Class I or Class II recall has been dispensed, the repository shall immediately
615.21 notify the recipient of the recalled drug or medical supply. A drug that potentially is subject
615.22 to a recall need not be destroyed if its packaging bears a lot number and that lot of the drug
615.23 is not subject to the recall. If no lot number is on the drug's packaging, it must be destroyed.

615.24 (f) A record of destruction of donated drugs and supplies that are not dispensed under
615.25 subdivision 8, are subject to a recall under paragraph (e), or are not suitable for donation
615.26 shall be maintained by the repository for at least five years. For each drug or supply
615.27 destroyed, the record shall include the following information:

615.28 (1) the date of destruction;

615.29 (2) the name, strength, and quantity of the drug destroyed; and

615.30 (3) the name of the person or firm that destroyed the drug.

615.31 Subd. 8. **Dispensing requirements.** (a) Donated drugs and supplies may be dispensed
615.32 if the drugs or supplies are prescribed by a practitioner for use by an eligible individual and
615.33 are dispensed by a pharmacist or practitioner. A repository shall dispense drugs and supplies

616.1 to eligible individuals in the following priority order: (1) individuals who are uninsured;
616.2 (2) individuals with no prescription drug coverage; and (3) individuals who are underinsured.
616.3 A repository shall dispense donated prescription drugs in compliance with applicable federal
616.4 and state laws and regulations for dispensing prescription drugs, including all requirements
616.5 relating to packaging, labeling, record keeping, drug utilization review, and patient
616.6 counseling.

616.7 (b) Before dispensing or administering a drug or supply, the pharmacist or practitioner
616.8 shall visually inspect the drug or supply for adulteration, misbranding, tampering, and date
616.9 of expiration. Drugs or supplies that have expired or appear upon visual inspection to be
616.10 adulterated, misbranded, or tampered with in any way must not be dispensed or administered.

616.11 (c) Before a drug or supply is dispensed or administered to an individual, the individual
616.12 must sign a drug repository recipient form acknowledging that the individual understands
616.13 the information stated on the form. The board shall develop the form and make it available
616.14 on the board's website. The form must include the following information:

616.15 (1) that the drug or supply being dispensed or administered has been donated and may
616.16 have been previously dispensed;

616.17 (2) that a visual inspection has been conducted by the pharmacist or practitioner to ensure
616.18 that the drug or supply has not expired, has not been adulterated or misbranded, and is in
616.19 its original, unopened packaging; and

616.20 (3) that the dispensing pharmacist, the dispensing or administering practitioner, the
616.21 central repository or local repository, the Board of Pharmacy, and any other participant of
616.22 the drug repository program cannot guarantee the safety of the drug or medical supply being
616.23 dispensed or administered and that the pharmacist or practitioner has determined that the
616.24 drug or supply is safe to dispense or administer based on the accuracy of the donor's form
616.25 submitted with the donated drug or medical supply and the visual inspection required to be
616.26 performed by the pharmacist or practitioner before dispensing or administering.

616.27 Subd. 9. **Handling fees.** (a) The central or local repository may charge the individual
616.28 receiving a drug or supply a handling fee of no more than 250 percent of the medical
616.29 assistance program dispensing fee for each drug or medical supply dispensed or administered
616.30 by that repository.

616.31 (b) A repository that dispenses or administers a drug or medical supply through the drug
616.32 repository program shall not receive reimbursement under the medical assistance program
616.33 or the MinnesotaCare program for that dispensed or administered drug or supply.

617.1 Subd. 10. **Distribution of donated drugs and supplies.** (a) The central repository and
617.2 local repositories may distribute drugs and supplies donated under the drug repository
617.3 program to other participating repositories for use pursuant to this program.

617.4 (b) A local repository that elects not to dispense donated drugs or supplies must transfer
617.5 all donated drugs and supplies to the central repository. A copy of the donor form that was
617.6 completed by the original donor under subdivision 6 must be provided to the central
617.7 repository at the time of transfer.

617.8 Subd. 11. **Forms and record-keeping requirements.** (a) The following forms developed
617.9 for the administration of this program shall be utilized by the participants of the program
617.10 and shall be available on the board's website:

617.11 (1) intake application form described under subdivision 5;

617.12 (2) local repository participation form described under subdivision 4;

617.13 (3) local repository withdrawal form described under subdivision 4;

617.14 (4) drug repository donor form described under subdivision 6;

617.15 (5) record of destruction form described under subdivision 7; and

617.16 (6) drug repository recipient form described under subdivision 8.

617.17 (b) All records, including drug inventory, inspection, and disposal of donated prescription
617.18 drugs and medical supplies must be maintained by a repository for a minimum of five years.
617.19 Records required as part of this program must be maintained pursuant to all applicable
617.20 practice acts.

617.21 (c) Data collected by the drug repository program from all local repositories shall be
617.22 submitted quarterly or upon request to the central repository. Data collected may consist of
617.23 the information, records, and forms required to be collected under this section.

617.24 (d) The central repository shall submit reports to the board as required by the contract
617.25 or upon request of the board.

617.26 Subd. 12. **Liability.** (a) The manufacturer of a drug or supply is not subject to criminal
617.27 or civil liability for injury, death, or loss to a person or to property for causes of action
617.28 described in clauses (1) and (2). A manufacturer is not liable for:

617.29 (1) the intentional or unintentional alteration of the drug or supply by a party not under
617.30 the control of the manufacturer; or

618.1 (2) the failure of a party not under the control of the manufacturer to transfer or
618.2 communicate product or consumer information or the expiration date of the donated drug
618.3 or supply.

618.4 (b) A health care facility participating in the program, a pharmacist dispensing a drug
618.5 or supply pursuant to the program, a practitioner dispensing or administering a drug or
618.6 supply pursuant to the program, or a donor of a drug or medical supply is immune from
618.7 civil liability for an act or omission that causes injury to or the death of an individual to
618.8 whom the drug or supply is dispensed and no disciplinary action by a health-related licensing
618.9 board shall be taken against a pharmacist or practitioner so long as the drug or supply is
618.10 donated, accepted, distributed, and dispensed according to the requirements of this section.
618.11 This immunity does not apply if the act or omission involves reckless, wanton, or intentional
618.12 misconduct, or malpractice unrelated to the quality of the drug or medical supply.

618.13 Subd. 13. **Drug returned for credit.** Nothing in this section allows a long-term care
618.14 facility to donate a drug to a central or local repository when federal or state law requires
618.15 the drug to be returned to the pharmacy that initially dispensed it, so that the pharmacy can
618.16 credit the payer for the amount of the drug returned.

618.17 **Sec. 32. [151.80] PRESCRIPTION DRUG PRICE TRANSPARENCY ACT.**

618.18 Sections 151.80 to 151.83 shall be known as the "Prescription Drug Price Transparency
618.19 Act."

618.20 **Sec. 33. [151.81] DEFINITIONS.**

618.21 Subdivision 1. **Applicability.** Only for purposes of sections 151.80 to 151.83, the terms
618.22 defined in this section have the meanings given.

618.23 Subd. 2. **Commissioner.** "Commissioner" means the commissioner of health.

618.24 Subd. 3. **New prescription drug.** "New prescription drug" means a prescription drug
618.25 approved for marketing by the United States Food and Drug Administration (FDA) for
618.26 which no previous wholesale acquisition cost has been established for comparison.

618.27 Subd. 4. **Patient assistance program or program.** "Patient assistance program" or
618.28 "program" means a program that a manufacturer offers to the general public in which a
618.29 consumer may reduce the out-of-pocket costs for prescription drugs paid by the consumer
618.30 by using coupons, discount cards, prepaid gift cards, manufacturer debit cards, or other
618.31 reduction in out-of-pocket costs by other means.

619.1 Subd. 5. **Prescription drug.** "Prescription drug" has the meaning provided in section
619.2 151.44, paragraph (d).

619.3 Subd. 6. **Price.** "Price" means the wholesale acquisition cost as defined in United States
619.4 Code, title 42, section 1395w-3a(c)(6)(B).

619.5 Subd. 7. **Profit.** "Profit" means the total sales revenue for a prescription drug during the
619.6 previous calendar year and the manufacturer's profit attributable to the same prescription
619.7 drug during the previous calendar year.

619.8 Sec. 34. **[151.83] REPORTING PRESCRIPTION DRUG PRICES.**

619.9 Subdivision 1. **Applicability.** Beginning October 1, 2019, a manufacturer shall report
619.10 the information described in subdivisions 2, 3, and 4 to the commissioner according to the
619.11 requirements in subdivision 2, 3, or 4 as applicable.

619.12 Subd. 2. **Prescription drug price increases reporting.** For every prescription drug
619.13 priced more than \$40 for a course of therapy, whose price increases by more than ten percent
619.14 in a 12-month period or more than 16 percent in a 24-month period, the manufacturer shall
619.15 report to the commissioner at least 60 days in advance of the increase, in the form and
619.16 manner prescribed by the commissioner, the following information in a form and format
619.17 the commissioner has determined is appropriate for public display:

619.18 (1) the wholesale acquisition cost of the drug for each of the last five calendar years, as
619.19 applicable;

619.20 (2) the price increase as a percentage of the drug's price for each of the last five calendar
619.21 years, as applicable;

619.22 (3) the price of the drug at its initial launch;

619.23 (4) the factors that contributed to the price increase;

619.24 (5) the introductory price of the prescription drug when it was approved for marketing
619.25 by the FDA;

619.26 (6) the direct costs incurred by the manufacturer that are associated with the drug, listed
619.27 separately:

619.28 (i) to manufacture the prescription drug;

619.29 (ii) to market the prescription drug, including advertising costs;

619.30 (iii) to research and develop the prescription drug;

619.31 (iv) to distribute the prescription drug;

- 620.1 (v) other administrative costs; and
- 620.2 (vi) profit;
- 620.3 (7) the percentage of the price spent on developing, manufacturing, and distributing the
620.4 drug;
- 620.5 (8) a description of the change or improvement in the drug, if any, that necessitates the
620.6 price increase;
- 620.7 (9) the total amount of financial assistance that the manufacturer has provided through
620.8 any patient prescription assistance program;
- 620.9 (10) any agreement between a manufacturer and another party contingent upon any delay
620.10 in offering to market a generic version of the manufacturer's drug;
- 620.11 (11) the patent expiration date of the drug if it is under patent;
- 620.12 (12) the research and development costs associated with the prescription drug that were
620.13 paid using public funds;
- 620.14 (13) any other information that the manufacturer deems relevant to the price increase
620.15 described in this subdivision; and
- 620.16 (14) the documentation necessary to support the information reported under this
620.17 subdivision.
- 620.18 **Subd. 3. New prescription drug price reporting.** For every new prescription drug that
620.19 is a brand name drug that is priced over \$500 for a 30-day supply or a generic name drug
620.20 that is priced over \$200 for a 30-day supply, 60 days or less after a manufacturer introduces
620.21 a new prescription drug for sale in the United States, the manufacturer shall notify the
620.22 commissioner, in the form and manner prescribed by the commissioner, of all the following
620.23 information in a form and format the commissioner has determined is appropriate for public
620.24 display:
- 620.25 (1) the wholesale acquisition cost of the drug;
- 620.26 (2) the price of the drug at its initial launch;
- 620.27 (3) the factors that contributed to the price;
- 620.28 (4) the direct costs incurred by the manufacturer that are associated with that drug, listed
620.29 separately:
- 620.30 (i) to manufacture the prescription drug;
- 620.31 (ii) to market the prescription drug, including advertising costs;

- 621.1 (iii) to research and develop the prescription drug;
- 621.2 (iv) to distribute the prescription drug;
- 621.3 (v) other administrative costs; and
- 621.4 (vi) profit;
- 621.5 (5) the percentage of the price spent on developing, manufacturing, and distributing the
- 621.6 drug;
- 621.7 (6) the total amount of financial assistance that the manufacturer has provided through
- 621.8 any patient prescription assistance program;
- 621.9 (7) any agreement between a manufacturer and another party contingent upon any delay
- 621.10 in offering to market a generic version of the manufacturer's drug;
- 621.11 (8) the patent expiration date of the drug if it is under patent;
- 621.12 (9) the research and development costs associated with the prescription drug that were
- 621.13 paid using public funds;
- 621.14 (10) any other information that the manufacturer deems relevant to the price described
- 621.15 in this subdivision; and
- 621.16 (11) the documentation necessary to support the information reported under this
- 621.17 subdivision.
- 621.18 **Subd. 4. Newly acquired prescription drug price reporting.** For every newly acquired
- 621.19 prescription drug that is a brand name drug that is priced over \$100 for a 30-day supply or
- 621.20 a generic name drug that is priced over \$50 for a 30-day supply, the acquiring manufacturer
- 621.21 shall report to the commissioner at least 60 days in advance of the acquisition, in the form
- 621.22 and manner prescribed by the commissioner, the following information in a form and format
- 621.23 the commissioner has determined is appropriate for public display:
- 621.24 (1) the wholesale acquisition cost at the time of acquisition and in the calendar year prior
- 621.25 to acquisition;
- 621.26 (2) the name of the company from which the drug was acquired, the date acquired, and
- 621.27 the purchase price;
- 621.28 (3) the year the drug was introduced to market and the wholesale acquisition cost of the
- 621.29 drug at the time of introduction;
- 621.30 (4) the previous five calendar years' wholesale acquisition cost of the newly acquired
- 621.31 brand name drug or newly acquired generic name drug;

622.1 (5) the direct costs incurred by the manufacturer that are associated with the drug, listed
622.2 separately:

622.3 (i) to manufacture the prescription drug;

622.4 (ii) to market the prescription drug, including advertising costs;

622.5 (iii) to research and develop the prescription drug;

622.6 (iv) to distribute the prescription drug;

622.7 (v) other administrative costs; and

622.8 (vi) profit;

622.9 (6) the percentage of the price projected to be spent on developing, manufacturing, and
622.10 distributing the drug;

622.11 (7) the total amount of financial assistance that the manufacturer has provided through
622.12 any patient prescription assistance program;

622.13 (8) any agreement between a manufacturer and another party contingent upon any delay
622.14 in offering to market a generic version of the manufacturer's drug;

622.15 (9) the patent expiration date of the drug if it is under patent;

622.16 (10) the research and development costs associated with the prescription drug that were
622.17 paid using public funds; and

622.18 (11) if available, the price as determined reasonable through effectiveness measures.

622.19 Subd. 5. **Comparison data.** The commissioner may use any publicly available
622.20 prescription drug price information the commissioner deems appropriate to verify that
622.21 manufacturers have properly reported price increases as required by subdivision 2 of this
622.22 section.

622.23 Subd. 6. **Additional information requested.** After receiving the report or information
622.24 described in subdivision 2, 3, 4, or 5, the commissioner may make a written request to the
622.25 manufacturer for supporting documentation or additional information concerning the report.

622.26 Subd. 7. **Public posting of prescription drug price information.** (a) Except as provided
622.27 in paragraph (c), the commissioner shall post to the department's website 30 days before a
622.28 price change is effective the information from the manufacturer, in an easy-to-read format,
622.29 that includes all of the following information:

622.30 (1) a list of the prescription drugs reported under subdivisions 2, 3, and 4 and the
622.31 manufacturers of those prescription drugs; and

623.1 (2) information reported to the commissioner under subdivisions 2 to 6.

623.2 The information shall be published in a manner that identifies the information that is disclosed
623.3 on a per-drug basis and shall not be aggregated in a manner that would not allow for
623.4 identification of the drug.

623.5 (b) The commissioner may not post to the department's website any information described
623.6 in this section if:

623.7 (1) the information is not public data under section 13.02, subdivision 8a; and

623.8 (2) the commissioner determines that public interest does not require disclosure of the
623.9 information that is unrelated to the price of a prescription drug.

623.10 (c) The commissioner shall publicly announce the posting of information required under
623.11 paragraph (a) and shall allow the public to comment on the posted information for a minimum
623.12 of 30 calendar days.

623.13 (d) If the commissioner withholds any information from public disclosure pursuant to
623.14 this subdivision, the commissioner shall post to the department's website a report describing
623.15 the nature of the information and the commissioner's basis for withholding the information
623.16 from disclosure.

623.17 Subd. 8. **Consultation.** The commissioner may consult with a nonprofit dedicated to
623.18 collecting and reporting health care data and the commissioner of commerce, as appropriate,
623.19 in issuing the form and format of the information reported under this section in posting
623.20 information on the department's website pursuant to subdivision 7, and in taking any other
623.21 action for the purpose of implementing this section.

623.22 Subd. 9. **Legislative report.** (a) No later than January 15, 2021, and annually on January
623.23 15 every year thereafter, the commissioner shall report to the chairs and ranking members
623.24 of the committees with jurisdiction over commerce, health and human services, and state
623.25 finance and operations on the implementation of the Prescription Drug Price Transparency
623.26 Act, including but not limited to the effectiveness in addressing the following goals:

623.27 (1) promoting transparency in pharmaceutical pricing for the state and other payers;

623.28 (2) enhancing understanding about pharmaceutical spending trends; and

623.29 (3) assisting the state and other payers in management of pharmaceutical costs.

623.30 (b) The report shall include a summary of the information reported to the commissioner
623.31 under subdivisions 2 to 7 as well as a summary of any public comments received.

624.1 (c) The report shall include recommendations for legislative changes, if any, to reduce
624.2 the cost of prescription drugs and reduce the impact of price increases on consumers, the
624.3 Department of Corrections, the State Employee Group Insurance Program, the Department
624.4 of Human Services, and health insurance premiums in the fully insured markets.

624.5 Sec. 35. **[151.84] ENFORCEMENT AND PENALTIES.**

624.6 Subdivision 1. **Civil monetary penalties.** A manufacturer may be subject to a civil
624.7 penalty, as provided in subdivision 2, for:

624.8 (1) failing to submit timely reports or notices as required by section 151.83;

624.9 (2) failing to provide information required under section 151.83;

624.10 (3) failing to respond in a timely manner to a written request by the commissioner for
624.11 additional information under section 151.83, subdivision 6; or

624.12 (4) providing inaccurate or incomplete information under section 151.83.

624.13 Subd. 2. **Enforcement.** (a) A manufacturer that fails to report or provide information
624.14 as required by section 151.83 may be subject to a civil penalty as provided in this section.

624.15 (b) The commissioner shall adopt a schedule of penalties, not to exceed \$10,000 per day
624.16 of violation, based on the severity of each violation.

624.17 (c) The commissioner shall impose civil penalties under this section as provided in
624.18 section 144.99, subdivision 4.

624.19 (d) The commissioner may remit or mitigate civil penalties under this section upon terms
624.20 and conditions the commissioner considers proper and consistent with public health and
624.21 safety.

624.22 (e) Civil penalties collected under this section shall be paid to the commissioner of
624.23 management and budget and deposited in the health care access fund to be made available
624.24 for people served by state public health care programs.

624.25 Sec. 36. **[256.937] INSULIN ASSISTANCE PROGRAM.**

624.26 Subdivision 1. **Establishment.** (a) The commissioner of human services shall implement
624.27 an insulin assistance program by July 1, 2020. Under the program, the commissioner shall:

624.28 (1) pay participating pharmacies for insulin that is dispensed by a participating pharmacy
624.29 to an eligible individual subject to a valid prescription; and

625.1 (2) ensure pharmacy participation in the program in all areas of the state and maintain
625.2 an up-to-date list of participating pharmacies on the department's website.

625.3 (b) The commissioner may contract with a private entity or enter into an interagency
625.4 agreement with another state agency to implement this program.

625.5 Subd. 2. **Eligible individual.** (a) To be eligible for the insulin assistance program, an
625.6 individual must submit to the commissioner an application form that is signed by the
625.7 individual. To be eligible, an individual must:

625.8 (1) be a resident of Minnesota;

625.9 (2) not be eligible for Medicare, medical assistance, or MinnesotaCare;

625.10 (3) have a family income that is equal to or less than 400 percent of the federal poverty
625.11 guidelines; and

625.12 (4) be uninsured, have no prescription drug coverage, or be covered by an individual or
625.13 group health plan with an out-of-pocket limit of \$5,000 or greater.

625.14 Eligibility for the insulin assistance program is subject to the limits of available funding.

625.15 (b) The commissioner shall develop an application form and make the form available
625.16 to pharmacies, health care providers, and to individuals on the department's website. An
625.17 applicant must include their income and insurance status information with the application.
625.18 The commissioner may require the applicant to submit additional information to verify
625.19 eligibility if deemed necessary by the commissioner.

625.20 (c) Upon receipt of a completed application and any additional information requested
625.21 by the commissioner, the commissioner shall determine eligibility to the program. Once
625.22 the individual has been determined eligible, the individual shall be issued an identification
625.23 card. The card shall be valid for 90 days from the date of issuance and may be used at any
625.24 participating pharmacy. An individual is not eligible for renewal until 12 months from the
625.25 card's expiration date, at which time the individual must submit a new application form and
625.26 meet the qualifications in paragraph (a).

625.27 Subd. 3. **Pharmacy participation.** (a) Pharmacy participation in the program is voluntary.
625.28 In order to participate, a pharmacy must register with the commissioner and agree to
625.29 reimbursement and other contract terms. A pharmacy may withdraw from participation at
625.30 any time by providing written notice to the commissioner.

625.31 (b) A pharmacy shall dispense insulin to eligible individuals who present a valid
625.32 prescription and an identification card.

626.1 (c) Eligible individuals are responsible for paying an insulin co-payment to the
 626.2 participating pharmacy that is equal to the prescription co-payment required under section
 626.3 256L.03, subdivision 5.

626.4 (d) Notwithstanding paragraph (c), if an eligible individual has coverage through an
 626.5 individual or group health plan, the pharmacy must process the insulin in accordance with
 626.6 the individual's health plan.

626.7 (e) When dispensing insulin to an eligible individual, a pharmacy must provide the
 626.8 individual with the address for the website established under section 151.06, subdivision
 626.9 6, paragraph (a).

626.10 Sec. 37. **[256.938] INSULIN ASSISTANCE ACCOUNT.**

626.11 Subdivision 1. **Establishment.** The insulin assistance account is established in the special
 626.12 revenue fund in the state treasury. The fees collected by the Board of Pharmacy under section
 626.13 151.252, subdivision 1, paragraph (b), shall be deposited into the account.

626.14 Subd. 2. **Use of account funds.** For fiscal year 2021 and subsequent fiscal years, money
 626.15 in the insulin assistance account is appropriated to the commissioner of human services to
 626.16 fund the insulin assistance program established under section 256.937.

626.17 Sec. 38. Minnesota Statutes 2018, section 256B.69, subdivision 6, is amended to read:

626.18 Subd. 6. **Service delivery.** (a) Each demonstration provider shall be responsible for the
 626.19 health care coordination for eligible individuals. Demonstration providers:

626.20 (1) shall authorize and arrange for the provision of all needed health services including
 626.21 but not limited to the full range of services listed in sections 256B.02, subdivision 8, and
 626.22 256B.0625 in order to ensure appropriate health care is delivered to enrollees.

626.23 Notwithstanding section 256B.0621, demonstration providers that provide nursing home
 626.24 and community-based services under this section shall provide relocation service coordination
 626.25 to enrolled persons age 65 and over;

626.26 (2) shall accept the prospective, per capita payment from the commissioner in return for
 626.27 the provision of comprehensive and coordinated health care services for eligible individuals
 626.28 enrolled in the program;

626.29 (3) may contract with other health care and social service practitioners to provide services
 626.30 to enrollees; and

627.1 (4) shall institute recipient grievance procedures according to the method established
627.2 by the project, utilizing applicable requirements of chapter 62D. Disputes not resolved
627.3 through this process shall be appealable to the commissioner as provided in subdivision 11.

627.4 (b) Demonstration providers must comply with the standards for claims settlement under
627.5 section 72A.201, subdivisions 4, 5, 7, and 8, when contracting with other health care and
627.6 social service practitioners to provide services to enrollees. A demonstration provider must
627.7 pay a clean claim, as defined in Code of Federal Regulations, title 42, section 447.45(b),
627.8 within 30 business days of the date of acceptance of the claim.

627.9 (c) Managed care plans and county-based purchasing plans must comply with section
627.10 62Q.83.

627.11 Sec. 39. **SEVERABILITY.**

627.12 If any provision of the amendments to Minnesota Statutes, sections 62Q.83, 62W.01 to
627.13 62W.13, and 151.21, subdivisions 7 and 7a, are held invalid or unenforceable, the remainder
627.14 of the sections are not affected and the provisions of the sections are severable.

627.15 Sec. 40. **CITATION.**

627.16 The amendments to Minnesota Statutes, sections 147.37, 148.192, 151.06, subdivision
627.17 6, 151.252, subdivision 1, 151.254, 256.937, and 256.938, may be cited as "The Alec Smith
627.18 Emergency Insulin Act."

627.19 Sec. 41. **REPEALER.**

627.20 (a) Minnesota Statutes 2018, sections 151.214, subdivision 2; 151.60; 151.61; 151.62;
627.21 151.63; 151.64; 151.65; 151.66; 151.67; 151.68; 151.69; 151.70; and 151.71, are repealed.

627.22 (b) Minnesota Statutes 2018, section 151.55, is repealed effective January 1, 2020.

627.23

ARTICLE 11

627.24

HEALTH-RELATED LICENSING BOARDS

627.25 Section 1. **[144A.291] FEES.**

627.26 Subdivision 1. **Nonrefundable fees.** All fees are nonrefundable.

627.27 Subd. 2. **Amounts.** (a) Fees may not exceed the following amounts but may be adjusted
627.28 lower by board direction and are for the exclusive use of the board as required to sustain
627.29 board operations. The maximum amounts of fees are:

- 628.1 (1) application for licensure, \$200;
- 628.2 (2) for a prospective applicant for a review of education and experience advisory to the
628.3 license application, \$100, to be applied to the fee for application for licensure if the latter
628.4 is submitted within one year of the request for review of education and experience;
- 628.5 (3) state examination, \$125;
- 628.6 (4) initial license, \$250 if issued between July 1 and December 31, \$100 if issued between
628.7 January 1 and June 30;
- 628.8 (5) acting administrator permit, \$400;
- 628.9 (6) renewal license, \$250;
- 628.10 (7) duplicate license, \$50;
- 628.11 (8) reinstatement fee, \$250;
- 628.12 (9) health services executive initial license, \$200;
- 628.13 (10) health services executive renewal license, \$200;
- 628.14 (11) reciprocity verification fee, \$50;
- 628.15 (12) second shared administrator assignment, \$250;
- 628.16 (13) continuing education fees:
- 628.17 (i) greater than 6 hours, \$50; and
- 628.18 (ii) 7 hours or more, \$75;
- 628.19 (14) education review, \$100;
- 628.20 (15) fee to a sponsor for review of individual continuing education seminars, institutes,
628.21 workshops, or home study courses:
- 628.22 (i) for less than seven clock hours, \$30; and
- 628.23 (ii) for seven or more clock hours, \$50;
- 628.24 (16) fee to a licensee for review of continuing education seminars, institutes, workshops,
628.25 or home study courses not previously approved for a sponsor and submitted with an
628.26 application for license renewal:
- 628.27 (i) for less than seven clock hours total, \$30; and
- 628.28 (ii) for seven or more clock hours total, \$50;
- 628.29 (17) late renewal fee, \$75;

- 629.1 (18) fee to a licensee for verification of licensure status and examination scores, \$30;
629.2 (19) registration as a registered continuing education sponsor, \$1,000; and
629.3 (20) mail labels, \$75.

629.4 (b) The revenue generated from the fees must be deposited in an account in the state
629.5 government special revenue fund.

629.6 Sec. 2. Minnesota Statutes 2018, section 147D.27, is amended by adding a subdivision to
629.7 read:

629.8 Subd. 5. **Additional fees.** (a) The following fees also apply:

- 629.9 (1) traditional midwifery annual registration fee, \$100;
629.10 (2) traditional midwifery application fee, \$100;
629.11 (3) traditional midwifery late fee, \$75;
629.12 (4) traditional midwifery inactive status, \$50;
629.13 (5) traditional midwifery temporary permit, \$75;
629.14 (6) traditional midwifery certification fee, \$25;
629.15 (7) duplicate license or registration fee, \$20;
629.16 (8) certification letter, \$25;
629.17 (9) education or training program approval fee, \$100; and
629.18 (10) report creation and generation, \$60 per hour billed in quarter-hour increments with
629.19 a quarter-hour minimum.

629.20 (b) The revenue generated from the fees must be deposited in an account in the state
629.21 government special revenue fund.

629.22 **EFFECTIVE DATE.** This section is effective the day following final enactment.

629.23 Sec. 3. Minnesota Statutes 2018, section 147E.40, subdivision 1, is amended to read:

629.24 Subdivision 1. **Fees.** (a) Fees are as follows:

- 629.25 (1) registration application fee, \$200;
629.26 (2) renewal fee, \$150;
629.27 (3) late fee, \$75;

- 630.1 (4) inactive status fee, \$50; ~~and~~
- 630.2 (5) temporary permit fee, \$25²;
- 630.3 (6) naturopathic doctor certification fee, \$25;
- 630.4 (7) naturopathic doctor duplicate license fee, \$20;
- 630.5 (8) naturopathic doctor emeritus registration fee, \$50;
- 630.6 (9) naturopathic doctor certification fee, \$25;
- 630.7 (10) duplicate license or registration fee, \$20;
- 630.8 (11) education or training program approval fee, \$100; and
- 630.9 (12) report creation and generation, \$60 per hour billed in quarter-hour increments with
- 630.10 a quarter-hour minimum.
- 630.11 (b) The revenue generated from the fees must be deposited in an account in the state
- 630.12 government special revenue fund.
- 630.13 **EFFECTIVE DATE.** This section is effective the day following final enactment.
- 630.14 Sec. 4. Minnesota Statutes 2018, section 147F.17, subdivision 1, is amended to read:
- 630.15 Subdivision 1. **Fees.** (a) Fees are as follows:
- 630.16 (1) license application fee, \$200;
- 630.17 (2) initial licensure and annual renewal, \$150; ~~and~~
- 630.18 (3) late fee, \$75²;
- 630.19 (4) genetic counselor certification fee, \$25;
- 630.20 (5) duplicate license fee, \$20;
- 630.21 (6) education or training program approval fee, \$100; and
- 630.22 (7) report creation and generation, \$60 per hour billed in quarter-hour increments with
- 630.23 a quarter-hour minimum.
- 630.24 (b) The revenue generated from the fees must be deposited in an account in the state
- 630.25 government special revenue fund.
- 630.26 **EFFECTIVE DATE.** This section is effective the day following final enactment.

631.1 Sec. 5. Minnesota Statutes 2018, section 148.59, is amended to read:

631.2 **148.59 LICENSE RENEWAL; LICENSE AND REGISTRATION FEES.**

631.3 A licensed optometrist shall pay to the state Board of Optometry a fee as set by the board
631.4 in order to renew a license as provided by board rule. No fees shall be refunded. Fees may
631.5 not exceed the following amounts but may be adjusted lower by board direction and are for
631.6 the exclusive use of the board:

- 631.7 (1) optometry licensure application, \$160;
- 631.8 (2) optometry annual licensure renewal, ~~\$135~~ \$200;
- 631.9 (3) optometry late penalty fee, \$75;
- 631.10 (4) annual license renewal card, \$10;
- 631.11 (5) continuing education provider application, \$45;
- 631.12 (6) emeritus registration, \$10;
- 631.13 (7) endorsement/reciprocity application, \$160;
- 631.14 (8) replacement of initial license, \$12; ~~and~~
- 631.15 (9) license verification, \$50;₂
- 631.16 (10) state juris prudence examination, \$75; and
- 631.17 (11) miscellaneous labels and data retrieval, \$50.

631.18 Sec. 6. Minnesota Statutes 2018, section 148.6445, subdivision 1, is amended to read:

631.19 Subdivision 1. **Initial licensure fee.** The initial licensure fee for occupational therapists
631.20 is ~~\$145~~ \$185. The initial licensure fee for occupational therapy assistants is ~~\$80~~ \$105. ~~The~~
631.21 ~~board shall prorate fees based on the number of quarters remaining in the biennial licensure~~
631.22 ~~period.~~

631.23 Sec. 7. Minnesota Statutes 2018, section 148.6445, subdivision 2, is amended to read:

631.24 Subd. 2. **Licensure renewal fee.** The biennial licensure renewal fee for occupational
631.25 therapists is ~~\$145~~ \$185. The biennial licensure renewal fee for occupational therapy assistants
631.26 is ~~\$80~~ \$105.

631.27 Sec. 8. Minnesota Statutes 2018, section 148.6445, subdivision 2a, is amended to read:

631.28 Subd. 2a. **Duplicate license fee.** The fee for a duplicate license is ~~\$25~~ \$30.

632.1 Sec. 9. Minnesota Statutes 2018, section 148.6445, subdivision 3, is amended to read:

632.2 Subd. 3. **Late fee.** The fee for late submission of a renewal application is ~~\$25~~ \$50.

632.3 Sec. 10. Minnesota Statutes 2018, section 148.6445, subdivision 4, is amended to read:

632.4 Subd. 4. **Temporary licensure fee.** The fee for temporary licensure is ~~\$50~~ \$75.

632.5 Sec. 11. Minnesota Statutes 2018, section 148.6445, subdivision 5, is amended to read:

632.6 Subd. 5. **Limited licensure fee.** The fee for limited licensure is ~~\$96~~ \$100.

632.7 Sec. 12. Minnesota Statutes 2018, section 148.6445, subdivision 6, is amended to read:

632.8 Subd. 6. **Fee for course approval after lapse of licensure.** The fee for course approval
632.9 after lapse of licensure is ~~\$96~~ \$100.

632.10 Sec. 13. Minnesota Statutes 2018, section 148.6445, subdivision 10, is amended to read:

632.11 Subd. 10. **Use of fees.** (a) All fees are nonrefundable. The board shall only use fees
632.12 collected under this section for the purposes of administering this chapter. The legislature
632.13 must not transfer money generated by these fees from the state government special revenue
632.14 fund to the general fund.

632.15 (b) Licensure fees are for the exclusive use of the board and shall be established by the
632.16 board not to exceed the nonrefundable amounts in this section.

632.17 Sec. 14. Minnesota Statutes 2018, section 148.7815, subdivision 1, is amended to read:

632.18 Subdivision 1. **Fees.** (a) The board shall establish fees as follows:

632.19 (1) application fee, \$50; ~~and~~

632.20 (2) annual license fee, \$100~~;~~

632.21 (3) athletic trainer certification fee, \$25;

632.22 (4) athletic trainer duplicate license fee, \$20;

632.23 (5) duplicate license or registration fee, \$20;

632.24 (6) education or training program approval fee, \$100;

632.25 (7) report creation and generation, \$60 per hour billed in quarter-hour increments with
632.26 a quarter-hour minimum; and

632.27 (8) examination administrative fee:

633.1 (i) half day, \$50; and

633.2 (ii) full day, \$80.

633.3 (b) The revenue generated from the fees must be deposited in an account in the state
633.4 government special revenue fund.

633.5 **EFFECTIVE DATE.** This section is effective the day following final enactment.

633.6 Sec. 15. **[148.981] FEES.**

633.7 Subdivision 1. **Licensing fees.** The nonrefundable fees for licensure shall be established
633.8 by the board, not to exceed the following amounts:

633.9 (1) application for admission to national standardized examination, \$150;

633.10 (2) application for professional responsibility examination, \$150;

633.11 (3) application for licensure as a licensed psychologist, \$500;

633.12 (4) renewal of license for a licensed psychologist, \$500;

633.13 (5) late renewal of license for a licensed psychologist, \$250;

633.14 (6) application for converting from master's to doctoral level licensure, \$150;

633.15 (7) application for guest licensure, \$150;

633.16 (8) certificate replacement fee, \$25;

633.17 (9) mailing and duplication fee, \$5;

633.18 (10) statute and rule book fee, \$10;

633.19 (11) verification fee, \$20; and

633.20 (12) fee for optional preapproval of postdoctoral supervision, \$50.

633.21 Subd. 2. **Continuing education sponsor fee.** A sponsor applying for approval of a
633.22 continuing education activity pursuant to Minnesota Rules, part 7200.3830, subpart 2, shall
633.23 submit with the application a fee to be established by the board, not to exceed \$80 for each
633.24 activity.

633.25 **EFFECTIVE DATE.** This section is effective the day following final enactment.

634.1 Sec. 16. Minnesota Statutes 2018, section 148E.180, is amended to read:

634.2 **148E.180 FEE AMOUNTS.**

634.3 Subdivision 1. **Application fees.** Nonrefundable application fees for licensure ~~are as~~
634.4 ~~follows~~ may not exceed the following amounts but may be adjusted lower by board action:

- 634.5 (1) for a licensed social worker, ~~\$45~~ \$75;
- 634.6 (2) for a licensed graduate social worker, ~~\$45~~ \$75;
- 634.7 (3) for a licensed independent social worker, ~~\$45~~ \$75;
- 634.8 (4) for a licensed independent clinical social worker, ~~\$45~~ \$75;
- 634.9 (5) for a temporary license, \$50; and
- 634.10 (6) for a ~~licensure~~ license by endorsement, ~~\$85~~ \$115.

634.11 The fee for criminal background checks is the fee charged by the Bureau of Criminal
634.12 Apprehension. The criminal background check fee must be included with the application
634.13 fee as required according to section 148E.055.

634.14 Subd. 2. **License fees.** Nonrefundable license fees ~~are as follows~~ may not exceed the
634.15 following amounts but may be adjusted lower by board action:

- 634.16 (1) for a licensed social worker, ~~\$81~~ \$115;
- 634.17 (2) for a licensed graduate social worker, ~~\$144~~ \$210;
- 634.18 (3) for a licensed independent social worker, ~~\$216~~ \$305;
- 634.19 (4) for a licensed independent clinical social worker, ~~\$238.50~~ \$335;
- 634.20 (5) for an emeritus inactive license, ~~\$43.20~~ \$65;
- 634.21 (6) for an emeritus active license, one-half of the renewal fee specified in subdivision
634.22 3; and
- 634.23 (7) for a temporary leave fee, the same as the renewal fee specified in subdivision 3.

634.24 If the licensee's initial license term is less or more than 24 months, the required license
634.25 fees must be prorated proportionately.

634.26 Subd. 3. **Renewal fees.** Nonrefundable renewal fees for licensure ~~are as follows~~ may
634.27 not exceed the following amounts but may be adjusted lower by board action:

- 634.28 (1) for a licensed social worker, ~~\$81~~ \$115;
- 634.29 (2) for a licensed graduate social worker, ~~\$144~~ \$210;

635.1 (3) for a licensed independent social worker, ~~\$216~~ \$305; and

635.2 (4) for a licensed independent clinical social worker, ~~\$238.50~~ \$335.

635.3 Subd. 4. **Continuing education provider fees.** Continuing education provider fees are
635.4 ~~as follows~~ the following nonrefundable amounts:

635.5 (1) for a provider who offers programs totaling one to eight clock hours in a one-year
635.6 period according to section 148E.145, \$50;

635.7 (2) for a provider who offers programs totaling nine to 16 clock hours in a one-year
635.8 period according to section 148E.145, \$100;

635.9 (3) for a provider who offers programs totaling 17 to 32 clock hours in a one-year period
635.10 according to section 148E.145, \$200;

635.11 (4) for a provider who offers programs totaling 33 to 48 clock hours in a one-year period
635.12 according to section 148E.145, \$400; and

635.13 (5) for a provider who offers programs totaling 49 or more clock hours in a one-year
635.14 period according to section 148E.145, \$600.

635.15 Subd. 5. **Late fees.** Late fees are ~~as follows~~ the following nonrefundable amounts:

635.16 (1) renewal late fee, one-fourth of the renewal fee specified in subdivision 3;

635.17 (2) supervision plan late fee, \$40; and

635.18 (3) license late fee, \$100 plus the prorated share of the license fee specified in subdivision
635.19 2 for the number of months during which the individual practiced social work without a
635.20 license.

635.21 Subd. 6. **License cards and wall certificates.** (a) The nonrefundable fee for a license
635.22 card as specified in section 148E.095 is \$10.

635.23 (b) The nonrefundable fee for a license wall certificate as specified in section 148E.095
635.24 is \$30.

635.25 Subd. 7. **Reactivation fees.** Reactivation fees are ~~as follows~~ the following nonrefundable
635.26 amounts:

635.27 (1) reactivation from a temporary leave or emeritus status, the prorated share of the
635.28 renewal fee specified in subdivision 3; and

635.29 (2) reactivation of an expired license, 1-1/2 times the renewal fees specified in subdivision
635.30 3.

636.1 Sec. 17. Minnesota Statutes 2018, section 150A.06, is amended by adding a subdivision
636.2 to read:

636.3 Subd. 10. **Emeritus inactive license.** A person licensed to practice dentistry, dental
636.4 therapy, dental hygiene, or dental assisting pursuant to section 150A.05 or Minnesota Rules,
636.5 part 3100.8500, who retires from active practice in the state may apply to the board for
636.6 emeritus inactive licensure. An application for emeritus inactive licensure may be made on
636.7 the biennial licensing form or by petitioning the board, and the applicant must pay a onetime
636.8 application fee pursuant to section 150A.091, subdivision 19. In order to receive emeritus
636.9 inactive licensure, the applicant must be in compliance with board requirements and cannot
636.10 be the subject of current disciplinary action resulting in suspension, revocation,
636.11 disqualification, condition, or restriction of the licensee to practice dentistry, dental therapy,
636.12 dental hygiene, or dental assisting. An emeritus inactive license is not a license to practice,
636.13 but is a formal recognition of completion of a person's dental career in good standing.

636.14 **EFFECTIVE DATE.** This section is effective July 1, 2019.

636.15 Sec. 18. Minnesota Statutes 2018, section 150A.06, is amended by adding a subdivision
636.16 to read:

636.17 Subd. 11. **Emeritus active licensure.** (a) A person licensed to practice dentistry, dental
636.18 therapy, dental hygiene, or dental assisting may apply for an emeritus active license if the
636.19 person is retired from active practice, is in compliance with board requirements, and is not
636.20 the subject of current disciplinary action resulting in suspension, revocation, disqualification,
636.21 condition, or restriction of the license to practice dentistry, dental therapy, dental hygiene,
636.22 or dental assisting.

636.23 (b) An emeritus active licensee may engage only in the following types of practice:

636.24 (1) pro bono or volunteer dental practice;

636.25 (2) paid practice not to exceed 500 hours per calendar year for the exclusive purpose of
636.26 providing licensing supervision to meet the board's requirements; or

636.27 (3) paid consulting services not to exceed 500 hours per calendar year.

636.28 (c) An emeritus active licensee shall not hold out as a full licensee and may only hold
636.29 out as authorized to practice as described in this subdivision. The board may take disciplinary
636.30 or corrective action against an emeritus active licensee based on violations of applicable
636.31 law or board requirements.

637.1 (d) A person may apply for an emeritus active license by completing an application form
 637.2 specified by the board and must pay the application fee pursuant to section 150A.091,
 637.3 subdivision 20.

637.4 (e) If an emeritus active license is not renewed every two years, the license expires. The
 637.5 renewal date is the same as the licensee's renewal date when the licensee was in active
 637.6 practice. In order to renew an emeritus active license, the licensee must:

637.7 (1) complete an application form as specified by the board;

637.8 (2) pay the required renewal fee pursuant to section 150A.091, subdivision 20; and

637.9 (3) report at least 25 continuing education hours completed since the last renewal, which
 637.10 must include:

637.11 (i) at least one hour in two different required CORE areas;

637.12 (ii) at least one hour of mandatory infection control;

637.13 (iii) for dentists and dental therapists, at least 15 hours of fundamental credits for dentists
 637.14 and dental therapists, and for dental hygienists and dental assistants, at least seven hours of
 637.15 fundamental credits; and

637.16 (iv) for dentists and dental therapists, no more than ten elective credits, and for dental
 637.17 hygienists and dental assistants, no more than six elective credits.

637.18 **EFFECTIVE DATE.** This section is effective July 1, 2019.

637.19 Sec. 19. Minnesota Statutes 2018, section 150A.091, is amended by adding a subdivision
 637.20 to read:

637.21 Subd. 19. **Emeritus inactive license.** An individual applying for emeritus inactive
 637.22 licensure under section 150A.06, subdivision 10, must pay a onetime fee of \$50. There is
 637.23 no renewal fee for an emeritus inactive license.

637.24 **EFFECTIVE DATE.** This section is effective July 1, 2019.

637.25 Sec. 20. Minnesota Statutes 2018, section 150A.091, is amended by adding a subdivision
 637.26 to read:

637.27 Subd. 20. **Emeritus active license.** An individual applying for emeritus active licensure
 637.28 under section 150A.06, subdivision 11, must pay a fee upon application and upon renewal
 637.29 every two years. The fees for emeritus active license application and renewal are as follows:
 637.30 dentist, \$212; dental therapist, \$100; dental hygienist, \$75; and dental assistant, \$55.

638.1 **EFFECTIVE DATE.** This section is effective July 1, 2019.

638.2 Sec. 21. Minnesota Statutes 2018, section 151.01, subdivision 31, is amended to read:

638.3 Subd. 31. **Central service pharmacy.** "Central service pharmacy" means a pharmacy
638.4 that ~~may provide~~ performs those activities involved in the dispensing functions, of a drug
638.5 ~~utilization review, packaging, labeling, or delivery of a prescription product to~~ for another
638.6 ~~pharmacy for the purpose of filling a prescription,~~ pursuant to the requirements of this
638.7 chapter and the rules of the board.

638.8 Sec. 22. Minnesota Statutes 2018, section 151.01, subdivision 35, is amended to read:

638.9 Subd. 35. **Compounding.** "Compounding" means preparing, mixing, assembling,
638.10 packaging, and labeling a drug for an identified individual patient as a result of a practitioner's
638.11 prescription drug order. Compounding also includes anticipatory compounding, as defined
638.12 in this section, and the preparation of drugs in which all bulk drug substances and components
638.13 are nonprescription substances. Compounding does not include mixing or reconstituting a
638.14 drug according to the product's labeling or to the manufacturer's directions, provided that
638.15 such labeling has been approved by the United States Food and Drug Administration (FDA)
638.16 or the manufacturer is licensed under section 151.252. Compounding does not include the
638.17 preparation of a drug for the purpose of, or incident to, research, teaching, or chemical
638.18 analysis, provided that the drug is not prepared for dispensing or administration to patients.
638.19 All compounding, regardless of the type of product, must be done pursuant to a prescription
638.20 drug order unless otherwise permitted in this chapter or by the rules of the board.
638.21 Compounding does not include a minor deviation from such directions with regard to
638.22 radioactivity, volume, or stability, which is made by or under the supervision of a licensed
638.23 nuclear pharmacist or a physician, and which is necessary in order to accommodate
638.24 circumstances not contemplated in the manufacturer's instructions, such as the rate of
638.25 radioactive decay or geographical distance from the patient.

638.26 Sec. 23. Minnesota Statutes 2018, section 151.01, is amended by adding a subdivision to
638.27 read:

638.28 Subd. 42. **Syringe services provider.** "Syringe services provider" means a public health
638.29 program, registered with the commissioner of health, that provides cost-free comprehensive
638.30 harm reduction services, including: sterile needles, syringes, and other injection equipment;
638.31 safe disposal containers for needles and syringes; education about overdose prevention,
638.32 safer injection practices, and infectious disease prevention; referral to or provision of blood

639.1 borne pathogen testing; referral to substance use disorder treatment, including
 639.2 medication-assisted treatment; and referral to medical, mental health, and social services.

639.3 Sec. 24. Minnesota Statutes 2018, section 151.065, subdivision 1, is amended to read:

639.4 Subdivision 1. **Application fees.** Application fees for licensure and registration are as
 639.5 follows:

639.6 (1) pharmacist licensed by examination, ~~\$145~~ \$175;

639.7 (2) pharmacist licensed by reciprocity, ~~\$240~~ \$275;

639.8 (3) pharmacy intern, ~~\$37.50~~ \$50;

639.9 (4) pharmacy technician, ~~\$37.50~~ \$50;

639.10 (5) pharmacy, ~~\$225~~ \$260;

639.11 (6) drug wholesaler, legend drugs only, ~~\$235~~ \$260;

639.12 (7) drug wholesaler, legend and nonlegend drugs, ~~\$235~~ \$260;

639.13 (8) drug wholesaler, nonlegend drugs, veterinary legend drugs, or both, ~~\$210~~ \$260;

639.14 (9) drug wholesaler, medical gases, ~~\$175~~ \$260;

639.15 (10) ~~drug wholesaler, also licensed as a pharmacy in Minnesota, \$150~~ third-party logistics
 639.16 provider, \$260;

639.17 (11) drug manufacturer, legend drugs only, ~~\$235~~ \$260;

639.18 (12) drug manufacturer, legend and nonlegend drugs, ~~\$235~~ \$260;

639.19 (13) drug manufacturer, nonlegend or veterinary legend drugs, ~~\$210~~ \$260;

639.20 (14) drug manufacturer, medical gases, ~~\$185~~ \$260;

639.21 (15) drug manufacturer, also licensed as a pharmacy in Minnesota, ~~\$150~~ \$260;

639.22 (16) medical gas distributor, ~~\$110~~ \$260; and

639.23 ~~(17) controlled substance researcher, \$75; and~~

639.24 ~~(18)~~ (17) pharmacy professional corporation, \$125 \$150.

639.25 Sec. 25. Minnesota Statutes 2018, section 151.065, subdivision 2, is amended to read:

639.26 Subd. 2. **Original license fee.** The pharmacist original licensure fee, ~~\$145~~ \$175.

640.1 Sec. 26. Minnesota Statutes 2018, section 151.065, subdivision 3, is amended to read:

640.2 Subd. 3. **Annual renewal fees.** Annual licensure and registration renewal fees are as
640.3 follows:

640.4 (1) pharmacist, ~~\$145~~ \$175;

640.5 (2) pharmacy technician, ~~\$37.50~~ \$50;

640.6 (3) pharmacy, ~~\$225~~ \$260;

640.7 (4) drug wholesaler, legend drugs only, ~~\$235~~ \$260;

640.8 (5) drug wholesaler, legend and nonlegend drugs, ~~\$235~~ \$260;

640.9 (6) drug wholesaler, nonlegend drugs, veterinary legend drugs, or both, ~~\$210~~ \$260;

640.10 (7) drug wholesaler, medical gases, ~~\$185~~ \$260;

640.11 (8) ~~drug wholesaler, also licensed as a pharmacy in Minnesota, \$150~~ third-party logistics
640.12 provider, \$260;

640.13 (9) drug manufacturer, legend drugs only, ~~\$235~~ \$260;

640.14 (10) drug manufacturer, legend and nonlegend drugs, ~~\$235~~ \$260;

640.15 (11) drug manufacturer, nonlegend, veterinary legend drugs, or both, ~~\$210~~ \$260;

640.16 (12) drug manufacturer, medical gases, ~~\$185~~ \$260;

640.17 (13) drug manufacturer, also licensed as a pharmacy in Minnesota, ~~\$150~~ \$260;

640.18 (14) medical gas distributor, ~~\$110~~ \$260; and

640.19 ~~(15) controlled substance researcher, \$75; and~~

640.20 ~~(16)~~ (15) pharmacy professional corporation, \$75 \$100.

640.21 Sec. 27. Minnesota Statutes 2018, section 151.065, subdivision 6, is amended to read:

640.22 Subd. 6. **Reinstatement fees.** (a) A pharmacist who has allowed the pharmacist's license
640.23 to lapse may reinstate the license with board approval and upon payment of any fees and
640.24 late fees in arrears, up to a maximum of \$1,000.

640.25 (b) A pharmacy technician who has allowed the technician's registration to lapse may
640.26 reinstate the registration with board approval and upon payment of any fees and late fees
640.27 in arrears, up to a maximum of \$90.

640.28 (c) An owner of a pharmacy, a drug wholesaler, a drug manufacturer, third-party logistics
640.29 provider, or a medical gas distributor who has allowed the license of the establishment to

641.1 lapse may reinstate the license with board approval and upon payment of any fees and late
641.2 fees in arrears.

641.3 (d) A controlled substance ~~researcher~~ registrant who has allowed ~~the researcher's~~ a
641.4 registration issued pursuant to subdivision 4 to lapse may reinstate the registration with
641.5 board approval and upon payment of any fees and late fees in arrears.

641.6 (e) A pharmacist owner of a professional corporation who has allowed the corporation's
641.7 registration to lapse may reinstate the registration with board approval and upon payment
641.8 of any fees and late fees in arrears.

641.9 Sec. 28. Minnesota Statutes 2018, section 151.071, subdivision 2, is amended to read:

641.10 Subd. 2. **Grounds for disciplinary action.** The following conduct is prohibited and is
641.11 grounds for disciplinary action:

641.12 (1) failure to demonstrate the qualifications or satisfy the requirements for a license or
641.13 registration contained in this chapter or the rules of the board. The burden of proof is on
641.14 the applicant to demonstrate such qualifications or satisfaction of such requirements;

641.15 (2) obtaining a license by fraud or by misleading the board in any way during the
641.16 application process or obtaining a license by cheating, or attempting to subvert the licensing
641.17 examination process. Conduct that subverts or attempts to subvert the licensing examination
641.18 process includes, but is not limited to: (i) conduct that violates the security of the examination
641.19 materials, such as removing examination materials from the examination room or having
641.20 unauthorized possession of any portion of a future, current, or previously administered
641.21 licensing examination; (ii) conduct that violates the standard of test administration, such as
641.22 communicating with another examinee during administration of the examination, copying
641.23 another examinee's answers, permitting another examinee to copy one's answers, or
641.24 possessing unauthorized materials; or (iii) impersonating an examinee or permitting an
641.25 impersonator to take the examination on one's own behalf;

641.26 (3) for a pharmacist, pharmacy technician, pharmacist intern, applicant for a pharmacist
641.27 or pharmacy license, or applicant for a pharmacy technician or pharmacist intern registration,
641.28 conviction of a felony reasonably related to the practice of pharmacy. Conviction as used
641.29 in this subdivision includes a conviction of an offense that if committed in this state would
641.30 be deemed a felony without regard to its designation elsewhere, or a criminal proceeding
641.31 where a finding or verdict of guilt is made or returned but the adjudication of guilt is either
641.32 withheld or not entered thereon. The board may delay the issuance of a new license or

642.1 registration if the applicant has been charged with a felony until the matter has been
642.2 adjudicated;

642.3 (4) for a facility, other than a pharmacy, licensed or registered by the board, if an owner
642.4 or applicant is convicted of a felony reasonably related to the operation of the facility. The
642.5 board may delay the issuance of a new license or registration if the owner or applicant has
642.6 been charged with a felony until the matter has been adjudicated;

642.7 (5) for a controlled substance researcher, conviction of a felony reasonably related to
642.8 controlled substances or to the practice of the researcher's profession. The board may delay
642.9 the issuance of a registration if the applicant has been charged with a felony until the matter
642.10 has been adjudicated;

642.11 (6) disciplinary action taken by another state or by one of this state's health licensing
642.12 agencies:

642.13 (i) revocation, suspension, restriction, limitation, or other disciplinary action against a
642.14 license or registration in another state or jurisdiction, failure to report to the board that
642.15 charges or allegations regarding the person's license or registration have been brought in
642.16 another state or jurisdiction, or having been refused a license or registration by any other
642.17 state or jurisdiction. The board may delay the issuance of a new license or registration if an
642.18 investigation or disciplinary action is pending in another state or jurisdiction until the
642.19 investigation or action has been dismissed or otherwise resolved; and

642.20 (ii) revocation, suspension, restriction, limitation, or other disciplinary action against a
642.21 license or registration issued by another of this state's health licensing agencies, failure to
642.22 report to the board that charges regarding the person's license or registration have been
642.23 brought by another of this state's health licensing agencies, or having been refused a license
642.24 or registration by another of this state's health licensing agencies. The board may delay the
642.25 issuance of a new license or registration if a disciplinary action is pending before another
642.26 of this state's health licensing agencies until the action has been dismissed or otherwise
642.27 resolved;

642.28 (7) for a pharmacist, pharmacy, pharmacy technician, or pharmacist intern, violation of
642.29 any order of the board, of any of the provisions of this chapter or any rules of the board or
642.30 violation of any federal, state, or local law or rule reasonably pertaining to the practice of
642.31 pharmacy;

642.32 (8) for a facility, other than a pharmacy, licensed by the board, violations of any order
642.33 of the board, of any of the provisions of this chapter or the rules of the board or violation
642.34 of any federal, state, or local law relating to the operation of the facility;

643.1 (9) engaging in any unethical conduct; conduct likely to deceive, defraud, or harm the
643.2 public, or demonstrating a willful or careless disregard for the health, welfare, or safety of
643.3 a patient; or pharmacy practice that is professionally incompetent, in that it may create
643.4 unnecessary danger to any patient's life, health, or safety, in any of which cases, proof of
643.5 actual injury need not be established;

643.6 (10) aiding or abetting an unlicensed person in the practice of pharmacy, except that it
643.7 is not a violation of this clause for a pharmacist to supervise a properly registered pharmacy
643.8 technician or pharmacist intern if that person is performing duties allowed by this chapter
643.9 or the rules of the board;

643.10 (11) for an individual licensed or registered by the board, adjudication as mentally ill
643.11 or developmentally disabled, or as a chemically dependent person, a person dangerous to
643.12 the public, a sexually dangerous person, or a person who has a sexual psychopathic
643.13 personality, by a court of competent jurisdiction, within or without this state. Such
643.14 adjudication shall automatically suspend a license for the duration thereof unless the board
643.15 orders otherwise;

643.16 (12) for a pharmacist or pharmacy intern, engaging in unprofessional conduct as specified
643.17 in the board's rules. In the case of a pharmacy technician, engaging in conduct specified in
643.18 board rules that would be unprofessional if it were engaged in by a pharmacist or pharmacist
643.19 intern or performing duties specifically reserved for pharmacists under this chapter or the
643.20 rules of the board;

643.21 (13) for a pharmacy, operation of the pharmacy without a pharmacist present and on
643.22 duty except as allowed by a variance approved by the board;

643.23 (14) for a pharmacist, the inability to practice pharmacy with reasonable skill and safety
643.24 to patients by reason of illness, ~~drunkenness~~, use of alcohol, drugs, narcotics, chemicals, or
643.25 any other type of material or as a result of any mental or physical condition, including
643.26 deterioration through the aging process or loss of motor skills. In the case of registered
643.27 pharmacy technicians, pharmacist interns, or controlled substance researchers, the inability
643.28 to carry out duties allowed under this chapter or the rules of the board with reasonable skill
643.29 and safety to patients by reason of illness, ~~drunkenness~~, use of alcohol, drugs, narcotics,
643.30 chemicals, or any other type of material or as a result of any mental or physical condition,
643.31 including deterioration through the aging process or loss of motor skills;

643.32 (15) for a pharmacist, pharmacy, pharmacist intern, pharmacy technician, medical gas
643.33 distributor, or controlled substance researcher, revealing a privileged communication from
643.34 or relating to a patient except when otherwise required or permitted by law;

644.1 (16) for a pharmacist or pharmacy, improper management of patient records, including
644.2 failure to maintain adequate patient records, to comply with a patient's request made pursuant
644.3 to sections 144.291 to 144.298, or to furnish a patient record or report required by law;

644.4 (17) fee splitting, including without limitation:

644.5 (i) paying, offering to pay, receiving, or agreeing to receive, a commission, rebate,
644.6 kickback, or other form of remuneration, directly or indirectly, for the referral of patients;
644.7 ~~and~~

644.8 (ii) referring a patient to any health care provider as defined in sections 144.291 to
644.9 144.298 in which the licensee or registrant has a financial or economic interest as defined
644.10 in section 144.6521, subdivision 3, unless the licensee or registrant has disclosed the
644.11 licensee's or registrant's financial or economic interest in accordance with section 144.6521;
644.12 and

644.13 (iii) any arrangement through which a pharmacy, in which the prescribing practitioner
644.14 does not have a significant ownership interest, fills a prescription drug order and the
644.15 prescribing practitioner is involved in any manner, directly or indirectly, in setting the price
644.16 for the filled prescription that is charged to the patient, the patient's insurer or pharmacy
644.17 benefit manager, or other person paying for the prescription or, in the case of veterinary
644.18 patients, the price for the filled prescription that is charged to the client or other person
644.19 paying for the prescription, except that a veterinarian and a pharmacy may enter into such
644.20 an arrangement provided that the client or other person paying for the prescription is notified,
644.21 in writing and with each prescription dispensed, about the arrangement, unless such
644.22 arrangement involves pharmacy services provided for livestock, poultry, and agricultural
644.23 production systems, in which case client notification would not be required;

644.24 (18) engaging in abusive or fraudulent billing practices, including violations of the
644.25 federal Medicare and Medicaid laws or state medical assistance laws or rules;

644.26 (19) engaging in conduct with a patient that is sexual or may reasonably be interpreted
644.27 by the patient as sexual, or in any verbal behavior that is seductive or sexually demeaning
644.28 to a patient;

644.29 (20) failure to make reports as required by section 151.072 or to cooperate with an
644.30 investigation of the board as required by section 151.074;

644.31 (21) knowingly providing false or misleading information that is directly related to the
644.32 care of a patient unless done for an accepted therapeutic purpose such as the dispensing and
644.33 administration of a placebo;

645.1 (22) aiding suicide or aiding attempted suicide in violation of section 609.215 as
645.2 established by any of the following:

645.3 (i) a copy of the record of criminal conviction or plea of guilty for a felony in violation
645.4 of section 609.215, subdivision 1 or 2;

645.5 (ii) a copy of the record of a judgment of contempt of court for violating an injunction
645.6 issued under section 609.215, subdivision 4;

645.7 (iii) a copy of the record of a judgment assessing damages under section 609.215,
645.8 subdivision 5; or

645.9 (iv) a finding by the board that the person violated section 609.215, subdivision 1 or 2.
645.10 The board shall investigate any complaint of a violation of section 609.215, subdivision 1
645.11 or 2;

645.12 (23) for a pharmacist, practice of pharmacy under a lapsed or nonrenewed license. For
645.13 a pharmacist intern, pharmacy technician, or controlled substance researcher, performing
645.14 duties permitted to such individuals by this chapter or the rules of the board under a lapsed
645.15 or nonrenewed registration. For a facility required to be licensed under this chapter, operation
645.16 of the facility under a lapsed or nonrenewed license or registration; and

645.17 (24) for a pharmacist, pharmacist intern, or pharmacy technician, termination or discharge
645.18 from the health professionals services program for reasons other than the satisfactory
645.19 completion of the program.

645.20 Sec. 29. Minnesota Statutes 2018, section 151.15, subdivision 1, is amended to read:

645.21 Subdivision 1. **Location.** It shall be unlawful for any person to compound, or dispense,
645.22 ~~vend, or sell~~ drugs, medicines, chemicals, or poisons in any place other than a pharmacy,
645.23 except as provided in this chapter; except that a licensed pharmacist or pharmacist intern
645.24 working within a licensed hospital may receive a prescription drug order and access the
645.25 hospital's pharmacy prescription processing system through secure and encrypted electronic
645.26 means in order to process the prescription drug order.

645.27 Sec. 30. Minnesota Statutes 2018, section 151.15, is amended by adding a subdivision to
645.28 read:

645.29 Subd. 5. Receipt of emergency prescription orders. A pharmacist, when that pharmacist
645.30 is not present within a licensed pharmacy, may accept a written, verbal, or electronic
645.31 prescription drug order from a practitioner only if:

646.1 (1) the prescription drug order is for an emergency situation where waiting for the
646.2 pharmacist to travel to a licensed pharmacy to accept the prescription drug order would
646.3 likely cause the patient to experience significant physical harm or discomfort;

646.4 (2) the pharmacy from which the prescription drug order will be dispensed is closed for
646.5 business;

646.6 (3) the pharmacist has been designated to be on call for the licensed pharmacy that will
646.7 fill the prescription drug order;

646.8 (4) electronic prescription drug orders are received through secure and encrypted
646.9 electronic means;

646.10 (5) the pharmacist takes reasonable precautions to ensure that the prescription drug order
646.11 will be handled in a manner consistent with federal and state statutes regarding the handling
646.12 of protected health information; and

646.13 (6) the pharmacy from which the prescription drug order will be dispensed has relevant
646.14 and appropriate policies and procedures in place and makes them available to the board
646.15 upon request.

646.16 Sec. 31. Minnesota Statutes 2018, section 151.15, is amended by adding a subdivision to
646.17 read:

646.18 Subd. 6. **Processing of emergency prescription orders.** A pharmacist, when that
646.19 pharmacist is not present within a licensed pharmacy, may access a pharmacy prescription
646.20 processing system through secure and encrypted electronic means in order to process an
646.21 emergency prescription accepted pursuant to subdivision 5 only if:

646.22 (1) the pharmacy from which the prescription drug order will be dispensed is closed for
646.23 business;

646.24 (2) the pharmacist has been designated to be on call for the licensed pharmacy that will
646.25 fill the prescription drug order;

646.26 (3) the prescription drug order is for a patient of a long-term care facility or a county
646.27 correctional facility;

646.28 (4) the prescription drug order is not being processed pursuant to section 151.58;

646.29 (5) the prescription drug order is processed pursuant to this chapter and the rules
646.30 promulgated thereunder; and

647.1 (6) the pharmacy from which the prescription drug order will be dispensed has relevant
647.2 and appropriate policies and procedures in place and makes them available to the board
647.3 upon request.

647.4 Sec. 32. Minnesota Statutes 2018, section 151.19, subdivision 1, is amended to read:

647.5 Subdivision 1. **Pharmacy licensure requirements.** (a) No person shall operate a
647.6 pharmacy without first obtaining a license from the board and paying any applicable fee
647.7 specified in section 151.065. The license shall be displayed in a conspicuous place in the
647.8 pharmacy for which it is issued and expires on June 30 following the date of issue. It is
647.9 unlawful for any person to operate a pharmacy unless the license has been issued to the
647.10 person by the board.

647.11 (b) Application for a pharmacy license under this section shall be made in a manner
647.12 specified by the board.

647.13 (c) No license shall be issued or renewed for a pharmacy located within the state unless
647.14 the applicant agrees to operate the pharmacy in a manner prescribed by federal and state
647.15 law and according to rules adopted by the board. No license shall be issued for a pharmacy
647.16 located outside of the state unless the applicant agrees to operate the pharmacy in a manner
647.17 prescribed by federal law and, when dispensing medications for residents of this state, the
647.18 laws of this state, and Minnesota Rules.

647.19 (d) No license shall be issued or renewed for a pharmacy that is required to be licensed
647.20 or registered by the state in which it is physically located unless the applicant supplies the
647.21 board with proof of such licensure or registration.

647.22 (e) The board shall require a separate license for each pharmacy located within the state
647.23 and for each pharmacy located outside of the state at which any portion of the dispensing
647.24 process occurs for drugs dispensed to residents of this state.

647.25 (f) ~~The board shall not issue~~ Prior to the issuance of an initial or renewed license for a
647.26 pharmacy unless, the board may require the pharmacy passes to pass an inspection conducted
647.27 by an authorized representative of the board. In the case of a pharmacy located outside of
647.28 the state, the board may require the applicant to pay the cost of the inspection, in addition
647.29 to the license fee in section 151.065, unless the applicant furnishes the board with a report,
647.30 issued by the appropriate regulatory agency of the state in which the facility is located, of
647.31 an inspection that has occurred within the 24 months immediately preceding receipt of the
647.32 license application by the board. The board may deny licensure unless the applicant submits

648.1 documentation satisfactory to the board that any deficiencies noted in an inspection report
648.2 have been corrected.

648.3 (g) The board shall not issue an initial or renewed license for a pharmacy located outside
648.4 of the state unless the applicant discloses and certifies:

648.5 (1) the location, names, and titles of all principal corporate officers and all pharmacists
648.6 who are involved in dispensing drugs to residents of this state;

648.7 (2) that it maintains its records of drugs dispensed to residents of this state so that the
648.8 records are readily retrievable from the records of other drugs dispensed;

648.9 (3) that it agrees to cooperate with, and provide information to, the board concerning
648.10 matters related to dispensing drugs to residents of this state;

648.11 (4) that, during its regular hours of operation, but no less than six days per week, for a
648.12 minimum of 40 hours per week, a toll-free telephone service is provided to facilitate
648.13 communication between patients in this state and a pharmacist at the pharmacy who has
648.14 access to the patients' records; the toll-free number must be disclosed on the label affixed
648.15 to each container of drugs dispensed to residents of this state; and

648.16 (5) that, upon request of a resident of a long-term care facility located in this state, the
648.17 resident's authorized representative, or a contract pharmacy or licensed health care facility
648.18 acting on behalf of the resident, the pharmacy will dispense medications prescribed for the
648.19 resident in unit-dose packaging or, alternatively, comply with section 151.415, subdivision
648.20 5.

648.21 (h) This subdivision does not apply to a manufacturer licensed under section 151.252,
648.22 subdivision 1, a wholesale drug distributor licensed under section 151.47, or a third-party
648.23 logistics provider, to the extent the manufacturer, wholesale drug distributor, or third-party
648.24 logistics provider is engaged in the distribution of dialysate or devices necessary to perform
648.25 home peritoneal dialysis on patients with end-stage renal disease, if:

648.26 (1) the manufacturer or its agent leases or owns the licensed manufacturing or wholesaling
648.27 facility from which the dialysate or devices will be delivered;

648.28 (2) the dialysate is comprised of dextrose or icodextrin and has been approved by the
648.29 United States Food and Drug Administration;

648.30 (3) the dialysate is stored and delivered in its original, sealed, and unopened
648.31 manufacturer's packaging;

648.32 (4) the dialysate or devices are delivered only upon:

- 649.1 (i) receipt of a physician's order by a Minnesota licensed pharmacy; and
649.2 (ii) the review and processing of the prescription by a pharmacist licensed by the state
649.3 in which the pharmacy is located, who is employed by or under contract to the pharmacy;
649.4 (5) prescriptions, policies, procedures, and records of delivery are maintained by the
649.5 manufacturer for a minimum of three years and are made available to the board upon request;
649.6 and
649.7 (6) the manufacturer or the manufacturer's agent delivers the dialysate or devices directly
649.8 to:
649.9 (i) a patient with end-stage renal disease for whom the prescription was written or the
649.10 patient's designee, for the patient's self-administration of the dialysis therapy; or
649.11 (ii) a health care provider or institution, for administration or delivery of the dialysis
649.12 therapy to a patient with end-stage renal disease for whom the prescription was written.

649.13 Sec. 33. Minnesota Statutes 2018, section 151.19, subdivision 3, is amended to read:

649.14 Subd. 3. **Sale of federally restricted medical gases.** (a) A person or establishment not
649.15 licensed as a pharmacy or a practitioner shall not engage in the retail sale or distribution of
649.16 federally restricted medical gases without first obtaining a registration from the board and
649.17 paying the applicable fee specified in section 151.065. The registration shall be displayed
649.18 in a conspicuous place in the business for which it is issued and expires on the date set by
649.19 the board. It is unlawful for a person to sell or distribute federally restricted medical gases
649.20 unless a certificate has been issued to that person by the board.

649.21 (b) Application for a medical gas distributor registration under this section shall be made
649.22 in a manner specified by the board.

649.23 (c) No registration shall be issued or renewed for a medical gas distributor located within
649.24 the state unless the applicant agrees to operate in a manner prescribed by federal and state
649.25 law and according to the rules adopted by the board. No license shall be issued for a medical
649.26 gas distributor located outside of the state unless the applicant agrees to operate in a manner
649.27 prescribed by federal law and, when distributing medical gases for residents of this state,
649.28 the laws of this state and Minnesota Rules.

649.29 (d) No registration shall be issued or renewed for a medical gas distributor that is required
649.30 to be licensed or registered by the state in which it is physically located unless the applicant
649.31 supplies the board with proof of the licensure or registration. The board may, by rule,

650.1 establish standards for the registration of a medical gas distributor that is not required to be
650.2 licensed or registered by the state in which it is physically located.

650.3 (e) The board shall require a separate registration for each medical gas distributor located
650.4 within the state and for each facility located outside of the state from which medical gases
650.5 are distributed to residents of this state.

650.6 (f) ~~The board shall not issue~~ Prior to the issuance of an initial or renewed registration
650.7 ~~for a medical gas distributor unless, the board may require~~ the medical gas distributor ~~passes~~
650.8 to pass an inspection conducted by an authorized representative of the board. In the case of
650.9 a medical gas distributor located outside of the state, the board may require the applicant
650.10 to pay the cost of the inspection, in addition to the license fee in section 151.065, unless the
650.11 applicant furnishes the board with a report, issued by the appropriate regulatory agency of
650.12 the state in which the facility is located, of an inspection that has occurred within the 24
650.13 months immediately preceding receipt of the license application by the board. The board
650.14 may deny licensure unless the applicant submits documentation satisfactory to the board
650.15 that any deficiencies noted in an inspection report have been corrected.

650.16 Sec. 34. Minnesota Statutes 2018, section 151.252, subdivision 1, is amended to read:

650.17 Subdivision 1. **Requirements.** (a) No person shall act as a drug manufacturer without
650.18 first obtaining a license from the board and paying any applicable fee specified in section
650.19 151.065.

650.20 (b) Application for a drug manufacturer license under this section shall be made in a
650.21 manner specified by the board.

650.22 (c) No license shall be issued or renewed for a drug manufacturer unless the applicant
650.23 agrees to operate in a manner prescribed by federal and state law and according to Minnesota
650.24 Rules.

650.25 (d) No license shall be issued or renewed for a drug manufacturer that is required to be
650.26 registered pursuant to United States Code, title 21, section 360, unless the applicant supplies
650.27 the board with proof of registration. The board may establish by rule the standards for
650.28 licensure of drug manufacturers that are not required to be registered under United States
650.29 Code, title 21, section 360.

650.30 (e) No license shall be issued or renewed for a drug manufacturer that is required to be
650.31 licensed or registered by the state in which it is physically located unless the applicant
650.32 supplies the board with proof of licensure or registration. The board may establish, by rule,

651.1 standards for the licensure of a drug manufacturer that is not required to be licensed or
651.2 registered by the state in which it is physically located.

651.3 (f) The board shall require a separate license for each facility located within the state at
651.4 which drug manufacturing occurs and for each facility located outside of the state at which
651.5 drugs that are shipped into the state are manufactured.

651.6 (g) ~~The board shall not issue~~ Prior to the issuance of an initial or renewed license for a
651.7 drug manufacturing facility unless, the board may require the facility passes an to pass a
651.8 current good manufacturing practices inspection conducted by an authorized representative
651.9 of the board. In the case of a drug manufacturing facility located outside of the state, the
651.10 board may require the applicant to pay the cost of the inspection, in addition to the license
651.11 fee in section 151.065, unless the applicant furnishes the board with a report, issued by the
651.12 appropriate regulatory agency of the state in which the facility is located or by the United
651.13 States Food and Drug Administration, of an inspection that has occurred within the 24
651.14 months immediately preceding receipt of the license application by the board. The board
651.15 may deny licensure unless the applicant submits documentation satisfactory to the board
651.16 that any deficiencies noted in an inspection report have been corrected.

651.17 Sec. 35. Minnesota Statutes 2018, section 151.252, subdivision 1a, is amended to read:

651.18 Subd. 1a. **Outsourcing facility.** (a) No person shall act as an outsourcing facility without
651.19 first obtaining a license from the board and paying any applicable manufacturer licensing
651.20 fee specified in section 151.065.

651.21 (b) Application for an outsourcing facility license under this section shall be made in a
651.22 manner specified by the board and may differ from the application required of other drug
651.23 manufacturers.

651.24 (c) No license shall be issued or renewed for an outsourcing facility unless the applicant
651.25 agrees to operate in a manner prescribed for outsourcing facilities by federal and state law
651.26 and according to Minnesota Rules.

651.27 (d) No license shall be issued or renewed for an outsourcing facility unless the applicant
651.28 supplies the board with proof of such registration by the United States Food and Drug
651.29 Administration as required by United States Code, title 21, section 353b.

651.30 (e) No license shall be issued or renewed for an outsourcing facility that is required to
651.31 be licensed or registered by the state in which it is physically located unless the applicant
651.32 supplies the board with proof of such licensure or registration. The board may establish, by

652.1 rule, standards for the licensure of an outsourcing facility that is not required to be licensed
652.2 or registered by the state in which it is physically located.

652.3 (f) The board shall require a separate license for each outsourcing facility located within
652.4 the state and for each outsourcing facility located outside of the state at which drugs that
652.5 are shipped into the state are prepared.

652.6 (g) The board shall not issue an initial or renewed license for an outsourcing facility
652.7 unless the facility passes ~~an~~ a current good manufacturing practices inspection conducted
652.8 by an authorized representative of the board. In the case of an outsourcing facility located
652.9 outside of the state, the board may require the applicant to pay the cost of the inspection,
652.10 in addition to the license fee in section 151.065, unless the applicant furnishes the board
652.11 with a report, issued by the appropriate regulatory agency of the state in which the facility
652.12 is located or by the United States Food and Drug Administration, of ~~an~~ a current good
652.13 manufacturing practices inspection that has occurred within the 24 months immediately
652.14 preceding receipt of the license application by the board. The board may deny licensure
652.15 unless the applicant submits documentation satisfactory to the board that any deficiencies
652.16 noted in an inspection report have been corrected.

652.17 Sec. 36. Minnesota Statutes 2018, section 151.252, subdivision 3, is amended to read:

652.18 Subd. 3. **Payment to practitioner; reporting.** Unless prohibited by United States Code,
652.19 title 42, section 1320a-7h, a drug manufacturer or outsourcing facility shall file with the
652.20 board an annual report, in a form and on the date prescribed by the board, identifying all
652.21 payments, honoraria, reimbursement, or other compensation authorized under section
652.22 151.461, clauses (4) and (5), paid to practitioners in Minnesota during the preceding calendar
652.23 year. The report shall identify the nature and value of any payments totaling \$100 or more
652.24 to a particular practitioner during the year, and shall identify the practitioner. Reports filed
652.25 under this subdivision are public data.

652.26 Sec. 37. Minnesota Statutes 2018, section 151.253, is amended by adding a subdivision
652.27 to read:

652.28 Subd. 4. **Emergency veterinary compounding.** A pharmacist working within a pharmacy
652.29 licensed by the board in the veterinary pharmacy license category may compound and
652.30 provide a drug product to a veterinarian without first receiving a patient-specific prescription
652.31 only when:

653.1 (1) the compounded drug product is needed to treat animals in urgent or emergency
 653.2 situations, meaning where the health of an animal is threatened, or where suffering or death
 653.3 of an animal is likely to result from failure to immediately treat;

653.4 (2) timely access to a compounding pharmacy is not available, as determined by the
 653.5 prescribing veterinarian;

653.6 (3) there is no commercially manufactured drug, approved by the United States Food
 653.7 and Drug Administration, that is suitable for treating the animal, or there is a documented
 653.8 shortage of such drug;

653.9 (4) the compounded drug is to be administered by a veterinarian or a bona fide employee
 653.10 of the veterinarian, or dispensed to a client of a veterinarian in an amount not to exceed
 653.11 what is necessary to treat an animal for a period of ten days;

653.12 (5) the pharmacy has selected the sterile or nonsterile compounding license category,
 653.13 in addition to the veterinary pharmacy licensing category; and

653.14 (6) the pharmacy is appropriately registered by the United States Drug Enforcement
 653.15 Administration when providing compounded products that contain controlled substances.

653.16 Sec. 38. Minnesota Statutes 2018, section 151.32, is amended to read:

653.17 **151.32 CITATION.**

653.18 The title of sections 151.01 to ~~151.40~~ 151.58 shall be the Pharmacy Practice and
 653.19 Wholesale Distribution Act.

653.20 Sec. 39. Minnesota Statutes 2018, section 151.40, subdivision 1, is amended to read:

653.21 Subdivision 1. **Generally.** ~~Except as otherwise provided in subdivision 2,~~ It is unlawful
 653.22 for any person to possess, control, manufacture, sell, furnish, dispense, or otherwise dispose
 653.23 of hypodermic syringes or needles or any instrument or implement which can be adapted
 653.24 for subcutaneous injections, except ~~by~~ for:

653.25 (1) The following persons when acting in the course of their practice or employment:

653.26 (i) licensed practitioners, ~~registered~~ and their employees, agents, or delegates;

653.27 (ii) licensed pharmacies and their employees or agents;

653.28 (iii) licensed pharmacists, ~~licensed doctors of veterinary medicine or their assistants;~~

653.29 (iv) registered nurses, and licensed practical nurses;

653.30 (v) registered medical technologists;

- 654.1 (vi) medical interns; and residents;
- 654.2 (vii) licensed drug wholesalers; and their employees or agents;
- 654.3 (viii) licensed hospitals;
- 654.4 (ix) bona fide hospitals in which animals are treated;
- 654.5 (x) licensed nursing homes; ~~bona fide hospitals where animals are treated;~~
- 654.6 (xi) licensed morticians;
- 654.7 (xii) syringe and needle manufacturers; and their dealers and agents;
- 654.8 (xiii) persons engaged in animal husbandry;
- 654.9 (xiv) clinical laboratories and their employees;
- 654.10 (xv) persons engaged in bona fide research or education or industrial use of hypodermic
 654.11 syringes and needles provided such persons cannot use hypodermic syringes and needles
 654.12 for the administration of drugs to human beings unless such drugs are prescribed, dispensed,
 654.13 and administered by a person lawfully authorized to do so;
- 654.14 (xvi) persons who administer drugs pursuant to an order or direction of a licensed ~~doctor~~
 654.15 ~~of medicine or of a licensed doctor of osteopathic medicine duly licensed to practice~~
 654.16 ~~medicine; practitioner; and~~
- 654.17 (xvii) syringe service providers and their employees or agents and individuals who obtain
 654.18 and dispose of hypodermic syringes and needles through such providers;
- 654.19 (2) a person who self-administers drugs pursuant to either the prescription or the direction
 654.20 of a practitioner, or a family member, caregiver, or other individual who is designated by
 654.21 such person to assist the person in obtaining and using needles and syringes for the
 654.22 administration of such drugs;
- 654.23 (3) a person who is disposing of hypodermic syringes and needles through an activity
 654.24 or program developed under section 325F.785; or
- 654.25 (4) a person who sells, possesses, or handles hypodermic syringes and needles pursuant
 654.26 to subdivision 2.

654.27 Sec. 40. Minnesota Statutes 2018, section 151.40, subdivision 2, is amended to read:

654.28 **Subd. 2. Sales of limited quantities of clean needles and syringes.** (a) A registered
 654.29 pharmacy ~~or its agent~~ or a licensed pharmacist may sell, without a the prescription or
 654.30 direction of a practitioner, unused hypodermic needles and syringes in quantities of ten or

655.1 fewer, provided the pharmacy or pharmacist complies with all of the requirements of this
655.2 subdivision.

655.3 (b) At any location where hypodermic needles and syringes are kept for retail sale under
655.4 this subdivision, the needles and syringes shall be stored in a manner that makes them
655.5 available only to authorized personnel and not openly available to customers.

655.6 ~~(e) No registered pharmacy or licensed pharmacist may advertise to the public the~~
655.7 ~~availability for retail sale, without a prescription, of hypodermic needles or syringes in~~
655.8 ~~quantities of ten or fewer.~~

655.9 ~~(d)~~ (c) A registered pharmacy or licensed pharmacist that sells hypodermic needles or
655.10 syringes under this subdivision may give the purchaser the materials developed by the
655.11 commissioner of health under section 325F.785.

655.12 ~~(e)~~ (d) A registered pharmacy or licensed pharmacist that sells hypodermic needles or
655.13 syringes under this subdivision must certify to the commissioner of health participation in
655.14 an activity, including but not limited to those developed under section 325F.785, that supports
655.15 proper disposal of used hypodermic needles or syringes.

655.16 Sec. 41. Minnesota Statutes 2018, section 151.43, is amended to read:

655.17 **151.43 SCOPE.**

655.18 Sections ~~151.42~~ 151.43 to 151.51 apply to any person, ~~partnership, corporation, or~~
655.19 ~~business firm~~ engaging in the wholesale distribution of ~~prescription~~ drugs within the state,
655.20 and to persons operating as third-party logistics providers.

655.21 Sec. 42. **[151.441] DEFINITIONS.**

655.22 Subdivision 1. **Scope.** As used in sections 151.43 to 151.51, the following terms have
655.23 the meanings given in this section.

655.24 Subd. 2. **Dispenser.** "Dispenser" means a retail pharmacy, hospital pharmacy, a group
655.25 of chain pharmacies under common ownership and control that do not act as a wholesale
655.26 distributor, or any other person authorized by law to dispense or administer prescription
655.27 drugs, and the affiliated warehouses or distribution centers of such entities under common
655.28 ownership and control that do not act as a wholesale distributor, but does not include a
655.29 person who dispenses only products to be used in animals in accordance with United States
655.30 Code, title 21, section 360b(a)(5).

656.1 Subd. 3. **Disposition.** "Disposition," with respect to a product within the possession or
656.2 control of an entity, means the removal of such product from the pharmaceutical distribution
656.3 supply chain, which may include disposal or return of the product for disposal or other
656.4 appropriate handling and other actions, such as retaining a sample of the product for further
656.5 additional physical examination or laboratory analysis of the product by a manufacturer or
656.6 regulatory or law enforcement agency.

656.7 Subd. 4. **Distribute or distribution.** "Distribute" or "distribution" means the sale,
656.8 purchase, trade, delivery, handling, storage, or receipt of a product, and does not include
656.9 the dispensing of a product pursuant to a prescription executed in accordance with United
656.10 States Code, title 21, section 353(b)(1), or the dispensing of a product approved under United
656.11 States Code, title 21, section 360b(b).

656.12 Subd. 5. **Manufacturer.** "Manufacturer" means, with respect to a product:

656.13 (1) a person who holds an application approved under United States Code, title 21,
656.14 section 355, or a license issued under United States Code, title 42, section 262, for such
656.15 product, or if such product is not the subject of an approved application or license, the person
656.16 who manufactured the product;

656.17 (2) a co-licensed partner of the person described in clause (1) that obtains the product
656.18 directly from a person described in this subdivision; or

656.19 (3) an affiliate of a person described in clause (1) or (2) that receives the product directly
656.20 from a person described in this subdivision.

656.21 Subd. 6. **Medical convenience kit.** "Medical convenience kit" means a collection of
656.22 finished medical devices, which may include a product or biological product, assembled in
656.23 kit form strictly for the convenience of the purchaser or user.

656.24 Subd. 7. **Package.** "Package" means the smallest individual salable unit of product for
656.25 distribution by a manufacturer or repackager that is intended by the manufacturer for ultimate
656.26 sale to the dispenser of such product. For purposes of this subdivision, an "individual salable
656.27 unit" is the smallest container of product introduced into commerce by the manufacturer or
656.28 repackager that is intended by the manufacturer or repackager for individual sale to a
656.29 dispenser.

656.30 Subd. 8. **Prescription drug.** "Prescription drug" means a drug for human use subject
656.31 to United States Code, title 21, section 353(b)(1).

656.32 Subd. 9. **Product.** "Product" means a prescription drug in a finished dosage form for
656.33 administration to a patient without substantial further manufacturing, but does not include

657.1 blood or blood components intended for transfusion; radioactive drugs or radioactive
657.2 biological products as defined in Code of Federal Regulations, title 21, section 600.3(ee),
657.3 that are regulated by the Nuclear Regulatory Commission or by a state pursuant to an
657.4 agreement with such commission under United States Code, title 42, section 2021; imaging
657.5 drugs; an intravenous product described in subdivision 12, paragraph (b), clauses (14) to
657.6 (16); any medical gas defined in United States Code, title 21, section 360ddd; homeopathic
657.7 drugs marketed in accordance with applicable federal law; or a drug compounded in
657.8 compliance with United States Code, title 21, section 353a or 353b.

657.9 Subd. 10. **Repackager.** "Repackager" means a person who owns or operates an
657.10 establishment that repacks and relabels a product or package for further sale or for distribution
657.11 without a further transaction.

657.12 Subd. 11. **Third-party logistics provider.** "Third-party logistics provider" means an
657.13 entity that provides or coordinates warehousing or other logistics services of a product in
657.14 interstate commerce on behalf of a manufacturer, wholesale distributor, or dispenser of a
657.15 product, but does not take ownership of the product nor have responsibility to direct the
657.16 sale or disposition of the product.

657.17 Subd. 12. **Transaction.** (a) "Transaction" means the transfer of product between persons
657.18 in which a change of ownership occurs.

657.19 (b) The term "transaction" does not include:

657.20 (1) intracompany distribution of any product between members of an affiliate or within
657.21 a manufacturer;

657.22 (2) the distribution of a product among hospitals or other health care entities that are
657.23 under common control;

657.24 (3) the distribution of a drug or an offer to distribute a drug for emergency medical
657.25 reasons, including:

657.26 (i) a public health emergency declaration pursuant to United States Code, title 42, section
657.27 247d;

657.28 (ii) a national security or peacetime emergency declared by the governor pursuant to
657.29 section 12.31; or

657.30 (iii) a situation involving an action taken by the commissioner of health pursuant to
657.31 section 144.4197, 144.4198 or 151.37, subdivisions 2, paragraph (b), and 10, except that,
657.32 for purposes of this paragraph, a drug shortage not caused by a public health emergency
657.33 shall not constitute an emergency medical reason;

- 658.1 (4) the dispensing of a drug pursuant to a valid prescription issued by a licensed
658.2 practitioner;
- 658.3 (5) the distribution of product samples by a manufacturer or a licensed wholesale
658.4 distributor in accordance with United States Code, title 21, section 353(d);
- 658.5 (6) the distribution of blood or blood components intended for transfusion;
- 658.6 (7) the distribution of minimal quantities of product by a licensed retail pharmacy to a
658.7 licensed practitioner for office use;
- 658.8 (8) the sale, purchase, or trade of a drug or an offer to sell, purchase, or trade a drug by
658.9 a charitable organization described in United States Code, title 26, section 501(c)(3), to a
658.10 nonprofit affiliate of the organization to the extent otherwise permitted by law;
- 658.11 (9) the distribution of a product pursuant to the sale or merger of a pharmacy or
658.12 pharmacies or a wholesale distributor or wholesale distributors, except that any records
658.13 required to be maintained for the product shall be transferred to the new owner of the
658.14 pharmacy or pharmacies or wholesale distributor or wholesale distributors;
- 658.15 (10) the dispensing of a product approved under United States Code, title 21, section
658.16 360b(c);
- 658.17 (11) transfer of products to or from any facility that is licensed by the Nuclear Regulatory
658.18 Commission or by a state pursuant to an agreement with such commission under United
658.19 States Code, title 42, section 2021;
- 658.20 (12) transfer of a combination product that is not subject to approval under United States
658.21 Code, title 21, section 355, or licensure under United States Code, title 42, section 262, and
658.22 that is:
- 658.23 (i) a product comprised of a device and one or more other regulated components (such
658.24 as a drug/device, biologic/device, or drug/device/biologic) that are physically, chemically,
658.25 or otherwise combined or mixed and produced as a single entity;
- 658.26 (ii) two or more separate products packaged together in a single package or as a unit
658.27 and comprised of a drug and device or device and biological product; or
- 658.28 (iii) two or more finished medical devices plus one or more drug or biological products
658.29 that are packaged together in a medical convenience kit;
- 658.30 (13) the distribution of a medical convenience kit if:

659.1 (i) the medical convenience kit is assembled in an establishment that is registered with
659.2 the Food and Drug Administration as a device manufacturer in accordance with United
659.3 States Code, title 21, section 360(b)(2);

659.4 (ii) the medical convenience kit does not contain a controlled substance that appears in
659.5 a schedule contained in the Comprehensive Drug Abuse Prevention and Control Act of
659.6 1970, United States Code, title 21, section 801, et seq.;

659.7 (iii) in the case of a medical convenience kit that includes a product, the person who
659.8 manufactures the kit:

659.9 (A) purchased the product directly from the pharmaceutical manufacturer or from a
659.10 wholesale distributor that purchased the product directly from the pharmaceutical
659.11 manufacturer; and

659.12 (B) does not alter the primary container or label of the product as purchased from the
659.13 manufacturer or wholesale distributor; and

659.14 (iv) in the case of a medical convenience kit that includes a product, the product is:

659.15 (A) an intravenous solution intended for the replenishment of fluids and electrolytes;

659.16 (B) a product intended to maintain the equilibrium of water and minerals in the body;

659.17 (C) a product intended for irrigation or reconstitution;

659.18 (D) an anesthetic;

659.19 (E) an anticoagulant;

659.20 (F) a vasopressor; or

659.21 (G) a sympathomimetic;

659.22 (14) the distribution of an intravenous product that, by its formulation, is intended for
659.23 the replenishment of fluids and electrolytes, such as sodium, chloride, and potassium; or
659.24 calories, such as dextrose and amino acids;

659.25 (15) the distribution of an intravenous product used to maintain the equilibrium of water
659.26 and minerals in the body, such as dialysis solutions;

659.27 (16) the distribution of a product that is intended for irrigation, or sterile water, whether
659.28 intended for such purposes or for injection;

659.29 (17) the distribution of a medical gas as defined in United States Code, title 21, section
659.30 360ddd; or

660.1 (18) the distribution or sale of any licensed product under United States Code, title 42,
660.2 section 262, that meets the definition of a device under United States Code, title 21, section
660.3 321(h).

660.4 Subd. 13. **Wholesale distribution.** "Wholesale distribution" means the distribution of
660.5 a drug to a person other than a consumer or patient, or receipt of a drug by a person other
660.6 than the consumer or patient, but does not include:

660.7 (1) intracompany distribution of any drug between members of an affiliate or within a
660.8 manufacturer;

660.9 (2) the distribution of a drug or an offer to distribute a drug among hospitals or other
660.10 health care entities that are under common control;

660.11 (3) the distribution of a drug or an offer to distribute a drug for emergency medical
660.12 reasons, including:

660.13 (i) a public health emergency declaration pursuant to United States Code, title 42, section
660.14 247d;

660.15 (ii) a national security or peacetime emergency declared by the governor pursuant to
660.16 section 12.31; or

660.17 (iii) a situation involving an action taken by the commissioner of health pursuant to
660.18 sections 144.4197, 144.4198 or 151.37, subdivisions 2, paragraph (b), and 10, except that,
660.19 for purposes of this paragraph, a drug shortage not caused by a public health emergency
660.20 shall not constitute an emergency medical reason;

660.21 (4) the dispensing of a drug pursuant to a valid prescription issued by a licensed
660.22 practitioner;

660.23 (5) the distribution of minimal quantities of a drug by a licensed retail pharmacy to a
660.24 licensed practitioner for office use;

660.25 (6) the distribution of a drug or an offer to distribute a drug by a charitable organization
660.26 to a nonprofit affiliate of the organization to the extent otherwise permitted by law;

660.27 (7) the purchase or other acquisition by a dispenser, hospital, or other health care entity
660.28 of a drug for use by such dispenser, hospital, or other health care entity;

660.29 (8) the distribution of a drug by the manufacturer of such drug;

660.30 (9) the receipt or transfer of a drug by an authorized third-party logistics provider provided
660.31 that such third-party logistics provider does not take ownership of the drug;

661.1 (10) a common carrier that transports a drug, provided that the common carrier does not
661.2 take ownership of the drug;

661.3 (11) the distribution of a drug or an offer to distribute a drug by an authorized repackager
661.4 that has taken ownership or possession of the drug and repacks it in accordance with United
661.5 States Code, title 21, section 360eee-1(e);

661.6 (12) salable drug returns when conducted by a dispenser;

661.7 (13) the distribution of a collection of finished medical devices, which may include a
661.8 product or biological product, assembled in kit form strictly for the convenience of the
661.9 purchaser or user, referred to in this section as a medical convenience kit, if:

661.10 (i) the medical convenience kit is assembled in an establishment that is registered with
661.11 the Food and Drug Administration as a device manufacturer in accordance with United
661.12 States Code, title 21, section 360(b)(2);

661.13 (ii) the medical convenience kit does not contain a controlled substance that appears in
661.14 a schedule contained in the Comprehensive Drug Abuse Prevention and Control Act of
661.15 1970, United States Code, title 21, section 801, et seq.;

661.16 (iii) in the case of a medical convenience kit that includes a product, the person that
661.17 manufactures the kit:

661.18 (A) purchased such product directly from the pharmaceutical manufacturer or from a
661.19 wholesale distributor that purchased the product directly from the pharmaceutical
661.20 manufacturer; and

661.21 (B) does not alter the primary container or label of the product as purchased from the
661.22 manufacturer or wholesale distributor; and

661.23 (iv) in the case of a medical convenience kit that includes a product, the product is:

661.24 (A) an intravenous solution intended for the replenishment of fluids and electrolytes;

661.25 (B) a product intended to maintain the equilibrium of water and minerals in the body;

661.26 (C) a product intended for irrigation or reconstitution;

661.27 (D) an anesthetic;

661.28 (E) an anticoagulant;

661.29 (F) a vasopressor; or

661.30 (G) a sympathomimetic;

662.1 (14) the distribution of an intravenous drug that, by its formulation, is intended for the
 662.2 replenishment of fluids and electrolytes, such as sodium, chloride, and potassium; or calories,
 662.3 such as dextrose and amino acids;

662.4 (15) the distribution of an intravenous drug used to maintain the equilibrium of water
 662.5 and minerals in the body, such as dialysis solutions;

662.6 (16) the distribution of a drug that is intended for irrigation, or sterile water, whether
 662.7 intended for such purposes or for injection;

662.8 (17) the distribution of medical gas, as defined in United States Code, title 21, section
 662.9 360ddd;

662.10 (18) facilitating the distribution of a product by providing solely administrative services,
 662.11 including processing of orders and payments; or

662.12 (19) the transfer of a product by a hospital or other health care entity, or by a wholesale
 662.13 distributor or manufacturer operating at the direction of the hospital or other health care
 662.14 entity, to a repackager described in United States Code, title 21, section 360eee(16)(B), and
 662.15 registered under United States Code, title 21, section 360, for the purpose of repackaging
 662.16 the drug for use by that hospital, or other health care entity and other health care entities
 662.17 that are under common control, if ownership of the drug remains with the hospital or other
 662.18 health care entity at all times.

662.19 Subd. 14. **Wholesale distributor.** "Wholesale distributor" means a person engaged in
 662.20 wholesale distribution but does not include a manufacturer, a manufacturer's co-licensed
 662.21 partner, a third-party logistics provider, or a repackager.

662.22 Sec. 43. Minnesota Statutes 2018, section 151.46, is amended to read:

662.23 **151.46 PROHIBITED DRUG PURCHASES OR RECEIPT.**

662.24 It is unlawful for any person to knowingly purchase or receive a prescription drug from
 662.25 a source other than a person or entity licensed under the laws of the state, except where
 662.26 otherwise provided. Licensed wholesale drug distributors ~~other than pharmacies~~ and licensed
 662.27 third-party logistics providers shall not dispense or distribute ~~prescription~~ drugs directly to
 662.28 patients. A person violating the provisions of this section is guilty of a misdemeanor.

662.29 Sec. 44. Minnesota Statutes 2018, section 151.47, subdivision 1, is amended to read:

662.30 Subdivision 1. **Requirements Generally.** ~~(a) All wholesale drug distributors are subject~~
 662.31 ~~to the requirements of this subdivision.~~ Each manufacturer, repackager, wholesale distributor,

663.1 and dispenser shall comply with the requirements set forth in United States Code, title 21,
663.2 section 360eee-1, with respect to the role of such manufacturer, repackager, wholesale
663.3 distributor, or dispenser in a transaction involving a product. If an entity meets the definition
663.4 of more than one of the entities listed in the preceding sentence, such entity shall comply
663.5 with all applicable requirements in United States Code, title 21, section 360eee-1, but shall
663.6 not be required to duplicate requirements.

663.7 ~~(b) No person or distribution outlet shall act as a wholesale drug distributor without first~~
663.8 ~~obtaining a license from the board and paying any applicable fee specified in section 151.065.~~

663.9 ~~(c) Application for a wholesale drug distributor license under this section shall be made~~
663.10 ~~in a manner specified by the board.~~

663.11 ~~(d) No license shall be issued or renewed for a wholesale drug distributor to operate~~
663.12 ~~unless the applicant agrees to operate in a manner prescribed by federal and state law and~~
663.13 ~~according to the rules adopted by the board.~~

663.14 ~~(e) No license may be issued or renewed for a drug wholesale distributor that is required~~
663.15 ~~to be licensed or registered by the state in which it is physically located unless the applicant~~
663.16 ~~supplies the board with proof of licensure or registration. The board may establish, by rule,~~
663.17 ~~standards for the licensure of a drug wholesale distributor that is not required to be licensed~~
663.18 ~~or registered by the state in which it is physically located.~~

663.19 ~~(f) The board shall require a separate license for each drug wholesale distributor facility~~
663.20 ~~located within the state and for each drug wholesale distributor facility located outside of~~
663.21 ~~the state from which drugs are shipped into the state or to which drugs are reverse distributed.~~

663.22 ~~(g) The board shall not issue an initial or renewed license for a drug wholesale distributor~~
663.23 ~~facility unless the facility passes an inspection conducted by an authorized representative~~
663.24 ~~of the board, or is accredited by an accreditation program approved by the board. In the~~
663.25 ~~case of a drug wholesale distributor facility located outside of the state, the board may~~
663.26 ~~require the applicant to pay the cost of the inspection, in addition to the license fee in section~~
663.27 ~~151.065, unless the applicant furnishes the board with a report, issued by the appropriate~~
663.28 ~~regulatory agency of the state in which the facility is located, of an inspection that has~~
663.29 ~~occurred within the 24 months immediately preceding receipt of the license application by~~
663.30 ~~the board, or furnishes the board with proof of current accreditation. The board may deny~~
663.31 ~~licensure unless the applicant submits documentation satisfactory to the board that any~~
663.32 ~~deficiencies noted in an inspection report have been corrected.~~

664.1 ~~(h) As a condition for receiving and retaining a wholesale drug distributor license issued~~
664.2 ~~under sections 151.42 to 151.51, an applicant shall satisfy the board that it has and will~~
664.3 ~~continuously maintain:~~

664.4 ~~(1) adequate storage conditions and facilities;~~

664.5 ~~(2) minimum liability and other insurance as may be required under any applicable~~
664.6 ~~federal or state law;~~

664.7 ~~(3) a viable security system that includes an after hours central alarm, or comparable~~
664.8 ~~entry detection capability; restricted access to the premises; comprehensive employment~~
664.9 ~~applicant screening; and safeguards against all forms of employee theft;~~

664.10 ~~(4) a system of records describing all wholesale drug distributor activities set forth in~~
664.11 ~~section 151.44 for at least the most recent two-year period, which shall be reasonably~~
664.12 ~~accessible as defined by board regulations in any inspection authorized by the board;~~

664.13 ~~(5) principals and persons, including officers, directors, primary shareholders, and key~~
664.14 ~~management executives, who must at all times demonstrate and maintain their capability~~
664.15 ~~of conducting business in conformity with sound financial practices as well as state and~~
664.16 ~~federal law;~~

664.17 ~~(6) complete, updated information, to be provided to the board as a condition for obtaining~~
664.18 ~~and retaining a license, about each wholesale drug distributor to be licensed, including all~~
664.19 ~~pertinent corporate licensee information, if applicable, or other ownership, principal, key~~
664.20 ~~personnel, and facilities information found to be necessary by the board;~~

664.21 ~~(7) written policies and procedures that assure reasonable wholesale drug distributor~~
664.22 ~~preparation for, protection against, and handling of any facility security or operation~~
664.23 ~~problems, including, but not limited to, those caused by natural disaster or government~~
664.24 ~~emergency, inventory inaccuracies or product shipping and receiving, outdated product or~~
664.25 ~~other unauthorized product control, appropriate disposition of returned goods, and product~~
664.26 ~~recalls;~~

664.27 ~~(8) sufficient inspection procedures for all incoming and outgoing product shipments;~~
664.28 ~~and~~

664.29 ~~(9) operations in compliance with all federal requirements applicable to wholesale drug~~
664.30 ~~distribution.~~

664.31 ~~(i) An agent or employee of any licensed wholesale drug distributor need not seek~~
664.32 ~~licensure under this section.~~

665.1 Sec. 45. Minnesota Statutes 2018, section 151.47, is amended by adding a subdivision to
665.2 read:

665.3 Subd. 1a. **Licensing.** (a) The board shall license wholesale distributors in a manner that
665.4 is consistent with United States Code, title 21, section 360eee-2, and the regulations
665.5 promulgated thereunder. In the event that the provisions of this section, or of the rules of
665.6 the board, conflict with the provisions of United States Code, title 21, section 360eee-2, or
665.7 the rules promulgated thereunder, the federal provisions shall prevail. The board shall not
665.8 license a person as a wholesale distributor unless the person is engaged in wholesale
665.9 distribution.

665.10 (b) No person shall act as a wholesale distributor without first obtaining a license from
665.11 the board and paying any applicable fee specified in section 151.065.

665.12 (c) Application for a wholesale distributor license under this section shall be made in a
665.13 manner specified by the board.

665.14 (d) No license shall be issued or renewed for a wholesale distributor unless the applicant
665.15 agrees to operate in a manner prescribed by federal and state law and according to the rules
665.16 adopted by the board.

665.17 (e) No license may be issued or renewed for a wholesale distributor facility that is located
665.18 in another state unless the applicant supplies the board with proof of licensure or registration
665.19 by the state in which the wholesale distributor is physically located or by the United States
665.20 Food and Drug Administration.

665.21 (f) The board shall require a separate license for each drug wholesale distributor facility
665.22 located within the state and for each drug wholesale distributor facility located outside of
665.23 the state from which drugs are shipped into the state or to which drugs are reverse distributed.

665.24 (g) The board shall not issue an initial or renewed license for a drug wholesale distributor
665.25 facility unless the facility passes an inspection conducted by an authorized representative
665.26 of the board or is inspected and accredited by an accreditation program approved by the
665.27 board. In the case of a drug wholesale distributor facility located outside of the state, the
665.28 board may require the applicant to pay the cost of the inspection, in addition to the license
665.29 fee in section 151.065, unless the applicant furnishes the board with a report, issued by the
665.30 appropriate regulatory agency of the state in which the facility is located, of an inspection
665.31 that has occurred within the 24 months immediately preceding receipt of the license
665.32 application by the board, or furnishes the board with proof of current accreditation. The
665.33 board may deny licensure unless the applicant submits documentation satisfactory to the
665.34 board that any deficiencies noted in an inspection report have been corrected.

666.1 (h) As a condition for receiving and retaining a wholesale drug distributor license issued
666.2 under this section, an applicant shall satisfy the board that it:

666.3 (1) has adequate storage conditions and facilities to allow for the safe receipt, storage,
666.4 handling, and sale of drugs;

666.5 (2) has minimum liability and other insurance as may be required under any applicable
666.6 federal or state law;

666.7 (3) has a functioning security system that includes an after-hours central alarm or
666.8 comparable entry detection capability, and security policies and procedures that include
666.9 provisions for restricted access to the premises, comprehensive employee applicant screening,
666.10 and safeguards against all forms of employee theft;

666.11 (4) will maintain appropriate records of the distribution of drugs, which shall be kept
666.12 for a minimum of two years and be made available to the board upon request;

666.13 (5) employs principals and other persons, including officers, directors, primary
666.14 shareholders, and key management executives, who will at all times demonstrate and maintain
666.15 their capability of conducting business in conformity with state and federal law, at least one
666.16 of whom will serve as the primary designated representative for each licensed facility and
666.17 who will be responsible for ensuring that the facility operates in a manner consistent with
666.18 state and federal law;

666.19 (6) will ensure that all personnel have sufficient education, training, and experience, in
666.20 any combination, so that they may perform assigned duties in a manner that maintains the
666.21 quality, safety, and security of drugs;

666.22 (7) will provide the board with updated information about each wholesale distributor
666.23 facility to be licensed, as requested by the board;

666.24 (8) will develop and, as necessary, update written policies and procedures that assure
666.25 reasonable wholesale drug distributor preparation for, protection against, and handling of
666.26 any facility security or operation problems, including but not limited to those caused by
666.27 natural disaster or government emergency, inventory inaccuracies or drug shipping and
666.28 receiving, outdated drugs, appropriate handling of returned goods, and drug recalls;

666.29 (9) will have sufficient policies and procedures in place for the inspection of all incoming
666.30 and outgoing drug shipments;

666.31 (10) will operate in compliance with all state and federal requirements applicable to
666.32 wholesale drug distribution; and

667.1 (11) will meet the requirements for inspections found in this subdivision.

667.2 (i) An agent or employee of any licensed wholesale drug distributor need not seek
667.3 licensure under this section. Paragraphs (i) to (p) apply to wholesaler personnel.

667.4 (j) The board is authorized to and shall require fingerprint-based criminal background
667.5 checks of facility managers or designated representatives, as required under United States
667.6 Code, title 21, section 360eee-2. The criminal background checks shall be conducted as
667.7 provided in section 214.075. The board shall use the criminal background check data received
667.8 to evaluate the qualifications of persons for ownership of or employment by a licensed
667.9 wholesaler and shall not disseminate this data except as allowed by law.

667.10 (k) A licensed wholesaler shall not be owned by, or employ, a person who has:

667.11 (1) been convicted of any felony for conduct relating to wholesale distribution, any
667.12 felony violation of United States Code, title 21, section 331, subsections (i) or (k), or any
667.13 felony violation of United States Code, title 18, section 1365, relating to product tampering;
667.14 or

667.15 (2) engaged in a pattern of violating the requirements of United States Code, title 21,
667.16 section 360eee-2, or the regulations promulgated thereunder, or state requirements for
667.17 licensure, that presents a threat of serious adverse health consequences or death to humans.

667.18 (l) An applicant for the issuance or renewal of a wholesale distributor license shall
667.19 execute and file with the board a surety bond.

667.20 (m) Prior to issuing or renewing a wholesale distributor license, the board shall require
667.21 an applicant that is not a government owned and operated wholesale distributor to submit
667.22 a surety bond of \$100,000, except that if the annual gross receipts of the applicant for the
667.23 previous tax year is \$10,000,000 or less, a surety bond of \$25,000 shall be required.

667.24 (n) If a wholesale distributor can provide evidence satisfactory to the board that it
667.25 possesses the required bond in another state, the requirement for a bond shall be waived.

667.26 (o) The purpose of the surety bond required under this subdivision is to secure payment
667.27 of any civil penalty imposed by the board pursuant to section 151.071, subdivision 1. The
667.28 board may make a claim against the bond if the licensee fails to pay a civil penalty within
667.29 30 days after the order imposing the fine or costs become final.

667.30 (p) A single surety bond shall satisfy the requirement for the submission of a bond for
667.31 all licensed wholesale distributor facilities under common ownership.

668.1 Sec. 46. [151.471] THIRD-PARTY LOGISTICS PROVIDER REQUIREMENTS.

668.2 Subdivision 1. Generally. Each third-party logistics provider shall comply with the
668.3 requirements set forth in United States Code, title 21, section 360eee to 360eee-4, that are
668.4 applicable to third-party logistics providers.

668.5 Subd. 2. Licensing. (a) The board shall license third-party logistics providers in a manner
668.6 that is consistent with United States Code, title 21, section 360eee-3, and the regulations
668.7 promulgated thereunder. In the event that the provisions of this section or of the rules of
668.8 the board conflict with the provisions of United States Code, title 21, section 360eee-3, or
668.9 the rules promulgated thereunder, the federal provisions shall prevail. The board shall not
668.10 license a person as a third-party logistics provider unless the person is operating as such.

668.11 (b) No person shall act as a third-party logistics provider without first obtaining a license
668.12 from the board and paying any applicable fee specified in section 151.065.

668.13 (c) Application for a third-party logistics provider license under this section shall be
668.14 made in a manner specified by the board.

668.15 (d) No license shall be issued or renewed for a third-party logistics provider unless the
668.16 applicant agrees to operate in a manner prescribed by federal and state law and according
668.17 to the rules adopted by the board.

668.18 (e) No license may be issued or renewed for a third-party logistics provider facility that
668.19 is located in another state unless the applicant supplies the board with proof of licensure or
668.20 registration by the state in which the third-party logistics provider facility is physically
668.21 located or by the United States Food and Drug Administration.

668.22 (f) The board shall require a separate license for each third-party logistics provider
668.23 facility located within the state and for each third-party logistics provider facility located
668.24 outside of the state from which drugs are shipped into the state or to which drugs are reverse
668.25 distributed.

668.26 (g) The board shall not issue an initial or renewed license for a third-party logistics
668.27 provider facility unless the facility passes an inspection conducted by an authorized
668.28 representative of the board or is inspected and accredited by an accreditation program
668.29 approved by the board. In the case of a third-party logistics provider facility located outside
668.30 of the state, the board may require the applicant to pay the cost of the inspection, in addition
668.31 to the license fee in section 151.065, unless the applicant furnishes the board with a report,
668.32 issued by the appropriate regulatory agency of the state in which the facility is located, of
668.33 an inspection that has occurred within the 24 months immediately preceding receipt of the

669.1 license application by the board, or furnishes the board with proof of current accreditation.
669.2 The board may deny licensure unless the applicant submits documentation satisfactory to
669.3 the board that any deficiencies noted in an inspection report have been corrected.

669.4 (h) As a condition for receiving and retaining a third-party logistics provider facility
669.5 license issued under this section, an applicant shall satisfy the board that it:

669.6 (1) has adequate storage conditions and facilities to allow for the safe receipt, storage,
669.7 handling, and transfer of drugs;

669.8 (2) has minimum liability and other insurance as may be required under any applicable
669.9 federal or state law;

669.10 (3) has a functioning security system that includes an after-hours central alarm or
669.11 comparable entry detection capability, and security policies and procedures that include
669.12 provisions for restricted access to the premises, comprehensive employee applicant screening,
669.13 and safeguards against all forms of employee theft;

669.14 (4) will maintain appropriate records of the handling of drugs, which shall be kept for
669.15 a minimum of two years and be made available to the board upon request;

669.16 (5) employs principals and other persons, including officers, directors, primary
669.17 shareholders, and key management executives, who will at all times demonstrate and maintain
669.18 their capability of conducting business in conformity with state and federal law, at least one
669.19 of whom will serve as the primary designated representative for each licensed facility and
669.20 who will be responsible for ensuring that the facility operates in a manner consistent with
669.21 state and federal law;

669.22 (6) will ensure that all personnel have sufficient education, training, and experience, in
669.23 any combination, so that they may perform assigned duties in a manner that maintains the
669.24 quality, safety, and security of drugs;

669.25 (7) will provide the board with updated information about each third-party logistics
669.26 provider facility to be licensed by the board;

669.27 (8) will develop and, as necessary, update written policies and procedures that ensure
669.28 reasonable preparation for, protection against, and handling of any facility security or
669.29 operation problems, including, but not limited to, those caused by natural disaster or
669.30 government emergency, inventory inaccuracies or drug shipping and receiving, outdated
669.31 drug, appropriate handling of returned goods, and drug recalls;

669.32 (9) will have sufficient policies and procedures in place for the inspection of all incoming
669.33 and outgoing drug shipments;

670.1 (10) will operate in compliance with all state and federal requirements applicable to
670.2 third-party logistics providers; and

670.3 (11) will meet the requirements for inspections found in this subdivision.

670.4 (i) An agent or employee of any licensed third-party logistics provider need not seek
670.5 licensure under this section. Paragraphs (j) and (k) apply to third-party logistics provider
670.6 personnel.

670.7 (j) The board is authorized to and shall require fingerprint-based criminal background
670.8 checks of facility managers or designated representatives. The criminal background checks
670.9 shall be conducted as provided in section 214.075. The board shall use the criminal
670.10 background check data received to evaluate the qualifications of persons for ownership of
670.11 or employment by a licensed third-party logistics provider and shall not disseminate this
670.12 data except as allowed by law.

670.13 (k) A licensed third-party logistics provider shall not have as a facility manager or
670.14 designated representative any person who has been convicted of any felony for conduct
670.15 relating to wholesale distribution, any felony violation of United States Code, title 21, section
670.16 331, subsection (i) or (k), or any felony violation of United States Code, title 18, section
670.17 1365, relating to product tampering.

670.18 Sec. 47. Minnesota Statutes 2018, section 152.126, subdivision 6, is amended to read:

670.19 Subd. 6. **Access to reporting system data.** (a) Except as indicated in this subdivision,
670.20 the data submitted to the board under subdivision 4 is private data on individuals as defined
670.21 in section 13.02, subdivision 12, and not subject to public disclosure.

670.22 (b) Except as specified in subdivision 5, the following persons shall be considered
670.23 permissible users and may access the data submitted under subdivision 4 in the same or
670.24 similar manner, and for the same or similar purposes, as those persons who are authorized
670.25 to access similar private data on individuals under federal and state law:

670.26 (1) a prescriber or an agent or employee of the prescriber to whom the prescriber has
670.27 delegated the task of accessing the data, to the extent the information relates specifically to
670.28 a current patient, to whom the prescriber is:

670.29 (i) prescribing or considering prescribing any controlled substance;

670.30 (ii) providing emergency medical treatment for which access to the data may be necessary;

670.31 (iii) providing care, and the prescriber has reason to believe, based on clinically valid
670.32 indications, that the patient is potentially abusing a controlled substance; or

671.1 (iv) providing other medical treatment for which access to the data may be necessary
671.2 for a clinically valid purpose and the patient has consented to access to the submitted data,
671.3 and with the provision that the prescriber remains responsible for the use or misuse of data
671.4 accessed by a delegated agent or employee;

671.5 (2) a dispenser or an agent or employee of the dispenser to whom the dispenser has
671.6 delegated the task of accessing the data, to the extent the information relates specifically to
671.7 a current patient to whom that dispenser is dispensing or considering dispensing any
671.8 controlled substance and with the provision that the dispenser remains responsible for the
671.9 use or misuse of data accessed by a delegated agent or employee;

671.10 (3) a licensed pharmacist who is providing pharmaceutical care for which access to the
671.11 data may be necessary to the extent that the information relates specifically to a current
671.12 patient for whom the pharmacist is providing pharmaceutical care: (i) if the patient has
671.13 consented to access to the submitted data; or (ii) if the pharmacist is consulted by a prescriber
671.14 who is requesting data in accordance with clause (1);

671.15 (4) an individual who is the recipient of a controlled substance prescription for which
671.16 data was submitted under subdivision 4, or a guardian of the individual, parent or guardian
671.17 of a minor, or health care agent of the individual acting under a health care directive under
671.18 chapter 145C;

671.19 (5) personnel or designees of a health-related licensing board listed in section 214.01,
671.20 subdivision 2, or of the Emergency Medical Services Regulatory Board, assigned to conduct
671.21 a bona fide investigation of a complaint received by that board that alleges that a specific
671.22 licensee is impaired by use of a drug for which data is collected under subdivision 4, has
671.23 engaged in activity that would constitute a crime as defined in section 152.025, or has
671.24 engaged in the behavior specified in subdivision 5, paragraph (a);

671.25 (6) personnel of the board engaged in the collection, review, and analysis of controlled
671.26 substance prescription information as part of the assigned duties and responsibilities under
671.27 this section;

671.28 (7) authorized personnel of a vendor under contract with the state of Minnesota who are
671.29 engaged in the design, implementation, operation, and maintenance of the prescription
671.30 monitoring program as part of the assigned duties and responsibilities of their employment,
671.31 provided that access to data is limited to the minimum amount necessary to carry out such
671.32 duties and responsibilities, and subject to the requirement of de-identification and time limit
671.33 on retention of data specified in subdivision 5, paragraphs (d) and (e);

672.1 (8) federal, state, and local law enforcement authorities acting pursuant to a valid search
672.2 warrant;

672.3 (9) personnel of the Minnesota health care programs assigned to use the data collected
672.4 under this section to identify and manage recipients whose usage of controlled substances
672.5 may warrant restriction to a single primary care provider, a single outpatient pharmacy, and
672.6 a single hospital;

672.7 (10) personnel of the Department of Human Services assigned to access the data pursuant
672.8 to paragraph (i);

672.9 (11) personnel of the health professionals services program established under section
672.10 214.31, to the extent that the information relates specifically to an individual who is currently
672.11 enrolled in and being monitored by the program, and the individual consents to access to
672.12 that information. The health professionals services program personnel shall not provide this
672.13 data to a health-related licensing board or the Emergency Medical Services Regulatory
672.14 Board, except as permitted under section 214.33, subdivision 3.

672.15 For purposes of clause (4), access by an individual includes persons in the definition of
672.16 an individual under section 13.02; and

672.17 (12) personnel or designees of a health-related licensing board listed in section 214.01,
672.18 subdivision 2, assigned to conduct a bona fide investigation of a complaint received by that
672.19 board that alleges that a specific licensee is inappropriately prescribing controlled substances
672.20 as defined in this section.

672.21 (c) By July 1, 2017, every prescriber licensed by a health-related licensing board listed
672.22 in section 214.01, subdivision 2, practicing within this state who is authorized to prescribe
672.23 controlled substances for humans and who holds a current registration issued by the federal
672.24 Drug Enforcement Administration, and every pharmacist licensed by the board and practicing
672.25 within the state, shall register and maintain a user account with the prescription monitoring
672.26 program. Data submitted by a prescriber, pharmacist, or their delegate during the registration
672.27 application process, other than their name, license number, and license type, is classified
672.28 as private pursuant to section 13.02, subdivision 12.

672.29 (d) Only permissible users identified in paragraph (b), clauses (1), (2), (3), (6), (7), (9),
672.30 and (10), may directly access the data electronically. No other permissible users may directly
672.31 access the data electronically. If the data is directly accessed electronically, the permissible
672.32 user shall implement and maintain a comprehensive information security program that
672.33 contains administrative, technical, and physical safeguards that are appropriate to the user's
672.34 size and complexity, and the sensitivity of the personal information obtained. The permissible

673.1 user shall identify reasonably foreseeable internal and external risks to the security,
673.2 confidentiality, and integrity of personal information that could result in the unauthorized
673.3 disclosure, misuse, or other compromise of the information and assess the sufficiency of
673.4 any safeguards in place to control the risks.

673.5 (e) The board shall not release data submitted under subdivision 4 unless it is provided
673.6 with evidence, satisfactory to the board, that the person requesting the information is entitled
673.7 to receive the data.

673.8 (f) The board shall maintain a log of all persons who access the data for a period of at
673.9 least three years and shall ensure that any permissible user complies with paragraph ~~(e)~~ (d)
673.10 prior to attaining direct access to the data.

673.11 (g) Section 13.05, subdivision 6, shall apply to any contract the board enters into pursuant
673.12 to subdivision 2. A vendor shall not use data collected under this section for any purpose
673.13 not specified in this section.

673.14 (h) The board may participate in an interstate prescription monitoring program data
673.15 exchange system provided that permissible users in other states have access to the data only
673.16 as allowed under this section, and that section 13.05, subdivision 6, applies to any contract
673.17 or memorandum of understanding that the board enters into under this paragraph.

673.18 (i) With available appropriations, the commissioner of human services shall establish
673.19 and implement a system through which the Department of Human Services shall routinely
673.20 access the data for the purpose of determining whether any client enrolled in an opioid
673.21 treatment program licensed according to chapter 245A has been prescribed or dispensed a
673.22 controlled substance in addition to that administered or dispensed by the opioid treatment
673.23 program. When the commissioner determines there have been multiple prescribers or multiple
673.24 prescriptions of controlled substances, the commissioner shall:

673.25 (1) inform the medical director of the opioid treatment program only that the
673.26 commissioner determined the existence of multiple prescribers or multiple prescriptions of
673.27 controlled substances; and

673.28 (2) direct the medical director of the opioid treatment program to access the data directly,
673.29 review the effect of the multiple prescribers or multiple prescriptions, and document the
673.30 review.

673.31 If determined necessary, the commissioner of human services shall seek a federal waiver
673.32 of, or exception to, any applicable provision of Code of Federal Regulations, title 42, section
673.33 2.34, paragraph (c), prior to implementing this paragraph.

674.1 (j) The board shall review the data submitted under subdivision 4 on at least a quarterly
674.2 basis and shall establish criteria, in consultation with the advisory task force, for referring
674.3 information about a patient to prescribers and dispensers who prescribed or dispensed the
674.4 prescriptions in question if the criteria are met.

674.5 (k) The board shall conduct random audits, on at least a quarterly basis, of electronic
674.6 access by permissible users, as identified in paragraph (b), clauses (1), (2), (3), (6), (7), (9),
674.7 and (10), to the data in subdivision 4, to ensure compliance with permissible use as defined
674.8 in this section. A permissible user whose account has been selected for a random audit shall
674.9 respond to an inquiry by the board, no later than 30 days after receipt of notice that an audit
674.10 is being conducted. Failure to respond may result in deactivation of access to the electronic
674.11 system and referral to the appropriate health licensing board, or the commissioner of human
674.12 services, for further action.

674.13 (l) A permissible user who has delegated the task of accessing the data in subdivision 4
674.14 to an agent or employee shall audit the use of the electronic system by delegated agents or
674.15 employees on at least a quarterly basis to ensure compliance with permissible use as defined
674.16 in this section. When a delegated agent or employee has been identified as inappropriately
674.17 accessing data, the permissible user must immediately remove access for that individual
674.18 and notify the board within seven days. The board shall notify all permissible users associated
674.19 with the delegated agent or employee of the alleged violation.

674.20 Sec. 48. **REPEALER.**

674.21 (a) Minnesota Statutes 2018, sections 151.42; 151.44; 151.49; 151.50; 151.51; and
674.22 151.55, are repealed.

674.23 (b) Minnesota Rules, parts 6400.6970; 7200.6100; and 7200.6105, are repealed.

674.24 **EFFECTIVE DATE.** This section is effective the day following final enactment.

674.25

ARTICLE 12

674.26

HEALTH DEPARTMENT

674.27 Section 1. Minnesota Statutes 2018, section 16A.151, subdivision 2, is amended to read:

674.28 Subd. 2. **Exceptions.** (a) If a state official litigates or settles a matter on behalf of specific
674.29 injured persons or entities, this section does not prohibit distribution of money to the specific
674.30 injured persons or entities on whose behalf the litigation or settlement efforts were initiated.
674.31 If money recovered on behalf of injured persons or entities cannot reasonably be distributed
674.32 to those persons or entities because they cannot readily be located or identified or because

675.1 the cost of distributing the money would outweigh the benefit to the persons or entities, the
675.2 money must be paid into the general fund.

675.3 (b) Money recovered on behalf of a fund in the state treasury other than the general fund
675.4 may be deposited in that fund.

675.5 (c) This section does not prohibit a state official from distributing money to a person or
675.6 entity other than the state in litigation or potential litigation in which the state is a defendant
675.7 or potential defendant.

675.8 (d) State agencies may accept funds as directed by a federal court for any restitution or
675.9 monetary penalty under United States Code, title 18, section 3663(a)(3) or United States
675.10 Code, title 18, section 3663A(a)(3). Funds received must be deposited in a special revenue
675.11 account and are appropriated to the commissioner of the agency for the purpose as directed
675.12 by the federal court.

675.13 (e) Tobacco settlement revenues as defined in section 16A.98, subdivision 1, paragraph
675.14 (t), may be deposited as provided in section 16A.98, subdivision 12.

675.15 (f) Money recovered by or ordered to be paid to the state from one or more tobacco
675.16 product manufacturers, including future annual payments and arrears payments, under the
675.17 terms of a settlement or judgment from litigation regarding annual tobacco settlement
675.18 payments on transferred tobacco brands, shall be deposited in the tobacco use prevention
675.19 account under section 144.398. For purposes of this paragraph, "litigation regarding annual
675.20 tobacco settlement payments on transferred tobacco brands" has the meaning given in section
675.21 144.398, subdivision 3, paragraph (c).

675.22 **EFFECTIVE DATE.** Paragraph (f) is effective the day following final enactment and
675.23 applies to settlements reached or judgments entered on or after that date.

675.24 Sec. 2. Minnesota Statutes 2018, section 18K.02, subdivision 3, is amended to read:

675.25 Subd. 3. **Industrial hemp.** "Industrial hemp" means the plant *Cannabis sativa* L. and
675.26 any part of the plant, whether growing or not, including the plant's seeds, and all the plant's
675.27 derivatives, extracts, cannabinoids, isomers, acids, salts, and salts of isomers, whether
675.28 growing or not, with a delta-9 tetrahydrocannabinol concentration of not more than 0.3
675.29 percent on a dry weight basis. Industrial hemp is not marijuana as defined in section 152.01,
675.30 subdivision 9.

676.1 Sec. 3. Minnesota Statutes 2018, section 18K.03, is amended to read:

676.2 **18K.03 AGRICULTURAL CROP; POSSESSION AUTHORIZED.**

676.3 Subdivision 1. **Industrial hemp.** Industrial hemp is an agricultural crop in this state. A
676.4 person may possess, transport, process, sell, or buy industrial hemp that is grown pursuant
676.5 to this chapter.

676.6 Subd. 2. **Sale to medical cannabis manufacturers.** A licensee under this chapter may
676.7 sell hemp to a medical cannabis manufacturer as authorized under sections 152.22 to 152.37.

676.8 Sec. 4. Minnesota Statutes 2018, section 144.121, subdivision 1a, is amended to read:

676.9 **Subd. 1a. Fees for ionizing radiation-producing equipment.** (a) A facility with ionizing
676.10 radiation-producing equipment must pay an annual initial or annual renewal registration
676.11 fee consisting of a base facility fee of \$100 and an additional fee for each radiation source,
676.12 as follows:

676.13	(1) medical or veterinary equipment	\$ 100
676.14	(2) dental x-ray equipment	\$ 40
676.15	(3) x-ray equipment not used on	\$ 100
676.16	humans or animals	
676.17	(4) devices with sources of ionizing	\$ 100
676.18	radiation not used on humans or	
676.19	animals	
676.20	<u>(5) security screening system</u>	<u>\$ 100</u>

676.21 (b) A facility with radiation therapy and accelerator equipment must pay an annual
676.22 registration fee of \$500. A facility with an industrial accelerator must pay an annual
676.23 registration fee of \$150.

676.24 (c) Electron microscopy equipment is exempt from the registration fee requirements of
676.25 this section.

676.26 (d) For purposes of this section, a security screening system means radiation-producing
676.27 equipment designed and used for security screening of humans who are in the custody of a
676.28 correctional or detention facility, and used by the facility to image and identify contraband
676.29 items concealed within or on all sides of a human body. For purposes of this section, a
676.30 correctional or detention facility is a facility licensed under section 241.021 and operated
676.31 by a state agency or political subdivision charged with detection, enforcement, or
676.32 incarceration in respect to state criminal and traffic laws.

677.1 Sec. 5. Minnesota Statutes 2018, section 144.121, is amended by adding a subdivision to
677.2 read:

677.3 Subd. 9. **Exemption from examination requirements; operators of security screening**
677.4 **systems.** (a) An employee of a correctional or detention facility who operates a security
677.5 screening system and the facility in which the system is being operated are exempt from
677.6 the requirements of subdivisions 5 and 6.

677.7 (b) An employee of a correctional or detention facility who operates a security screening
677.8 system and the facility in which the system is being operated must meet the requirements
677.9 of a variance to Minnesota Rules, parts 4732.0305 and 4732.0565, issued under Minnesota
677.10 Rules, parts 4717.7000 to 4717.7050. This paragraph expires on December 31 of the year
677.11 that the permanent rules adopted by the commissioner governing security screening systems
677.12 are published in the State Register.

677.13 **EFFECTIVE DATE.** This section is effective the day following final enactment.

677.14 Sec. 6. Minnesota Statutes 2018, section 144.3831, subdivision 1, is amended to read:

677.15 Subdivision 1. **Fee setting.** The commissioner of health may assess an annual fee of
677.16 ~~\$6.36~~ \$9.72 for every service connection to a public water supply that is owned or operated
677.17 by a home rule charter city, a statutory city, a city of the first class, or a town. The
677.18 commissioner of health may also assess an annual fee for every service connection served
677.19 by a water user district defined in section 110A.02.

677.20 **EFFECTIVE DATE.** This section is effective January 1, 2020.

677.21 Sec. 7. **[144.397] STATEWIDE TOBACCO CESSATION SERVICES.**

677.22 (a) The commissioner of health shall administer, or contract for the administration of,
677.23 statewide tobacco cessation services to assist Minnesotans who are seeking advice or services
677.24 to help them quit using tobacco products. The commissioner shall establish statewide public
677.25 awareness activities to inform the public of the availability of the services and encourage
677.26 the public to utilize the services because of the dangers and harm of tobacco use and
677.27 dependence.

677.28 (b) Services to be provided may include but are not limited to:

677.29 (1) telephone-based coaching and counseling;

677.30 (2) referrals;

677.31 (3) written materials mailed upon request;

678.1 (4) web-based texting or e-mail services; and

678.2 (5) free Food and Drug Administration-approved tobacco cessation medications.

678.3 (c) Services provided must be consistent with evidence-based best practices in tobacco
678.4 cessation services. Services provided must be coordinated with health plan company tobacco
678.5 prevention and cessation services that may be available to individuals depending on their
678.6 health coverage.

678.7 **Sec. 8. [144.398] TOBACCO USE PREVENTION ACCOUNT.**

678.8 Subdivision 1. **Account created.** A tobacco use prevention account is created in the
678.9 special revenue fund. The commissioner of management and budget shall deposit into the
678.10 account all money recovered by or ordered to be paid to the state from one or more tobacco
678.11 product manufacturers, including future annual payments and arrears payments, under the
678.12 terms of a settlement or judgment from litigation regarding annual tobacco settlement
678.13 payments on transferred tobacco brands.

678.14 Subd. 2. **Uses of money in account.** Each fiscal year, \$12,000,000 from the tobacco
678.15 use prevention account is appropriated to the commissioner of health for tobacco use
678.16 prevention activities in section 144.396. In the event that the balance in the tobacco use
678.17 prevention account is less than \$12,000,000 on July 1, all money in the account on that date
678.18 is appropriated to the commissioner of health for tobacco use prevention activities in section
678.19 144.396.

678.20 Subd. 3. **Definitions.** (a) The definitions in this subdivision apply to this section.

678.21 (b) "Consent judgment" has the meaning given in section 16A.98, subdivision 1,
678.22 paragraph (f).

678.23 (c) "Litigation regarding annual tobacco settlement payments on transferred tobacco
678.24 brands" means litigation between the state and certain tobacco product manufacturers related
678.25 to the obligation of these manufacturers to make past and future annual tobacco settlement
678.26 payments according to the settlement agreement and consent judgment in amounts that
678.27 include tobacco brands transferred from one or more tobacco product manufacturers to
678.28 another tobacco product manufacturer.

678.29 (d) "Settlement agreement" has the meaning given in section 16A.98, subdivision 1,
678.30 paragraph (h).

678.31 **EFFECTIVE DATE.** This section is effective the day following final enactment and
678.32 applies to settlements reached or judgments entered on or after that date.

679.1 Sec. 9. Minnesota Statutes 2018, section 144.4165, is amended to read:

679.2 **144.4165 TOBACCO PRODUCTS PROHIBITED IN PUBLIC SCHOOLS.**

679.3 No person shall at any time smoke, chew, or otherwise ingest tobacco ~~or a tobacco~~
 679.4 ~~product~~, or inhale or exhale aerosol or vapor from an electronic delivery device as defined
 679.5 in section 609.685, subdivision 1, in a public school, as defined in section 120A.05,
 679.6 subdivisions 9, 11, and 13, ~~and no person under the age of 18 shall possess any of these~~
 679.7 ~~items~~ or in a charter school governed by chapter 124E. This prohibition extends to all
 679.8 facilities, whether owned, rented, or leased, and all vehicles that a school district owns,
 679.9 leases, rents, contracts for, or controls. Nothing in this section shall prohibit the lighting of
 679.10 tobacco by an adult as a part of a traditional Indian spiritual or cultural ceremony. For
 679.11 purposes of this section, an Indian is a person who is a member of an Indian tribe as defined
 679.12 in section 260.755₂ subdivision 12.

679.13 Sec. 10. Minnesota Statutes 2018, section 144.4167, subdivision 4, is amended to read:

679.14 Subd. 4. **Tobacco products shop.** Sections 144.414 to 144.417 do not prohibit the
 679.15 lighting, heating, or activation of tobacco in a tobacco products shop by a customer or
 679.16 potential customer for the specific purpose of sampling tobacco products. For the purposes
 679.17 of this subdivision, a tobacco products shop is a retail establishment with that cannot be
 679.18 entered at any time by persons younger than 21 years of age, that has an entrance door
 679.19 opening directly to the outside, and that derives more than 90 percent of its gross revenue
 679.20 from the sale of loose tobacco, plants, or herbs and cigars, cigarettes, pipes, and other
 679.21 ~~smoking devices for burning tobacco and related smoking accessories~~ tobacco-related
 679.22 devices, and electronic delivery devices, as defined in section 609.685, and in which the
 679.23 sale of other products is merely incidental. "Tobacco products shop" does not include a
 679.24 tobacco department or section of any individual business establishment with any type of
 679.25 liquor, food, or restaurant license.

679.26 Sec. 11. Minnesota Statutes 2018, section 144.562, subdivision 2, is amended to read:

679.27 Subd. 2. **Eligibility for license condition.** (a) A hospital is not eligible to receive a
 679.28 license condition for swing beds unless (1) it either has a licensed bed capacity of less than
 679.29 50 beds defined in the federal Medicare regulations, Code of Federal Regulations, title 42,
 679.30 section 482.66, or it has a licensed bed capacity of 50 beds or more and has swing beds that
 679.31 were approved for Medicare reimbursement before May 1, 1985, or it has a licensed bed
 679.32 capacity of less than 65 beds and the available nursing homes within 50 miles have had, in
 679.33 the aggregate, an average occupancy rate of 96 percent or higher in the most recent two

680.1 years as documented on the statistical reports to the Department of Health; and (2) it is
680.2 located in a rural area as defined in the federal Medicare regulations, Code of Federal
680.3 Regulations, title 42, section 482.66.

680.4 (b) Except for those critical access hospitals established under section 144.1483, clause
680.5 (9), and section 1820 of the federal Social Security Act, United States Code, title 42, section
680.6 1395i-4, that have an attached nursing home or that owned a nursing home located in the
680.7 same municipality as of May 1, 2005, eligible hospitals are allowed a total of ~~2,000~~ 9,125
680.8 days of swing bed use per year as provided in federal law. Critical access hospitals that have
680.9 an attached nursing home or that owned a nursing home located in the same municipality
680.10 as of May 1, 2005, are allowed swing bed use as provided in federal law.

680.11 ~~(e) Except for critical access hospitals that have an attached nursing home or that owned~~
680.12 ~~a nursing home located in the same municipality as of May 1, 2005, the commissioner of~~
680.13 ~~health may approve swing bed use beyond 2,000 days as long as there are no Medicare~~
680.14 ~~certified skilled nursing facility beds available within 25 miles of that hospital that are~~
680.15 ~~willing to admit the patient and the patient agrees to the referral being sent to the skilled~~
680.16 ~~nursing facility. Critical access hospitals exceeding 2,000 swing bed days must maintain~~
680.17 ~~documentation that they have contacted skilled nursing facilities within 25 miles to determine~~
680.18 ~~if any skilled nursing facility beds are available that are willing to admit the patient and the~~
680.19 ~~patient agrees to the referral being sent to the skilled nursing facility.~~

680.20 ~~(d) After reaching 2,000 days of swing bed use in a year, an eligible hospital to which~~
680.21 ~~this limit applies may admit six additional patients to swing beds each year without seeking~~
680.22 ~~approval from the commissioner or being in violation of this subdivision. These six swing~~
680.23 ~~bed admissions are exempt from the limit of 2,000 annual swing bed days for hospitals~~
680.24 ~~subject to this limit.~~

680.25 ~~(e) A health care system that is in full compliance with this subdivision may allocate its~~
680.26 ~~total limit of swing bed days among the hospitals within the system, provided that no hospital~~
680.27 ~~in the system without an attached nursing home may exceed 2,000 swing bed days per year.~~

680.28 Sec. 12. Minnesota Statutes 2018, section 144.966, subdivision 2, is amended to read:

680.29 Subd. 2. **Newborn Hearing Screening Advisory Committee.** (a) The commissioner
680.30 of health shall establish a Newborn Hearing Screening Advisory Committee to advise and
680.31 assist the Department of Health and the Department of Education in:

- 681.1 (1) developing protocols and timelines for screening, rescreening, and diagnostic
681.2 audiological assessment and early medical, audiological, and educational intervention
681.3 services for children who are deaf or hard-of-hearing;
- 681.4 (2) designing protocols for tracking children from birth through age three that may have
681.5 passed newborn screening but are at risk for delayed or late onset of permanent hearing
681.6 loss;
- 681.7 (3) designing a technical assistance program to support facilities implementing the
681.8 screening program and facilities conducting rescreening and diagnostic audiological
681.9 assessment;
- 681.10 (4) designing implementation and evaluation of a system of follow-up and tracking; and
- 681.11 (5) evaluating program outcomes to increase effectiveness and efficiency and ensure
681.12 culturally appropriate services for children with a confirmed hearing loss and their families.
- 681.13 (b) The commissioner of health shall appoint at least one member from each of the
681.14 following groups with no less than two of the members being deaf or hard-of-hearing:
- 681.15 (1) a representative from a consumer organization representing culturally deaf persons;
- 681.16 (2) a parent with a child with hearing loss representing a parent organization;
- 681.17 (3) a consumer from an organization representing oral communication options;
- 681.18 (4) a consumer from an organization representing cued speech communication options;
- 681.19 (5) an audiologist who has experience in evaluation and intervention of infants and
681.20 young children;
- 681.21 (6) a speech-language pathologist who has experience in evaluation and intervention of
681.22 infants and young children;
- 681.23 (7) two primary care providers who have experience in the care of infants and young
681.24 children, one of which shall be a pediatrician;
- 681.25 (8) a representative from the early hearing detection intervention teams;
- 681.26 (9) a representative from the Department of Education resource center for the deaf and
681.27 hard-of-hearing or the representative's designee;
- 681.28 (10) a representative of the Commission of the Deaf, DeafBlind and Hard of Hearing;
- 681.29 (11) a representative from the Department of Human Services Deaf and Hard-of-Hearing
681.30 Services Division;

682.1 (12) one or more of the Part C coordinators from the Department of Education, the
682.2 Department of Health, or the Department of Human Services or the department's designees;

682.3 (13) the Department of Health early hearing detection and intervention coordinators;

682.4 (14) two birth hospital representatives from one rural and one urban hospital;

682.5 (15) a pediatric geneticist;

682.6 (16) an otolaryngologist;

682.7 (17) a representative from the Newborn Screening Advisory Committee under this
682.8 subdivision; ~~and~~

682.9 (18) a representative of the Department of Education regional low-incidence facilitators;₂

682.10 (19) a representative from the deaf mentor program; and

682.11 (20) a representative of the Minnesota State Academy for the Deaf from the Minnesota
682.12 State Academies staff.

682.13 The commissioner must complete the initial appointments required under this subdivision
682.14 by September 1, 2007, and the initial appointments under clauses (19) and (20) by September
682.15 1, 2019.

682.16 (c) The Department of Health member shall chair the first meeting of the committee. At
682.17 the first meeting, the committee shall elect a chair from its membership. The committee
682.18 shall meet at the call of the chair, at least four times a year. The committee shall adopt
682.19 written bylaws to govern its activities. The Department of Health shall provide technical
682.20 and administrative support services as required by the committee. These services shall
682.21 include technical support from individuals qualified to administer infant hearing screening,
682.22 rescreening, and diagnostic audiological assessments.

682.23 Members of the committee shall receive no compensation for their service, but shall be
682.24 reimbursed as provided in section 15.059 for expenses incurred as a result of their duties
682.25 as members of the committee.

682.26 (d) By February 15, 2015, and by February 15 of the odd-numbered years after that date,
682.27 the commissioner shall report to the chairs and ranking minority members of the legislative
682.28 committees with jurisdiction over health and data privacy on the activities of the committee
682.29 that have occurred during the past two years.

682.30 (e) This subdivision expires June 30, ~~2019~~ 2025.

682.31 **EFFECTIVE DATE.** This section is effective the day following final enactment.

683.1 Sec. 13. Minnesota Statutes 2018, section 144.99, subdivision 1, is amended to read:

683.2 Subdivision 1. **Remedies available.** The provisions of chapters 103I and 157 and sections
683.3 115.71 to 115.77; 144.12, subdivision 1, paragraphs (1), (2), (5), (6), (10), (12), (13), (14),
683.4 and (15); 144.1201 to 144.1204; 144.121; 144.1215; 144.1222; 144.35; 144.381 to 144.385;
683.5 144.411 to 144.417; 144.495; 144.71 to 144.74; 144.9501 to 144.9512; 144.97 to 144.98;
683.6 144.992; 152.22 to 152.37; 326.70 to 326.785; 327.10 to 327.131; and 327.14 to 327.28
683.7 and all rules, orders, stipulation agreements, settlements, compliance agreements, licenses,
683.8 registrations, certificates, and permits adopted or issued by the department or under any
683.9 other law now in force or later enacted for the preservation of public health may, in addition
683.10 to provisions in other statutes, be enforced under this section.

683.11 Sec. 14. Minnesota Statutes 2018, section 144A.43, subdivision 11, is amended to read:

683.12 Subd. 11. **Medication administration.** "Medication administration" means performing
683.13 a set of tasks ~~to ensure a client takes medications, and includes~~ that include the following:

683.14 (1) checking the client's medication record;

683.15 (2) preparing the medication as necessary;

683.16 (3) administering the medication to the client;

683.17 (4) documenting the administration or reason for not administering the medication; and

683.18 (5) reporting to a registered nurse or appropriate licensed health professional any concerns
683.19 about the medication, the client, or the client's refusal to take the medication.

683.20 Sec. 15. Minnesota Statutes 2018, section 144A.43, is amended by adding a subdivision
683.21 to read:

683.22 Subd. 12a. **Medication reconciliation.** "Medication reconciliation" means the process
683.23 of identifying the most accurate list of all medications the client is taking, including the
683.24 name, dosage, frequency, and route by comparing the client record to an external list of
683.25 medications obtained from the client, hospital, prescriber, or other provider.

683.26 Sec. 16. Minnesota Statutes 2018, section 144A.43, subdivision 30, is amended to read:

683.27 Subd. 30. **Standby assistance.** "Standby assistance" means the presence of another
683.28 person ~~within arm's reach to minimize the risk of injury while performing daily activities~~
683.29 ~~through physical intervention or cueing~~ to assist a client with an assistive task by providing
683.30 cues, oversight, and minimal physical assistance.

684.1 Sec. 17. Minnesota Statutes 2018, section 144A.472, subdivision 5, is amended to read:

684.2 Subd. 5. **Transfers prohibited; Changes in ownership.** ~~Any~~ (a) A home care license
 684.3 issued by the commissioner may not be transferred to another party. Before acquiring
 684.4 ownership of or a controlling interest in a home care provider business, a prospective
 684.5 applicant owner must apply for a new ~~temporary~~ license. A change of ownership is a transfer
 684.6 of operational control ~~to a different business entity~~ of the home care provider business and
 684.7 includes:

684.8 (1) transfer of the business to a different or new corporation;

684.9 (2) in the case of a partnership, the dissolution or termination of the partnership under
 684.10 chapter 323A, with the business continuing by a successor partnership or other entity;

684.11 (3) relinquishment of control of the provider to another party, including to a contract
 684.12 management firm that is not under the control of the owner of the business' assets;

684.13 (4) transfer of the business by a sole proprietor to another party or entity; or

684.14 (5) ~~in the case of a privately held corporation, the change in~~ transfer of ownership or
 684.15 control of 50 percent or more of the ~~outstanding voting stock~~ controlling interest of a home
 684.16 care provider business not covered by clauses (1) to (4).

684.17 (b) An employee who was employed by the previous owner of the home care provider
 684.18 business prior to the effective date of a change in ownership under paragraph (a), and who
 684.19 will be employed by the new owner in the same or a similar capacity, shall be treated as if
 684.20 no change in employer occurred, with respect to orientation, training, tuberculosis testing,
 684.21 background studies, and competency testing and training on the policies identified in
 684.22 subdivision 1, clause (14), and subdivision 2, if applicable.

684.23 (c) Notwithstanding paragraph (b), a new owner of a home care provider business must
 684.24 ensure that employees of the provider receive and complete training and testing on any
 684.25 provisions of policies that differ from those of the previous owner within 90 days after the
 684.26 date of the change in ownership.

684.27 Sec. 18. Minnesota Statutes 2018, section 144A.472, subdivision 7, is amended to read:

684.28 Subd. 7. **Fees; application, change of ownership, and renewal, and failure to**
 684.29 **notify.** (a) An initial applicant seeking temporary home care licensure must submit the
 684.30 following application fee to the commissioner along with a completed application:

684.31 (1) for a basic home care provider, \$2,100; or

684.32 (2) for a comprehensive home care provider, \$4,200.

685.1 (b) A home care provider who is filing a change of ownership as required under
 685.2 subdivision 5 must submit the following application fee to the commissioner, along with
 685.3 the documentation required for the change of ownership:

685.4 (1) for a basic home care provider, \$2,100; or

685.5 (2) for a comprehensive home care provider, \$4,200.

685.6 (c) For the period ending June 30, 2018, a home care provider who is seeking to renew
 685.7 the provider's license shall pay a fee to the commissioner based on revenues derived from
 685.8 the provision of home care services during the calendar year prior to the year in which the
 685.9 application is submitted, according to the following schedule:

685.10 **License Renewal Fee**

685.11	Provider Annual Revenue	Fee
685.12	greater than \$1,500,000	\$6,625
685.13	greater than \$1,275,000 and no more than	
685.14	\$1,500,000	\$5,797
685.15	greater than \$1,100,000 and no more than	
685.16	\$1,275,000	\$4,969
685.17	greater than \$950,000 and no more than	
685.18	\$1,100,000	\$4,141
685.19	greater than \$850,000 and no more than \$950,000	\$3,727
685.20	greater than \$750,000 and no more than \$850,000	\$3,313
685.21	greater than \$650,000 and no more than \$750,000	\$2,898
685.22	greater than \$550,000 and no more than \$650,000	\$2,485
685.23	greater than \$450,000 and no more than \$550,000	\$2,070
685.24	greater than \$350,000 and no more than \$450,000	\$1,656
685.25	greater than \$250,000 and no more than \$350,000	\$1,242
685.26	greater than \$100,000 and no more than \$250,000	\$828
685.27	greater than \$50,000 and no more than \$100,000	\$500
685.28	greater than \$25,000 and no more than \$50,000	\$400
685.29	no more than \$25,000	\$200

685.30 (d) For the period between July 1, 2018, and June 30, 2020, a home care provider who
 685.31 is seeking to renew the provider's license shall pay a fee to the commissioner in an amount
 685.32 that is ten percent higher than the applicable fee in paragraph (c). A home care provider's
 685.33 fee shall be based on revenues derived from the provision of home care services during the
 685.34 calendar year prior to the year in which the application is submitted.

685.35 (e) Beginning July 1, 2020, a home care provider who is seeking to renew the provider's
 685.36 license shall pay a fee to the commissioner based on revenues derived from the provision

686.1 of home care services during the calendar year prior to the year in which the application is
686.2 submitted, according to the following schedule:

686.3 **License Renewal Fee**

686.4	Provider Annual Revenue	Fee
686.5	greater than \$1,500,000	\$7,651
686.6	greater than \$1,275,000 and no more than	\$6,695
686.7	\$1,500,000	
686.8	greater than \$1,100,000 and no more than	\$5,739
686.9	\$1,275,000	
686.10	greater than \$950,000 and no more than	\$4,783
686.11	\$1,100,000	
686.12	greater than \$850,000 and no more than \$950,000	\$4,304
686.13	greater than \$750,000 and no more than \$850,000	\$3,826
686.14	greater than \$650,000 and no more than \$750,000	\$3,347
686.15	greater than \$550,000 and no more than \$650,000	\$2,870
686.16	greater than \$450,000 and no more than \$550,000	\$2,391
686.17	greater than \$350,000 and no more than \$450,000	\$1,913
686.18	greater than \$250,000 and no more than \$350,000	\$1,434
686.19	greater than \$100,000 and no more than \$250,000	\$957
686.20	greater than \$50,000 and no more than \$100,000	\$577
686.21	greater than \$25,000 and no more than \$50,000	\$462
686.22	no more than \$25,000	\$231

686.23 (f) If requested, the home care provider shall provide the commissioner information to
686.24 verify the provider's annual revenues or other information as needed, including copies of
686.25 documents submitted to the Department of Revenue.

686.26 (g) At each annual renewal, a home care provider may elect to pay the highest renewal
686.27 fee for its license category, and not provide annual revenue information to the commissioner.

686.28 (h) A temporary license or license applicant, or temporary licensee or licensee that
686.29 knowingly provides the commissioner incorrect revenue amounts for the purpose of paying
686.30 a lower license fee, shall be subject to a civil penalty in the amount of double the fee the
686.31 provider should have paid.

686.32 (i) The fee for failure to comply with the notification requirements of section 144A.473,
686.33 subdivision 2, paragraph (c), is \$1,000.

686.34 (j) Fees and penalties collected under this section shall be deposited in the state treasury
686.35 and credited to the state government special revenue fund. All fees are nonrefundable. Fees

687.1 collected under paragraphs (c), (d), and (e) are nonrefundable even if received before July
687.2 1, 2017, for temporary licenses or licenses being issued effective July 1, 2017, or later.

687.3 **EFFECTIVE DATE.** This section is effective the day following final enactment.

687.4 Sec. 19. Minnesota Statutes 2018, section 144A.473, is amended to read:

687.5 **144A.473 ISSUANCE OF TEMPORARY LICENSE AND LICENSE RENEWAL.**

687.6 Subdivision 1. **Temporary license and renewal of license.** (a) The department shall
687.7 review each application to determine the applicant's knowledge of and compliance with
687.8 Minnesota home care regulations. Before granting a temporary license or renewing a license,
687.9 the commissioner may further evaluate the applicant or licensee by requesting additional
687.10 information or documentation or by conducting an on-site survey of the applicant to
687.11 determine compliance with sections 144A.43 to 144A.482.

687.12 (b) Within 14 calendar days after receiving an application for a license, the commissioner
687.13 shall acknowledge receipt of the application in writing. The acknowledgment must indicate
687.14 whether the application appears to be complete or whether additional information is required
687.15 before the application will be considered complete.

687.16 (c) Within 90 days after receiving a complete application, the commissioner shall issue
687.17 a temporary license, renew the license, or deny the license.

687.18 (d) The commissioner shall issue a license that contains the home care provider's name,
687.19 address, license level, expiration date of the license, and unique license number. All licenses,
687.20 except for temporary licenses issued under subdivision 2, are valid for up to one year from
687.21 the date of issuance.

687.22 Subd. 2. **Temporary license.** (a) For new license applicants, the commissioner shall
687.23 issue a temporary license for either the basic or comprehensive home care level. A temporary
687.24 license is effective for up to one year from the date of issuance, except that a temporary
687.25 license may be extended according to subdivision 3. Temporary licensees must comply with
687.26 sections 144A.43 to 144A.482.

687.27 (b) During the temporary license year period, the commissioner shall survey the temporary
687.28 licensee within 90 calendar days after the commissioner is notified or has evidence that the
687.29 temporary licensee is providing home care services.

687.30 (c) Within five days of beginning the provision of services, the temporary licensee must
687.31 notify the commissioner that it is serving clients. The notification to the commissioner may
687.32 be mailed or e-mailed to the commissioner at the address provided by the commissioner. If

688.1 the temporary licensee does not provide home care services during the temporary license
688.2 year period, then the temporary license expires at the end of the year period and the applicant
688.3 must reapply for a temporary home care license.

688.4 (d) A temporary licensee may request a change in the level of licensure prior to being
688.5 surveyed and granted a license by notifying the commissioner in writing and providing
688.6 additional documentation or materials required to update or complete the changed temporary
688.7 license application. The applicant must pay the difference between the application fees
688.8 when changing from the basic level to the comprehensive level of licensure. No refund will
688.9 be made if the provider chooses to change the license application to the basic level.

688.10 (e) If the temporary licensee notifies the commissioner that the licensee has clients within
688.11 45 days prior to the temporary license expiration, the commissioner may extend the temporary
688.12 license for up to 60 days in order to allow the commissioner to complete the on-site survey
688.13 required under this section and follow-up survey visits.

688.14 Subd. 3. **Temporary licensee survey.** (a) If the temporary licensee is in substantial
688.15 compliance with the survey, the commissioner shall issue either a basic or comprehensive
688.16 home care license. If the temporary licensee is not in substantial compliance with the survey,
688.17 the commissioner shall either: (1) not issue a basic or comprehensive license and there will
688.18 be no contested hearing right under chapter 14; terminate the temporary license; or (2)
688.19 extend the temporary license for a period not to exceed 90 days and apply conditions, as
688.20 permitted under section 144A.475, subdivision 2, to the extension of a temporary license.
688.21 If the temporary licensee is not in substantial compliance with the survey within the time
688.22 period of the extension, or if the temporary licensee does not satisfy the license conditions,
688.23 the commissioner may deny the license.

688.24 (b) If the temporary licensee whose basic or comprehensive license has been denied or
688.25 extended with conditions disagrees with the conclusions of the commissioner, then the
688.26 temporary licensee may request a reconsideration by the commissioner or commissioner's
688.27 designee. The reconsideration request process must be conducted internally by the
688.28 commissioner or commissioner's designee, and chapter 14 does not apply.

688.29 (c) The temporary licensee requesting reconsideration must make the request in writing
688.30 and must list and describe the reasons why the temporary licensee disagrees with the decision
688.31 to deny the basic or comprehensive home care license or the decision to extend the temporary
688.32 license with conditions.

689.1 (d) The reconsideration request and supporting documentation must be received by the
689.2 commissioner within 15 calendar days after the date the temporary licensee receives the
689.3 correction order.

689.4 (e) A temporary licensee whose license is denied, is permitted to continue operating as
689.5 a home care provider during the period of time when:

689.6 (1) a reconsideration request is in process;

689.7 (2) an extension of a temporary license is being negotiated;

689.8 (3) the placement of conditions on a temporary license is being negotiated; or

689.9 (4) a transfer of home care clients from the temporary licensee to a new home care
689.10 provider is in process.

689.11 (f) A temporary licensee whose license is denied must comply with the requirements
689.12 for notification and transfer of clients in section 144A.475, subdivision 5.

689.13 Sec. 20. Minnesota Statutes 2018, section 144A.474, subdivision 2, is amended to read:

689.14 Subd. 2. **Types of home care surveys.** (a) "Initial full survey" means the survey of a
689.15 new temporary licensee conducted after the department is notified or has evidence that the
689.16 temporary licensee is providing home care services to determine if the provider is in
689.17 compliance with home care requirements. Initial full surveys must be completed within 14
689.18 months after the department's issuance of a temporary basic or comprehensive license.

689.19 (b) "Change in ownership survey" means a full survey of a new licensee due to a change
689.20 in ownership. Change in ownership surveys must be completed within six months after the
689.21 department's issuance of a new license due to a change in ownership.

689.22 (c) "Core survey" means periodic inspection of home care providers to determine ongoing
689.23 compliance with the home care requirements, focusing on the essential health and safety
689.24 requirements. Core surveys are available to licensed home care providers who have been
689.25 licensed for three years and surveyed at least once in the past three years with the latest
689.26 survey having no widespread violations beyond Level 1 as provided in subdivision 11.
689.27 Providers must also not have had any substantiated licensing complaints, substantiated
689.28 complaints against the agency under the Vulnerable Adults Act or Maltreatment of Minors
689.29 Act, or an enforcement action as authorized in section 144A.475 in the past three years.

689.30 (1) The core survey for basic home care providers must review compliance in the
689.31 following areas:

689.32 (i) reporting of maltreatment;

- 690.1 (ii) orientation to and implementation of the home care bill of rights;
- 690.2 (iii) statement of home care services;
- 690.3 (iv) initial evaluation of clients and initiation of services;
- 690.4 (v) client review and monitoring;
- 690.5 (vi) service plan implementation and changes to the service plan;
- 690.6 (vii) client complaint and investigative process;
- 690.7 (viii) competency of unlicensed personnel; and
- 690.8 (ix) infection control.

690.9 (2) For comprehensive home care providers, the core survey must include everything
 690.10 in the basic core survey plus these areas:

- 690.11 (i) delegation to unlicensed personnel;
- 690.12 (ii) assessment, monitoring, and reassessment of clients; and
- 690.13 (iii) medication, treatment, and therapy management.

690.14 ~~(e)~~ (d) "Full survey" means the periodic inspection of home care providers to determine
 690.15 ongoing compliance with the home care requirements that cover the core survey areas and
 690.16 all the legal requirements for home care providers. A full survey is conducted for all
 690.17 temporary licensees ~~and~~, for licensees that receive licenses due to an approved change in
 690.18 ownership, for providers who do not meet the requirements needed for a core survey, and
 690.19 when a surveyor identifies unacceptable client health or safety risks during a core survey.
 690.20 A full survey must include all the tasks identified as part of the core survey and any additional
 690.21 review deemed necessary by the department, including additional observation, interviewing,
 690.22 or records review of additional clients and staff.

690.23 ~~(d)~~ (e) "Follow-up surveys" means surveys conducted to determine if a home care
 690.24 provider has corrected deficient issues and systems identified during a core survey, full
 690.25 survey, or complaint investigation. Follow-up surveys may be conducted via phone, e-mail,
 690.26 fax, mail, or on-site reviews. Follow-up surveys, other than complaint surveys, shall be
 690.27 concluded with an exit conference and written information provided on the process for
 690.28 requesting a reconsideration of the survey results.

690.29 ~~(e)~~ (f) Upon receiving information alleging that a home care provider has violated or is
 690.30 currently violating a requirement of sections 144A.43 to 144A.482, the commissioner shall
 690.31 investigate the complaint according to sections 144A.51 to 144A.54.

691.1 Sec. 21. Minnesota Statutes 2018, section 144A.475, subdivision 1, is amended to read:

691.2 Subdivision 1. **Conditions.** (a) The commissioner may refuse to grant a temporary
691.3 license, refuse to grant a license as a result of a change in ownership, refuse to renew a
691.4 license, suspend or revoke a license, or impose a conditional license if the home care provider
691.5 or owner or managerial official of the home care provider:

691.6 (1) is in violation of, or during the term of the license has violated, any of the requirements
691.7 in sections 144A.471 to 144A.482;

691.8 (2) permits, aids, or abets the commission of any illegal act in the provision of home
691.9 care;

691.10 (3) performs any act detrimental to the health, safety, and welfare of a client;

691.11 (4) obtains the license by fraud or misrepresentation;

691.12 (5) knowingly made or makes a false statement of a material fact in the application for
691.13 a license or in any other record or report required by this chapter;

691.14 (6) denies representatives of the department access to any part of the home care provider's
691.15 books, records, files, or employees;

691.16 (7) interferes with or impedes a representative of the department in contacting the home
691.17 care provider's clients;

691.18 (8) interferes with or impedes a representative of the department in the enforcement of
691.19 this chapter or has failed to fully cooperate with an inspection, survey, or investigation by
691.20 the department;

691.21 (9) destroys or makes unavailable any records or other evidence relating to the home
691.22 care provider's compliance with this chapter;

691.23 (10) refuses to initiate a background study under section 144.057 or 245A.04;

691.24 (11) fails to timely pay any fines assessed by the department;

691.25 (12) violates any local, city, or township ordinance relating to home care services;

691.26 (13) has repeated incidents of personnel performing services beyond their competency
691.27 level; or

691.28 (14) has operated beyond the scope of the home care provider's license level.

691.29 (b) A violation by a contractor providing the home care services of the home care provider
691.30 is a violation by the home care provider.

692.1 Sec. 22. Minnesota Statutes 2018, section 144A.475, subdivision 2, is amended to read:

692.2 Subd. 2. **Terms to suspension or conditional license.** (a) A suspension or conditional
692.3 license designation may include terms that must be completed or met before a suspension
692.4 or conditional license designation is lifted. A conditional license designation may include
692.5 restrictions or conditions that are imposed on the provider. Terms for a suspension or
692.6 conditional license may include one or more of the following and the scope of each will be
692.7 determined by the commissioner:

692.8 (1) requiring a consultant to review, evaluate, and make recommended changes to the
692.9 home care provider's practices and submit reports to the commissioner at the cost of the
692.10 home care provider;

692.11 (2) requiring supervision of the home care provider or staff practices at the cost of the
692.12 home care provider by an unrelated person who has sufficient knowledge and qualifications
692.13 to oversee the practices and who will submit reports to the commissioner;

692.14 (3) requiring the home care provider or employees to obtain training at the cost of the
692.15 home care provider;

692.16 (4) requiring the home care provider to submit reports to the commissioner;

692.17 (5) prohibiting the home care provider from taking any new clients for a period of time;
692.18 or

692.19 (6) any other action reasonably required to accomplish the purpose of this subdivision
692.20 and section 144A.45, subdivision 2.

692.21 (b) A home care provider subject to this subdivision may continue operating during the
692.22 period of time home care clients are being transferred to other providers.

692.23 Sec. 23. Minnesota Statutes 2018, section 144A.475, subdivision 5, is amended to read:

692.24 Subd. 5. **Plan required.** (a) The process of suspending or revoking a license must include
692.25 a plan for transferring affected clients to other providers by the home care provider, which
692.26 will be monitored by the commissioner. Within three business days of being notified of the
692.27 final revocation or suspension action, the home care provider shall provide the commissioner,
692.28 the lead agencies as defined in section 256B.0911, and the ombudsman for long-term care
692.29 with the following information:

692.30 (1) a list of all clients, including full names and all contact information on file;

692.31 (2) a list of each client's representative or emergency contact person, including full names
692.32 and all contact information on file;

693.1 (3) the location or current residence of each client;

693.2 (4) the payor sources for each client, including payor source identification numbers; and

693.3 (5) for each client, a copy of the client's service plan, and a list of the types of services
693.4 being provided.

693.5 (b) The revocation or suspension notification requirement is satisfied by mailing the
693.6 notice to the address in the license record. The home care provider shall cooperate with the
693.7 commissioner and the lead agencies during the process of transferring care of clients to
693.8 qualified providers. Within three business days of being notified of the final revocation or
693.9 suspension action, the home care provider must notify and disclose to each of the home
693.10 care provider's clients, or the client's representative or emergency contact persons, that the
693.11 commissioner is taking action against the home care provider's license by providing a copy
693.12 of the revocation or suspension notice issued by the commissioner.

693.13 (c) A home care provider subject to this subdivision may continue operating during the
693.14 period of time home care clients are being transferred to other providers.

693.15 Sec. 24. Minnesota Statutes 2018, section 144A.476, subdivision 1, is amended to read:

693.16 Subdivision 1. **Prior criminal convictions; owner and managerial officials.** (a) Before
693.17 the commissioner issues a temporary license, issues a license as a result of an approved
693.18 change in ownership, or renews a license, an owner or managerial official is required to
693.19 complete a background study under section 144.057. No person may be involved in the
693.20 management, operation, or control of a home care provider if the person has been disqualified
693.21 under chapter 245C. If an individual is disqualified under section 144.057 or chapter 245C,
693.22 the individual may request reconsideration of the disqualification. If the individual requests
693.23 reconsideration and the commissioner sets aside or rescinds the disqualification, the individual
693.24 is eligible to be involved in the management, operation, or control of the provider. If an
693.25 individual has a disqualification under section 245C.15, subdivision 1, and the disqualification
693.26 is affirmed, the individual's disqualification is barred from a set aside, and the individual
693.27 must not be involved in the management, operation, or control of the provider.

693.28 (b) For purposes of this section, owners of a home care provider subject to the background
693.29 check requirement are those individuals whose ownership interest provides sufficient
693.30 authority or control to affect or change decisions related to the operation of the home care
693.31 provider. An owner includes a sole proprietor, a general partner, or any other individual
693.32 whose individual ownership interest can affect the management and direction of the policies
693.33 of the home care provider.

694.1 (c) For the purposes of this section, managerial officials subject to the background check
694.2 requirement are individuals who provide direct contact as defined in section 245C.02,
694.3 subdivision 11, or individuals who have the responsibility for the ongoing management or
694.4 direction of the policies, services, or employees of the home care provider. Data collected
694.5 under this subdivision shall be classified as private data on individuals under section 13.02,
694.6 subdivision 12.

694.7 (d) The department shall not issue any license if the applicant or owner or managerial
694.8 official has been unsuccessful in having a background study disqualification set aside under
694.9 section 144.057 and chapter 245C; if the owner or managerial official, as an owner or
694.10 managerial official of another home care provider, was substantially responsible for the
694.11 other home care provider's failure to substantially comply with sections 144A.43 to
694.12 144A.482; or if an owner that has ceased doing business, either individually or as an owner
694.13 of a home care provider, was issued a correction order for failing to assist clients in violation
694.14 of this chapter.

694.15 Sec. 25. Minnesota Statutes 2018, section 144A.479, subdivision 7, is amended to read:

694.16 Subd. 7. **Employee records.** The home care provider must maintain current records of
694.17 each paid employee, regularly scheduled volunteers providing home care services, and of
694.18 each individual contractor providing home care services. The records must include the
694.19 following information:

694.20 (1) evidence of current professional licensure, registration, or certification, if licensure,
694.21 registration, or certification is required by this statute or other rules;

694.22 (2) records of orientation, required annual training and infection control training, and
694.23 competency evaluations;

694.24 (3) current job description, including qualifications, responsibilities, and identification
694.25 of staff providing supervision;

694.26 (4) documentation of annual performance reviews which identify areas of improvement
694.27 needed and training needs;

694.28 (5) for individuals providing home care services, verification that ~~required~~ any health
694.29 screenings required by infection control programs established under section 144A.4798
694.30 have taken place and the dates of those screenings; and

694.31 (6) documentation of the background study as required under section 144.057.

695.1 Each employee record must be retained for at least three years after a paid employee, home
695.2 care volunteer, or contractor ceases to be employed by or under contract with the home care
695.3 provider. If a home care provider ceases operation, employee records must be maintained
695.4 for three years.

695.5 Sec. 26. Minnesota Statutes 2018, section 144A.4791, subdivision 1, is amended to read:

695.6 Subdivision 1. **Home care bill of rights; notification to client.** (a) The home care
695.7 provider shall provide the client or the client's representative a written notice of the rights
695.8 under section 144A.44 before the ~~initiation of~~ date that services are first provided to that
695.9 client. The provider shall make all reasonable efforts to provide notice of the rights to the
695.10 client or the client's representative in a language the client or client's representative can
695.11 understand.

695.12 (b) In addition to the text of the home care bill of rights in section 144A.44, subdivision
695.13 1, the notice shall also contain the following statement describing how to file a complaint
695.14 with these offices.

695.15 "If you have a complaint about the provider or the person providing your home care
695.16 services, you may call, write, or visit the Office of Health Facility Complaints, Minnesota
695.17 Department of Health. You may also contact the Office of Ombudsman for Long-Term
695.18 Care or the Office of Ombudsman for Mental Health and Developmental Disabilities."

695.19 The statement should include the telephone number, website address, e-mail address,
695.20 mailing address, and street address of the Office of Health Facility Complaints at the
695.21 Minnesota Department of Health, the Office of the Ombudsman for Long-Term Care, and
695.22 the Office of the Ombudsman for Mental Health and Developmental Disabilities. The
695.23 statement should also include the home care provider's name, address, e-mail, telephone
695.24 number, and name or title of the person at the provider to whom problems or complaints
695.25 may be directed. It must also include a statement that the home care provider will not retaliate
695.26 because of a complaint.

695.27 (c) The home care provider shall obtain written acknowledgment of the client's receipt
695.28 of the home care bill of rights or shall document why an acknowledgment cannot be obtained.
695.29 The acknowledgment may be obtained from the client or the client's representative.
695.30 Acknowledgment of receipt shall be retained in the client's record.

696.1 Sec. 27. Minnesota Statutes 2018, section 144A.4791, subdivision 3, is amended to read:

696.2 Subd. 3. **Statement of home care services.** Prior to the ~~initiation of~~ date that services
696.3 are first provided to the client, a home care provider must provide to the client or the client's
696.4 representative a written statement which identifies if the provider has a basic or
696.5 comprehensive home care license, the services the provider is authorized to provide, and
696.6 which services the provider cannot provide under the scope of the provider's license. The
696.7 home care provider shall obtain written acknowledgment from the clients that the provider
696.8 has provided the statement or must document why the provider could not obtain the
696.9 acknowledgment.

696.10 Sec. 28. Minnesota Statutes 2018, section 144A.4791, subdivision 6, is amended to read:

696.11 Subd. 6. **Initiation of services.** When a provider ~~initiates~~ provides home care services
696.12 ~~and to a client before~~ the individualized review or assessment by a licensed health
696.13 professional or registered nurse as required in subdivisions 7 and 8 ~~has not been~~ is completed,
696.14 the ~~provider~~ licensed health professional or registered nurse must complete a temporary
696.15 ~~plan and agreement~~ with the client ~~for services~~ and orient staff assigned to deliver services
696.16 as identified in the temporary plan.

696.17 Sec. 29. Minnesota Statutes 2018, section 144A.4791, subdivision 7, is amended to read:

696.18 Subd. 7. **Basic individualized client review and monitoring.** (a) When services being
696.19 provided are basic home care services, an individualized initial review of the client's needs
696.20 and preferences must be conducted at the client's residence with the client or client's
696.21 representative. This initial review must be completed within 30 days after the ~~initiation of~~
696.22 ~~the~~ date that home care services are first provided.

696.23 (b) Client monitoring and review must be conducted as needed based on changes in the
696.24 needs of the client and cannot exceed 90 days from the date of the last review. The monitoring
696.25 and review may be conducted at the client's residence or through the utilization of
696.26 telecommunication methods based on practice standards that meet the individual client's
696.27 needs.

696.28 Sec. 30. Minnesota Statutes 2018, section 144A.4791, subdivision 8, is amended to read:

696.29 Subd. 8. **Comprehensive assessment, monitoring, and reassessment.** (a) When the
696.30 services being provided are comprehensive home care services, an individualized initial
696.31 assessment must be conducted in person by a registered nurse. When the services are provided
696.32 by other licensed health professionals, the assessment must be conducted by the appropriate

697.1 health professional. This initial assessment must be completed within five days after ~~initiation~~
697.2 of the date that home care services are first provided.

697.3 (b) Client monitoring and reassessment must be conducted in the client's home no more
697.4 than 14 days after ~~initiation of~~ the date that home care services are first provided.

697.5 (c) Ongoing client monitoring and reassessment must be conducted as needed based on
697.6 changes in the needs of the client and cannot exceed 90 days from the last date of the
697.7 assessment. The monitoring and reassessment may be conducted at the client's residence
697.8 or through the utilization of telecommunication methods based on practice standards that
697.9 meet the individual client's needs.

697.10 Sec. 31. Minnesota Statutes 2018, section 144A.4791, subdivision 9, is amended to read:

697.11 **Subd. 9. Service plan, implementation, and revisions to service plan.** (a) No later
697.12 than 14 days after the ~~initiation of~~ date that home care services are first provided, a home
697.13 care provider shall finalize a current written service plan.

697.14 (b) The service plan and any revisions must include a signature or other authentication
697.15 by the home care provider and by the client or the client's representative documenting
697.16 agreement on the services to be provided. The service plan must be revised, if needed, based
697.17 on client review or reassessment under subdivisions 7 and 8. The provider must provide
697.18 information to the client about changes to the provider's fee for services and how to contact
697.19 the Office of the Ombudsman for Long-Term Care.

697.20 (c) The home care provider must implement and provide all services required by the
697.21 current service plan.

697.22 (d) The service plan and revised service plan must be entered into the client's record,
697.23 including notice of a change in a client's fees when applicable.

697.24 (e) Staff providing home care services must be informed of the current written service
697.25 plan.

697.26 (f) The service plan must include:

697.27 (1) a description of the home care services to be provided, the fees for services, and the
697.28 frequency of each service, according to the client's current review or assessment and client
697.29 preferences;

697.30 (2) the identification of the staff or categories of staff who will provide the services;

697.31 (3) the schedule and methods of monitoring reviews or assessments of the client;

698.1 (4) ~~the frequency of sessions of supervision of staff and type of personnel who will~~
 698.2 ~~supervise staff; and~~ the schedule and methods of monitoring staff providing home care
 698.3 services; and

698.4 (5) a contingency plan that includes:

698.5 (i) the action to be taken by the home care provider and by the client or client's
 698.6 representative if the scheduled service cannot be provided;

698.7 (ii) information and a method for a client or client's representative to contact the home
 698.8 care provider;

698.9 (iii) names and contact information of persons the client wishes to have notified in an
 698.10 emergency or if there is a significant adverse change in the client's condition, ~~including~~
 698.11 ~~identification of and information as to who has authority to sign for the client in an~~
 698.12 ~~emergency; and~~

698.13 (iv) the circumstances in which emergency medical services are not to be summoned
 698.14 consistent with chapters 145B and 145C, and declarations made by the client under those
 698.15 chapters.

698.16 Sec. 32. Minnesota Statutes 2018, section 144A.4792, subdivision 1, is amended to read:

698.17 Subdivision 1. **Medication management services; comprehensive home care**
 698.18 **license.** (a) This subdivision applies only to home care providers with a comprehensive
 698.19 home care license that provide medication management services to clients. Medication
 698.20 management services may not be provided by a home care provider who has a basic home
 698.21 care license.

698.22 (b) A comprehensive home care provider who provides medication management services
 698.23 must develop, implement, and maintain current written medication management policies
 698.24 and procedures. The policies and procedures must be developed under the supervision and
 698.25 direction of a registered nurse, licensed health professional, or pharmacist consistent with
 698.26 current practice standards and guidelines.

698.27 (c) The written policies and procedures must address requesting and receiving
 698.28 prescriptions for medications; preparing and giving medications; verifying that prescription
 698.29 drugs are administered as prescribed; documenting medication management activities;
 698.30 controlling and storing medications; monitoring and evaluating medication use; resolving
 698.31 medication errors; communicating with the prescriber, pharmacist, and client and client
 698.32 representative, if any; disposing of unused medications; and educating clients and client
 698.33 representatives about medications. When controlled substances are being managed, stored,

699.1 and secured by the comprehensive home care provider, the policies and procedures must
699.2 also identify how the provider will ensure security and accountability for the overall
699.3 management, control, and disposition of those substances in compliance with state and
699.4 federal regulations and with subdivision 22.

699.5 Sec. 33. Minnesota Statutes 2018, section 144A.4792, subdivision 2, is amended to read:

699.6 Subd. 2. **Provision of medication management services.** (a) For each client who
699.7 requests medication management services, the comprehensive home care provider shall,
699.8 prior to providing medication management services, have a registered nurse, licensed health
699.9 professional, or authorized prescriber under section 151.37 conduct an assessment to
699.10 determine what medication management services will be provided and how the services
699.11 will be provided. This assessment must be conducted face-to-face with the client. The
699.12 assessment must include an identification and review of all medications the client is known
699.13 to be taking. The review and identification must include indications for medications, side
699.14 effects, contraindications, allergic or adverse reactions, and actions to address these issues.

699.15 (b) The assessment must:

699.16 (1) identify interventions needed in management of medications to prevent diversion of
699.17 medication by the client or others who may have access to the medications; and

699.18 (2) provide instructions to the client or client's representative on interventions to manage
699.19 the client's medications and prevent diversion of medications.

699.20 "Diversion of medications" means the misuse, theft, or illegal or improper disposition of
699.21 medications.

699.22 Sec. 34. Minnesota Statutes 2018, section 144A.4792, subdivision 5, is amended to read:

699.23 Subd. 5. **Individualized medication management plan.** (a) For each client receiving
699.24 medication management services, the comprehensive home care provider must prepare and
699.25 include in the service plan a written statement of the medication management services that
699.26 will be provided to the client. The provider must develop and maintain a current
699.27 individualized medication management record for each client based on the client's assessment
699.28 that must contain the following:

699.29 (1) a statement describing the medication management services that will be provided;

699.30 (2) a description of storage of medications based on the client's needs and preferences,
699.31 risk of diversion, and consistent with the manufacturer's directions;

700.1 (3) documentation of specific client instructions relating to the administration of
700.2 medications;

700.3 (4) identification of persons responsible for monitoring medication supplies and ensuring
700.4 that medication refills are ordered on a timely basis;

700.5 (5) identification of medication management tasks that may be delegated to unlicensed
700.6 personnel;

700.7 (6) procedures for staff notifying a registered nurse or appropriate licensed health
700.8 professional when a problem arises with medication management services; and

700.9 (7) any client-specific requirements relating to documenting medication administration,
700.10 verifications that all medications are administered as prescribed, and monitoring of
700.11 medication use to prevent possible complications or adverse reactions.

700.12 (b) The medication management record must be current and updated when there are any
700.13 changes.

700.14 (c) Medication reconciliation must be completed when a licensed nurse, licensed health
700.15 professional, or authorized prescriber is providing medication management.

700.16 Sec. 35. Minnesota Statutes 2018, section 144A.4792, subdivision 10, is amended to read:

700.17 Subd. 10. **Medication management for clients who will be away from home.** (a) A
700.18 home care provider who is providing medication management services to the client and
700.19 controls the client's access to the medications must develop and implement policies and
700.20 procedures for giving accurate and current medications to clients for planned or unplanned
700.21 times away from home according to the client's individualized medication management
700.22 plan. The policy and procedures must state that:

700.23 (1) for planned time away, the medications must be obtained from the pharmacy or set
700.24 up by ~~the registered~~ a licensed nurse according to appropriate state and federal laws and
700.25 nursing standards of practice;

700.26 (2) for unplanned time away, when the pharmacy is not able to provide the medications,
700.27 a licensed nurse or unlicensed personnel shall give the client or client's representative
700.28 medications in amounts and dosages needed for the length of the anticipated absence, not
700.29 to exceed ~~120 hours~~ seven calendar days;

700.30 (3) the client or client's representative must be provided written information on
700.31 medications, including any special instructions for administering or handling the medications,
700.32 including controlled substances;

701.1 (4) the medications must be placed in a medication container or containers appropriate
701.2 to the provider's medication system and must be labeled with the client's name and the dates
701.3 and times that the medications are scheduled; and

701.4 (5) the client or client's representative must be provided in writing the home care
701.5 provider's name and information on how to contact the home care provider.

701.6 (b) For unplanned time away when the licensed nurse is not available, the registered
701.7 nurse may delegate this task to unlicensed personnel if:

701.8 (1) the registered nurse has trained the unlicensed staff and determined the unlicensed
701.9 staff is competent to follow the procedures for giving medications to clients; and

701.10 (2) the registered nurse has developed written procedures for the unlicensed personnel,
701.11 including any special instructions or procedures regarding controlled substances that are
701.12 prescribed for the client. The procedures must address:

701.13 (i) the type of container or containers to be used for the medications appropriate to the
701.14 provider's medication system;

701.15 (ii) how the container or containers must be labeled;

701.16 (iii) the written information about the medications to be given to the client or client's
701.17 representative;

701.18 (iv) how the unlicensed staff must document in the client's record that medications have
701.19 been given to the client or the client's representative, including documenting the date the
701.20 medications were given to the client or the client's representative and who received the
701.21 medications, the person who gave the medications to the client, the number of medications
701.22 that were given to the client, and other required information;

701.23 (v) how the registered nurse shall be notified that medications have been given to the
701.24 client or client's representative and whether the registered nurse needs to be contacted before
701.25 the medications are given to the client or the client's representative; ~~and~~

701.26 (vi) a review by the registered nurse of the completion of this task to verify that this task
701.27 was completed accurately by the unlicensed personnel; and

701.28 (vii) how the unlicensed staff must document in the client's record any unused medications
701.29 that are returned to the provider, including the name of each medication and the doses of
701.30 each returned medication.

702.1 Sec. 36. Minnesota Statutes 2018, section 144A.4793, subdivision 6, is amended to read:

702.2 Subd. 6. **Treatment and therapy orders** ~~or prescriptions~~. There must be an up-to-date
702.3 written or electronically recorded order ~~or prescription~~ from an authorized prescriber for
702.4 all treatments and therapies. The order must contain the name of the client, a description of
702.5 the treatment or therapy to be provided, and the frequency, duration, and other information
702.6 needed to administer the treatment or therapy. Treatment and therapy orders must be renewed
702.7 at least every 12 months.

702.8 Sec. 37. Minnesota Statutes 2018, section 144A.4796, subdivision 2, is amended to read:

702.9 Subd. 2. **Content.** (a) The orientation must contain the following topics:

702.10 (1) an overview of sections 144A.43 to 144A.4798;

702.11 (2) introduction and review of all the provider's policies and procedures related to the
702.12 provision of home care services by the individual staff person;

702.13 (3) handling of emergencies and use of emergency services;

702.14 (4) compliance with and reporting of the maltreatment of minors or vulnerable adults
702.15 under sections 626.556 and 626.557;

702.16 (5) home care bill of rights under section 144A.44;

702.17 (6) handling of clients' complaints, reporting of complaints, and where to report
702.18 complaints including information on the Office of Health Facility Complaints and the
702.19 Common Entry Point;

702.20 (7) consumer advocacy services of the Office of Ombudsman for Long-Term Care,
702.21 Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care
702.22 Ombudsman at the Department of Human Services, county managed care advocates, or
702.23 other relevant advocacy services; and

702.24 (8) review of the types of home care services the employee will be providing and the
702.25 provider's scope of licensure.

702.26 (b) In addition to the topics listed in paragraph (a), orientation may also contain training
702.27 on providing services to clients with hearing loss. Any training on hearing loss provided
702.28 under this subdivision must be high quality and research-based, may include online training,
702.29 and must include training on one or more of the following topics:

702.30 (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence,
702.31 and challenges it poses to communication;

703.1 (2) health impacts related to untreated age-related hearing loss, such as increased
703.2 incidence of dementia, falls, hospitalizations, isolation, and depression; or

703.3 (3) information about strategies and technology that may enhance communication and
703.4 involvement, including communication strategies, assistive listening devices, hearing aids,
703.5 visual and tactile alerting devices, communication access in real time, and closed captions.

703.6 Sec. 38. Minnesota Statutes 2018, section 144A.4797, subdivision 3, is amended to read:

703.7 Subd. 3. **Supervision of staff providing delegated nursing or therapy home care**
703.8 **tasks.** (a) Staff who perform delegated nursing or therapy home care tasks must be supervised
703.9 by an appropriate licensed health professional or a registered nurse periodically where the
703.10 services are being provided to verify that the work is being performed competently and to
703.11 identify problems and solutions related to the staff person's ability to perform the tasks.
703.12 Supervision of staff performing medication or treatment administration shall be provided
703.13 by a registered nurse or appropriate licensed health professional and must include observation
703.14 of the staff administering the medication or treatment and the interaction with the client.

703.15 (b) The direct supervision of staff performing delegated tasks must be provided within
703.16 30 days after the date on which the individual begins working for the home care provider
703.17 and first performs delegated tasks for clients and thereafter as needed based on performance.
703.18 This requirement also applies to staff who have not performed delegated tasks for one year
703.19 or longer.

703.20 Sec. 39. Minnesota Statutes 2018, section 144A.4798, is amended to read:

703.21 **144A.4798 EMPLOYEE HEALTH STATUS DISEASE PREVENTION AND**
703.22 **INFECTION CONTROL.**

703.23 Subdivision 1. **Tuberculosis (TB) ~~prevention and infection control.~~** (a) A home care
703.24 provider must establish and maintain a TB prevention and comprehensive tuberculosis
703.25 infection control program based on according to the most current tuberculosis infection
703.26 control guidelines issued by the United States Centers for Disease Control and Prevention
703.27 (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and
703.28 Mortality Weekly Report. Components of a TB prevention and control program include
703.29 screening all staff providing home care services, both paid and unpaid, at the time of hire
703.30 for active TB disease and latent TB infection, and developing and implementing a written
703.31 TB infection control plan. The commissioner shall make the most recent CDC standards
703.32 available to home care providers on the department's website. This program must include
703.33 a tuberculosis infection control plan that covers all paid and unpaid employees, contractors,

704.1 students, and volunteers. The commissioner shall provide technical assistance regarding
 704.2 implementation of the guidelines.

704.3 (b) The home care provider must maintain written evidence of compliance with this
 704.4 subdivision.

704.5 Subd. 2. **Communicable diseases.** A home care provider must follow current ~~federal~~
 704.6 ~~or state guidelines~~ state requirements for prevention, control, and reporting of ~~human~~
 704.7 ~~immunodeficiency virus (HIV), hepatitis B virus (HBV), hepatitis C virus, or other~~
 704.8 communicable diseases as defined in Minnesota Rules, ~~part parts~~ 4605.7040, 4605.7044,
 704.9 4605.7050, 4605.7075, 4605.7080, and 4605.7090.

704.10 Subd. 3. **Infection control program.** A home care provider must establish and maintain
 704.11 an effective infection control program that complies with accepted health care, medical,
 704.12 and nursing standards for infection control.

704.13 Sec. 40. Minnesota Statutes 2018, section 144A.4799, subdivision 1, is amended to read:

704.14 Subdivision 1. **Membership.** The commissioner of health shall appoint eight persons
 704.15 to a home care and assisted living program advisory council consisting of the following:

704.16 (1) three public members as defined in section 214.02 who shall be ~~either~~ persons who
 704.17 are currently receiving home care services ~~or~~, persons who have received home care services
 704.18 within five years of the application date, persons who have family members receiving home
 704.19 care services, or persons who have family members who have received home care services
 704.20 within five years of the application date;

704.21 (2) three Minnesota home care licensees representing basic and comprehensive levels
 704.22 of licensure who may be a managerial official, an administrator, a supervising registered
 704.23 nurse, or an unlicensed personnel performing home care tasks;

704.24 (3) one member representing the Minnesota Board of Nursing; and

704.25 (4) one member representing the Office of Ombudsman for Long-Term Care.

704.26 Sec. 41. Minnesota Statutes 2018, section 144A.4799, subdivision 3, is amended to read:

704.27 Subd. 3. **Duties.** (a) At the commissioner's request, the advisory council shall provide
 704.28 advice regarding regulations of Department of Health licensed home care providers in this
 704.29 chapter, including advice on the following:

704.30 (1) community standards for home care practices;

- 705.1 (2) enforcement of licensing standards and whether certain disciplinary actions are
 705.2 appropriate;
- 705.3 (3) ways of distributing information to licensees and consumers of home care;
- 705.4 (4) training standards;
- 705.5 (5) identifying emerging issues and opportunities in ~~the home care field, including and~~
 705.6 assisted living;
- 705.7 (6) identifying the use of technology in home and telehealth capabilities;
- 705.8 ~~(6)~~ (7) allowable home care licensing modifications and exemptions, including a method
 705.9 for an integrated license with an existing license for rural licensed nursing homes to provide
 705.10 limited home care services in an adjacent independent living apartment building owned by
 705.11 the licensed nursing home; and
- 705.12 ~~(7)~~ (8) recommendations for studies using the data in section 62U.04, subdivision 4,
 705.13 including but not limited to studies concerning costs related to dementia and chronic disease
 705.14 among an elderly population over 60 and additional long-term care costs, as described in
 705.15 section 62U.10, subdivision 6.
- 705.16 (b) The advisory council shall perform other duties as directed by the commissioner.
- 705.17 (c) The advisory council shall annually review the balance of the account in the state
 705.18 government special revenue fund described in section 144A.474, subdivision 11, paragraph
 705.19 (i), and make annual recommendations by January 15 directly to the chairs and ranking
 705.20 minority members of the legislative committees with jurisdiction over health and human
 705.21 services regarding appropriations to the commissioner for the purposes in section 144A.474,
 705.22 subdivision 11, paragraph (i).

705.23 Sec. 42. Minnesota Statutes 2018, section 144A.484, subdivision 1, is amended to read:

705.24 Subdivision 1. **Integrated licensing established.** ~~(a) From January 1, 2014, to June 30,~~
 705.25 ~~2015, the commissioner of health shall enforce the home and community-based services~~
 705.26 ~~standards under chapter 245D for those providers who also have a home care license pursuant~~
 705.27 ~~to this chapter as required under Laws 2013, chapter 108, article 8, section 60, and article~~
 705.28 ~~11, section 31. During this period, the commissioner shall provide technical assistance to~~
 705.29 ~~achieve and maintain compliance with applicable law or rules governing the provision of~~
 705.30 ~~home and community-based services, including complying with the service recipient rights~~
 705.31 ~~notice in subdivision 4, clause (4). If during the survey, the commissioner finds that the~~
 705.32 ~~licensee has failed to achieve compliance with an applicable law or rule under chapter 245D~~

706.1 ~~and this failure does not imminently endanger the health, safety, or rights of the persons~~
706.2 ~~served by the program, the commissioner may issue a licensing survey report with~~
706.3 ~~recommendations for achieving and maintaining compliance.~~

706.4 (b) ~~Beginning July 1, 2015,~~ A home care provider applicant or license holder may apply
706.5 to the commissioner of health for a home and community-based services designation for
706.6 the provision of basic support services identified under section 245D.03, subdivision 1,
706.7 paragraph (b). The designation allows the license holder to provide basic support services
706.8 that would otherwise require licensure under chapter 245D, under the license holder's home
706.9 care license governed by sections 144A.43 to ~~144A.481~~ 144A.4799.

706.10 Sec. 43. Minnesota Statutes 2018, section 145.4235, subdivision 2, is amended to read:

706.11 Subd. 2. **Eligibility for grants.** (a) The commissioner shall award grants to eligible
706.12 applicants under paragraph (c) for the reasonable expenses of alternatives to abortion
706.13 programs to support, encourage, and assist women in carrying their pregnancies to term and
706.14 caring for their babies after birth by providing information on, referral to, and assistance
706.15 with securing necessary services that enable women to carry their pregnancies to term and
706.16 care for their babies after birth. Necessary services must include, but are not limited to:

706.17 (1) medical care;

706.18 (2) nutritional services;

706.19 (3) housing assistance;

706.20 (4) adoption services;

706.21 (5) education and employment assistance, including services that support the continuation
706.22 and completion of high school;

706.23 (6) child care assistance; and

706.24 (7) parenting education and support services.

706.25 An applicant may not provide or assist a woman to obtain adoption services from a provider
706.26 of adoption services that is not licensed.

706.27 (b) In addition to providing information and referral under paragraph (a), an eligible
706.28 program may provide one or more of the necessary services under paragraph (a) that assists
706.29 women in carrying their pregnancies to term. To avoid duplication of efforts, grantees may
706.30 refer to other public or private programs, rather than provide the care directly, if a woman
706.31 meets eligibility criteria for the other programs.

- 707.1 (c) To be eligible for a grant, an agency or organization must:
- 707.2 (1) be a private, nonprofit organization;
- 707.3 (2) demonstrate that the program is conducted under appropriate supervision;
- 707.4 (3) not charge women for services provided under the program;
- 707.5 (4) provide each pregnant woman counseled with accurate information on the
- 707.6 developmental characteristics of babies and of unborn children, including offering the printed
- 707.7 information described in section 145.4243;
- 707.8 (5) ensure that its alternatives-to-abortion program's purpose is to assist and encourage
- 707.9 women in carrying their pregnancies to term and to maximize their potentials thereafter;
- 707.10 (6) ensure that none of the money provided is used to encourage or affirmatively counsel
- 707.11 a woman to have an abortion not necessary to prevent her death, to provide her an abortion,
- 707.12 or to directly refer her to an abortion provider for an abortion. The agency or organization
- 707.13 may provide nondirective counseling; and
- 707.14 (7) have had the alternatives to abortion program in existence for at least one year as of
- 707.15 July 1, 2011; or incorporated an alternative to abortion program that has been in existence
- 707.16 for at least one year as of July 1, 2011.
- 707.17 (d) The provisions, words, phrases, and clauses of paragraph (c) are inseverable from
- 707.18 this subdivision, and if any provision, word, phrase, or clause of paragraph (c) or its
- 707.19 application to any person or circumstance is held invalid, the invalidity applies to all of this
- 707.20 subdivision.
- 707.21 (e) An organization that provides abortions, promotes abortions, or directly refers to an
- 707.22 abortion provider for an abortion is ineligible to receive a grant under this program. An
- 707.23 affiliate of an organization that provides abortions, promotes abortions, or directly refers
- 707.24 to an abortion provider for an abortion is ineligible to receive a grant under this section
- 707.25 unless the organizations are separately incorporated and independent from each other. To
- 707.26 be independent, the organizations may not share any of the following:
- 707.27 (1) the same or a similar name;
- 707.28 (2) medical facilities or nonmedical facilities, including but not limited to, business
- 707.29 offices, treatment rooms, consultation rooms, examination rooms, and waiting rooms;
- 707.30 (3) expenses;
- 707.31 (4) employee wages or salaries; or

708.1 (5) equipment or supplies, including but not limited to, computers, telephone systems,
708.2 telecommunications equipment, and office supplies.

708.3 (f) An organization that receives a grant under this section and that is affiliated with an
708.4 organization that provides abortion services must maintain financial records that demonstrate
708.5 strict compliance with this subdivision and that demonstrate that its independent affiliate
708.6 that provides abortion services receives no direct or indirect economic or marketing benefit
708.7 from the grant under this section.

708.8 (g) An organization that receives a grant under this section must, in its name, signage,
708.9 and printed materials, clearly convey to the public and to pregnant women seeking services
708.10 that the purpose of the organization is to support, encourage, and assist women in carrying
708.11 their pregnancies to term and caring for their babies after birth, and that the organization
708.12 does not provide counseling for abortion services or referrals for abortion services.

708.13 (h) All written materials provided by a grantee must be medically accurate. The
708.14 commissioner shall approve any written information provided by a grantee ~~on the health~~
708.15 ~~risks associated with abortions~~ to ensure that the information is medically accurate. For
708.16 purposes of this subdivision, "medically accurate" means information that is:

708.17 (1) verified or supported by the weight of peer-reviewed medical research conducted in
708.18 compliance with accepted scientific methods;

708.19 (2) recognized as medically sound and objective by:

708.20 (i) leading health care organizations with relevant expertise, such as the American
708.21 Medical Association, the American Congress of Obstetricians and Gynecologists, the
708.22 American Public Health Association, the American Psychological Association, the American
708.23 Academy of Pediatrics, the American College of Physicians, and the American Academy
708.24 of Family Physicians;

708.25 (ii) federal agencies such as the Centers for Disease Control and Prevention, the Food
708.26 and Drug Administration, the National Cancer Institute, and the National Institutes of Health;
708.27 or

708.28 (iii) leading national or international scientific advisory groups such as the Health and
708.29 Medicine Division and the Advisory Committee on Immunization Practices; or

708.30 (3) recommended by or affirmed in the health care practice guidelines of a nationally
708.31 recognized health care accreditation organization.

709.1 Sec. 44. Minnesota Statutes 2018, section 145.4235, subdivision 3, is amended to read:

709.2 Subd. 3. **Privacy protection.** (a) Any program receiving a grant under this section must
709.3 have a privacy policy and procedures in place to ensure that the name, address, telephone
709.4 number, or any other information that might identify any woman seeking the services of
709.5 the program is not made public or shared with any other agency or organization without the
709.6 written consent of the woman. A disclosure of individually identifiable information under
709.7 this subdivision shall be limited to disclosures expressly permitted in the woman's written
709.8 consent. All communications between the program and the woman must remain confidential.
709.9 For purposes of any medical care provided by the program, including, but not limited to,
709.10 pregnancy tests or ultrasonic scanning, the program must adhere to the requirements in
709.11 sections 144.291 to 144.298 that apply to providers before releasing any information relating
709.12 to the medical care provided.

709.13 (b) Notwithstanding paragraph (a), the commissioner has access to any information
709.14 necessary to monitor and review a grantee's program as required under subdivision 4.

709.15 (c) Notwithstanding section 144.292, subdivisions 5 and 6, a program receiving a grant
709.16 under this section must, at the request of a woman who received services from the program:

709.17 (1) if the program holds the woman's health record, make the health record held by the
709.18 program available to the woman for examination and copying at the program site during
709.19 the program's regular business hours, or provide the woman with a copy of the health record.
709.20 The program must provide the woman with the opportunity to copy the woman's health
709.21 record on site, or a copy of the woman's health record, at no cost to the woman, and must
709.22 provide the copy or opportunity to copy promptly but no later than 15 working days after
709.23 her request; or

709.24 (2) if the program does not hold the woman's health record, inform the woman that the
709.25 health record does not exist or cannot be found or that the health record is held by another
709.26 entity. If the program can identify the entity that currently holds the woman's health record,
709.27 the program must provide the woman with the name and contact information of that entity.
709.28 This information must be provided promptly after the woman's request.

709.29 Sec. 45. Minnesota Statutes 2018, section 145.4235, is amended by adding a subdivision
709.30 to read:

709.31 Subd. 3a. **Provision of pregnancy test results.** A program receiving a grant under this
709.32 section that provides or assists in the provision of pregnancy tests shall provide a woman
709.33 who undergoes a pregnancy test with a written statement of the pregnancy test results, at

710.1 no cost to the woman. This written statement must be provided in the language requested
710.2 by the woman and must be provided to the woman immediately after the test results are
710.3 available.

710.4 Sec. 46. Minnesota Statutes 2018, section 145.4235, subdivision 4, is amended to read:

710.5 Subd. 4. **Duties of commissioner.** The commissioner shall make grants under subdivision
710.6 2 beginning no later than July 1, 2006. In awarding grants, the commissioner shall consider
710.7 the program's demonstrated capacity in providing services to assist a pregnant woman in
710.8 carrying her pregnancy to term. The commissioner shall monitor and review the programs
710.9 of each grantee to ensure that the grantee carefully adheres to the purposes and requirements
710.10 of subdivision 2 and shall cease funding a grantee that fails to do so. The commissioner
710.11 shall also establish an evaluation process for grants awarded under this section, shall use
710.12 this evaluation process to evaluate programs receiving grants each grant cycle, and shall
710.13 use the evaluation results to inform grant award decisions for subsequent grant cycles.

710.14 Sec. 47. [145.87] HOME VISITING FOR PREGNANT WOMEN AND FAMILIES
710.15 WITH YOUNG CHILDREN.

710.16 Subdivision 1. Definitions. (a) The definitions in this subdivision apply to this section.

710.17 (b) "Evidence-based home visiting program" means a program that:

710.18 (1) is based on a clear, consistent program or model that is research-based and grounded
710.19 in relevant, empirically based knowledge;

710.20 (2) is linked to program-determined outcomes and is associated with a national
710.21 organization, institution of higher education, or national or state public health institute;

710.22 (3) has comprehensive home visitation standards that ensure high-quality service delivery
710.23 and continuous quality improvement;

710.24 (4) has demonstrated significant, sustained positive outcomes; and

710.25 (5) either (i) has been evaluated using rigorous, randomized controlled research designs
710.26 with the evaluations published in a peer-reviewed journal; or (ii) is based on
710.27 quasi-experimental research using two or more separate, comparable client samples.

710.28 (c) "Evidence-informed home visiting program" means a program that:

710.29 (1) has data or evidence demonstrating the program's effectiveness at achieving positive
710.30 outcomes for pregnant women and young children; and

711.1 (2) either has (i) an active evaluation of the program; or (ii) a plan and timeline for an
711.2 active evaluation of the program to be conducted.

711.3 (d) "Health equity" means every individual has a fair opportunity to attain the individual's
711.4 full health potential, and no individual is prevented from achieving this potential.

711.5 Subd. 2. **Grants for home visiting programs.** The commissioner shall award grants to
711.6 community health boards, nonprofit organizations, and tribal nations to start up or expand
711.7 home visiting programs serving pregnant women and families with young children. Home
711.8 visiting programs supported under this section shall provide home visits by early childhood
711.9 professionals or health professionals, including nurses, social workers, early childhood
711.10 educators, or trained paraprofessionals. Grant funds shall be used:

711.11 (1) to start up or expand evidence-based home visiting programs that address health
711.12 equity, or evidence-informed home visiting programs that address health equity; and

711.13 (2) to serve families with young children or pregnant women who are high risk or have
711.14 high needs. For purposes of this clause, high risk includes but is not limited to a family with
711.15 low income, or a parent or pregnant woman with mental illness or a substance use disorder
711.16 or experiencing domestic abuse.

711.17 Subd. 3. **Grant prioritization.** (a) In awarding grants, the commissioner shall give
711.18 priority to community health boards, nonprofit organizations, and tribal nations seeking to
711.19 expand home visiting services with community or regional partnerships.

711.20 (b) The commissioner shall allocate at least 75 percent of the grant funds awarded each
711.21 grant cycle to evidence-based home visiting programs that address health equity and up to
711.22 25 percent of the grant funds awarded each grant cycle to evidence-informed home visiting
711.23 programs that address health equity.

711.24 Subd. 4. **No supplanting of existing funds.** Funding awarded under this section shall
711.25 only be used to supplement, and not to replace, funds being used for evidence-based home
711.26 visiting programs or evidence-informed home visiting programs.

711.27 Subd. 5. **Administrative costs.** The commissioner may use up to ten percent of the
711.28 annual appropriation under this section to provide training and technical assistance and to
711.29 administer and evaluate the program. The commissioner may contract for training,
711.30 capacity-building support for grantees or potential grantees, technical assistance, and
711.31 evaluation support.

712.1 Sec. 48. **[145.9275] COMMUNITY-BASED OPIOID PREVENTION; PILOT GRANT**
712.2 **PROGRAM.**

712.3 To the extent funds are appropriated for the purposes of this section, the commissioner
712.4 shall establish a grant program to fund community opioid abuse prevention pilot grants to
712.5 reduce emergency room and other health care provider visits resulting from opioid use or
712.6 abuse and to reduce rates of opioid addiction in the community using the following six
712.7 activities:

712.8 (1) establishing multidisciplinary controlled substance care teams that may consist of
712.9 physicians, pharmacists, social workers, nurse care coordinators, and mental health
712.10 professionals;

712.11 (2) delivering health care services and care coordination, through controlled substance
712.12 care teams, to reduce the inappropriate use of opioids by patients and rates of opioid
712.13 addiction;

712.14 (3) addressing any unmet social services needs that create barriers to managing pain
712.15 effectively and obtaining optimal health outcomes;

712.16 (4) providing prescriber and dispenser education and assistance to reduce the inappropriate
712.17 prescribing and dispensing of opioids;

712.18 (5) promoting the adoption of best practices related to opioid disposal and reducing
712.19 opportunities for illegal access to opioids; and

712.20 (6) engaging partners outside of the health care system, including schools, law
712.21 enforcement, and social services, to address root causes of opioid abuse and addiction at
712.22 the community level.

712.23 Sec. 49. **[145.9285] COMMUNITY SOLUTIONS FOR HEALTHY CHILD**
712.24 **DEVELOPMENT GRANT PROGRAM.**

712.25 Subdivision 1. **Establishment.** The commissioner shall establish the community solutions
712.26 for healthy child development grant program. The purposes of the program are to:

712.27 (1) improve child development outcomes as related to the well-being of children of color
712.28 and American Indian children from prenatal to grade 3 and their families, including but not
712.29 limited to the goals outlined by the Department of Human Service's early childhood systems
712.30 reform effort: early learning; health and well-being; economic security; and safe, stable,
712.31 nurturing relationships and environments by funding community-based solutions for
712.32 challenges that are identified by the affected community;

713.1 (2) reduce racial disparities in children's health and development, from prenatal to grade
 713.2 3; and

713.3 (3) promote racial and geographic equity.

713.4 Subd. 2. Commissioner's duties. The commissioner of health shall:

713.5 (1) develop a request for proposals for the healthy child development grant program in
 713.6 consultation with the Community Solutions Advisory Council;

713.7 (2) provide outreach, technical assistance, and program development support to increase
 713.8 capacity for new and existing service providers in order to better meet statewide needs,
 713.9 particularly in greater Minnesota and areas where services to reduce health disparities have
 713.10 not been established;

713.11 (3) review responses to requests for proposals, in consultation with the Community
 713.12 Solutions Advisory Council, and award grants under this section;

713.13 (4) ensure communication with the ethnic councils, Minnesota Indian Affairs Council,
 713.14 and the governor's early learning council on the request for proposal process;

713.15 (5) establish a transparent and objective accountability process, in consultation with the
 713.16 Community Solutions Advisory Council, focused on outcomes that grantees agree to achieve;

713.17 (6) provide grantees with access to data to assist grantees in establishing and
 713.18 implementing effective community-led solutions;

713.19 (7) maintain data on outcomes reported by grantees; and

713.20 (8) contract with an independent third-party entity to evaluate the success of the grant
 713.21 program and to build the evidence base for effective community solutions in reducing health
 713.22 disparities of children of color and American Indian children from prenatal to grade 3.

713.23 Subd. 3. Community Solutions Advisory Council; establishment; duties;

713.24 compensation. (a) No later than October 1, 2019, the commissioner shall convene a
 713.25 12-member Community Solutions Advisory Council as follows:

713.26 (1) two members representing the African Heritage community;

713.27 (2) two members representing the Latino community;

713.28 (3) two members representing the Asian-Pacific Islander community;

713.29 (4) two members representing the American Indian community;

713.30 (5) two parents of children of color or that are American Indian with children under nine
 713.31 years of age;

714.1 (6) one member with research or academic expertise in racial equity and healthy child
 714.2 development; and

714.3 (7) one member representing an organization that advocates on behalf of communities
 714.4 of color or American Indians.

714.5 (b) At least three of the 12 members of the advisory council must come from outside
 714.6 the seven-county metropolitan area.

714.7 (c) The Community Solutions Advisory Council shall:

714.8 (1) advise the commissioner on the development of the request for proposals for
 714.9 community solutions healthy child development grants. In advising the commissioner, the
 714.10 council must consider how to build on the capacity of communities to promote child and
 714.11 family well-being and address social determinants of healthy child development;

714.12 (2) review responses to requests for proposals and advise the commissioner on the
 714.13 selection of grantees and grant awards;

714.14 (3) advise the commissioner on the establishment of a transparent and objective
 714.15 accountability process focused on outcomes the grantees agree to achieve;

714.16 (4) advise the commissioner on ongoing oversight and necessary support in the
 714.17 implementation of the program; and

714.18 (5) support the commissioner on other racial equity and early childhood grant efforts.

714.19 (d) Each advisory council member shall be compensated in accordance with section
 714.20 15.059, subdivision 3.

714.21 Subd. 4. **Eligible grantees.** Organizations eligible to receive grant funding under this
 714.22 section include:

714.23 (1) organizations or entities that work with communities of color and American Indian
 714.24 communities;

714.25 (2) tribal nations and tribal organizations as defined in section 658P of the Child Care
 714.26 and Development Block Grant Act of 1990; and

714.27 (3) organizations or entities focused on supporting healthy child development.

714.28 Subd. 5. **Strategic consideration and priority of proposals; eligible populations;**

714.29 **grant awards.** (a) The commissioner, in consultation with the Community Solutions
 714.30 Advisory Council, shall develop a request for proposals for healthy child development
 714.31 grants. In developing the proposals and awarding the grants, the commissioner shall consider

715.1 building on the capacity of communities to promote child and family well-being and address
715.2 social determinants of healthy child development. Proposals must focus on increasing racial
715.3 equity and healthy child development and reducing health disparities experienced by children
715.4 of color and American Indian children from prenatal to grade 3 and their families.

715.5 (b) In awarding the grants, the commissioner shall provide strategic consideration and
715.6 give priority to proposals from:

715.7 (1) organizations or entities led by people of color and serving communities of color;

715.8 (2) organizations or entities led by American Indians and serving American Indians,
715.9 including tribal nations and tribal organizations;

715.10 (3) organizations or entities with proposals focused on healthy development from prenatal
715.11 to age three;

715.12 (4) organizations or entities with proposals focusing on multigenerational solutions;

715.13 (5) organizations or entities located in or with proposals to serve communities located
715.14 in counties that are moderate to high risk according to the Wilder Research Risk and Reach
715.15 Report; and

715.16 (6) community-based organizations that have historically served communities of color
715.17 and American Indians and have not traditionally had access to state grant funding.

715.18 The advisory council may recommend additional strategic considerations and priorities to
715.19 the commissioner.

715.20 (c) The first round of grants must be awarded no later than April 15, 2020.

715.21 Subd. 6. **Geographic distribution of grants.** The commissioner and the advisory council
715.22 shall ensure that grant funds are prioritized and awarded to organizations and entities that
715.23 are within counties that have a higher proportion of people of color and American Indians
715.24 than the state average, to the extent possible.

715.25 Subd. 7. **Report.** Grantees must report grant program outcomes to the commissioner on
715.26 the forms and according to the timelines established by the commissioner.

715.27 Sec. 50. **[145.987] DOMESTIC VIOLENCE AND SEXUAL ASSAULT**
715.28 **PREVENTION PROGRAM.**

715.29 Subdivision 1. **Program establishment.** The commissioner of health, through the
715.30 Department of Health's injury and violence prevention unit, shall administer the domestic
715.31 violence and sexual assault prevention program as established under this section.

716.1 Subd. 2. Grant criteria. (a) The commissioner shall award grants to nonprofit
716.2 organizations for the purpose of funding programs that incorporate community-driven and
716.3 culturally relevant practices to prevent domestic violence and sexual assault. Grants made
716.4 pursuant to this section may either (1) encourage the development and deployment of new
716.5 prevention efforts, or (2) enhance, sustain, or expand existing prevention efforts.

716.6 (b) The commissioner of health shall award grants to nonprofit organizations supporting
716.7 activities that:

716.8 (1) promote the general development of domestic violence and sexual assault prevention
716.9 programs and activities;

716.10 (2) implement prevention activities through community outreach that address the root
716.11 causes of domestic violence and sexual assault;

716.12 (3) identify risk and protective factors for developing domestic violence and sexual
716.13 assault prevention strategies and outreach activities;

716.14 (4) provide trauma-informed domestic violence and sexual assault prevention services;

716.15 (5) educate youth and adults about healthy relationships and changing social norms;

716.16 (6) develop culturally and linguistically appropriate domestic violence and sexual assault
716.17 prevention programs for historically underserved communities;

716.18 (7) work collaboratively with educational institutions, including school districts, to
716.19 implement domestic violence and sexual assault prevention strategies for students, teachers,
716.20 and administrators; or

716.21 (8) work collaboratively with other nonprofit organizations, for-profit organizations,
716.22 and other community-based organizations to implement domestic violence and sexual assault
716.23 prevention strategies within their communities.

716.24 Subd. 3. Definition. For purposes of this section, "domestic violence and sexual assault"
716.25 includes, but is not limited to, the following:

716.26 (1) intimate partner violence, including emotional, psychological, and economic abuse;

716.27 (2) sex trafficking as defined in section 609.321, subdivision 7a;

716.28 (3) domestic abuse as defined in section 518B.01, subdivision 2;

716.29 (4) any criminal sexual conduct crime in sections 609.342 to 609.3453;

716.30 (5) abusive international marriage;

716.31 (6) forced marriage; and

717.1 (7) female genital mutilation, as defined in section 609.2245, subdivision 1.

717.2 Subd. 4. **Promotion; administration.** The commissioner may spend up to 15 percent
717.3 of the total program funding for each fiscal year to promote and administer the program
717.4 authorized under this section and to provide technical assistance to program grantees.

717.5 Subd. 5. **Nonstate sources.** The commissioner may accept contributions from nonstate
717.6 sources to supplement state appropriations for the program authorized under this section.
717.7 Contributions received under this subdivision are appropriated to the commissioner for
717.8 purposes of this section.

717.9 Subd. 6. **Program evaluation.** (a) The commissioner of health shall report by February
717.10 28 of each even-numbered year to the legislative committees with jurisdiction over health
717.11 detailing the expenditures of funds authorized under this section. The commissioner shall
717.12 use the data to evaluate the effectiveness of the program. The commissioner must include
717.13 in the report:

717.14 (1) the number of organizations receiving grant money under this section;

717.15 (2) the number of individuals served by the grant program;

717.16 (3) a description and analysis of the practices implemented by program grantees; and

717.17 (4) best practices recommendations to prevent domestic violence and sexual assault,
717.18 including best practices recommendations that are culturally relevant to historically
717.19 underserved communities.

717.20 (b) Any organization receiving grant money under this section must collect and make
717.21 available to the commissioner of health aggregate data related to the activity funded by the
717.22 grant program under this section.

717.23 (c) The commissioner of health shall use the information and data from the program
717.24 evaluation under paragraph (a), including best practices and culturally specific responses,
717.25 to inform the administration of existing Department of Health programming and the
717.26 development of Department of Health policies, programs, and procedures.

717.27 Sec. 51. Minnesota Statutes 2018, section 152.22, is amended by adding a subdivision to
717.28 read:

717.29 Subd. 5a. **Hemp.** "Hemp" has the meaning given to industrial hemp in section 18K.02,
717.30 subdivision 3. Hemp is not marijuana as defined in section 152.01, subdivision 9.

718.1 Sec. 52. Minnesota Statutes 2018, section 152.22, is amended by adding a subdivision to
718.2 read:

718.3 Subd. 5b. **Hemp grower.** "Hemp grower" means a person licensed by the commissioner
718.4 of agriculture under chapter 18K to grow hemp for commercial purposes.

718.5 Sec. 53. Minnesota Statutes 2018, section 152.22, subdivision 11, is amended to read:

718.6 Subd. 11. **Registered designated caregiver.** "Registered designated caregiver" means
718.7 a person who:

718.8 (1) is at least ~~24~~ 18 years old;

718.9 (2) does not have a conviction for a disqualifying felony offense;

718.10 (3) has been approved by the commissioner to assist a patient who has been identified
718.11 by a health care practitioner as developmentally or physically disabled and therefore ~~unable~~
718.12 ~~to self-administer medication~~ requires assistance in administering medical cannabis or
718.13 ~~acquire~~ obtaining medical cannabis from a distribution facility due to the disability; and

718.14 (4) is authorized by the commissioner to assist the patient with the use of medical
718.15 cannabis.

718.16 Sec. 54. Minnesota Statutes 2018, section 152.22, subdivision 13, is amended to read:

718.17 Subd. 13. **Registry verification.** "Registry verification" means the verification provided
718.18 by the commissioner that a patient is enrolled in the registry program and that includes the
718.19 patient's name, registry number, ~~and qualifying medical condition~~ and, if applicable, the
718.20 name of the patient's registered designated caregiver or parent ~~or~~ legal guardian, or spouse.

718.21 Sec. 55. Minnesota Statutes 2018, section 152.25, subdivision 1, is amended to read:

718.22 Subdivision 1. **Medical cannabis manufacturer registration.** (a) The commissioner
718.23 shall register two in-state manufacturers for the production of all medical cannabis within
718.24 the state. A registration agreement between the commissioner and a manufacturer is
718.25 nontransferable. The commissioner shall register new manufacturers or reregister the existing
718.26 manufacturers by December 1 every two years, using the factors described in this subdivision.
718.27 The commissioner shall accept applications after December 1, 2014, if one of the
718.28 manufacturers registered before December 1, 2014, ceases to be registered as a manufacturer.
718.29 The commissioner's determination that no manufacturer exists to fulfill the duties under
718.30 sections 152.22 to 152.37 is subject to judicial review in Ramsey County District Court.
718.31 Data submitted during the application process are private data on individuals or nonpublic

719.1 data as defined in section 13.02 until the manufacturer is registered under this section. Data
719.2 on a manufacturer that is registered are public data, unless the data are trade secret or security
719.3 information under section 13.37.

719.4 (b) As a condition for registration, a manufacturer must agree to:

719.5 (1) begin supplying medical cannabis to patients by July 1, 2015; and

719.6 (2) comply with all requirements under sections 152.22 to 152.37.

719.7 (c) The commissioner shall consider the following factors when determining which
719.8 manufacturer to register:

719.9 (1) the technical expertise of the manufacturer in cultivating medical cannabis and
719.10 converting the medical cannabis into an acceptable delivery method under section 152.22,
719.11 subdivision 6;

719.12 (2) the qualifications of the manufacturer's employees;

719.13 (3) the long-term financial stability of the manufacturer;

719.14 (4) the ability to provide appropriate security measures on the premises of the
719.15 manufacturer;

719.16 (5) whether the manufacturer has demonstrated an ability to meet the medical cannabis
719.17 production needs required by sections 152.22 to 152.37; and

719.18 (6) the manufacturer's projection and ongoing assessment of fees on patients with a
719.19 qualifying medical condition.

719.20 (d) If an officer, director, or controlling person of the manufacturer pleads or is found
719.21 guilty of intentionally diverting medical cannabis to a person other than allowed by law
719.22 under section 152.33, subdivision 1, the commissioner may decide not to renew the
719.23 registration of the manufacturer, provided the violation occurred while the person was an
719.24 officer, director, or controlling person of the manufacturer.

719.25 (e) The commissioner shall require each medical cannabis manufacturer to contract with
719.26 an independent laboratory to test medical cannabis produced by the manufacturer. The
719.27 commissioner shall approve the laboratory chosen by each manufacturer and require that
719.28 the laboratory report testing results to the manufacturer in a manner determined by the
719.29 commissioner.

720.1 Sec. 56. Minnesota Statutes 2018, section 152.25, subdivision 1a, is amended to read:

720.2 Subd. 1a. ~~Revocation, or nonrenewal, or denial of consent to transfer of a medical~~
720.3 **cannabis manufacturer registration.** If the commissioner intends to revoke, or not renew,
720.4 ~~or deny consent to transfer~~ a registration issued under this section, the commissioner must
720.5 first notify in writing the manufacturer against whom the action is to be taken and provide
720.6 the manufacturer with an opportunity to request a hearing under the contested case provisions
720.7 of chapter 14. If the manufacturer does not request a hearing by notifying the commissioner
720.8 in writing within 20 days after receipt of the notice of proposed action, the commissioner
720.9 may proceed with the action without a hearing. For revocations, the registration of a
720.10 manufacturer is considered revoked on the date specified in the commissioner's written
720.11 notice of revocation.

720.12 Sec. 57. Minnesota Statutes 2018, section 152.25, subdivision 1c, is amended to read:

720.13 Subd. 1c. **Notice to patients.** Upon the revocation or nonrenewal of a manufacturer's
720.14 registration under subdivision 1a or implementation of an enforcement action under
720.15 subdivision 1b that may affect the ability of a registered patient, registered designated
720.16 caregiver, or a registered patient's parent ~~or~~ legal guardian, or spouse to obtain medical
720.17 cannabis from the manufacturer subject to the enforcement action, the commissioner shall
720.18 notify in writing each registered patient and the patient's registered designated caregiver or
720.19 registered patient's parent ~~or~~ legal guardian, or spouse about the outcome of the proceeding
720.20 and information regarding alternative registered manufacturers. This notice must be provided
720.21 two or more business days prior to the effective date of the revocation, nonrenewal, or other
720.22 enforcement action.

720.23 Sec. 58. Minnesota Statutes 2018, section 152.25, subdivision 4, is amended to read:

720.24 Subd. 4. **Reports.** (a) The commissioner shall provide regular updates to the task force
720.25 on medical cannabis therapeutic research and to the chairs and ranking minority members
720.26 of the legislative committees with jurisdiction over health and human services, public safety,
720.27 judiciary, and civil law regarding: (1) any changes in federal law or regulatory restrictions
720.28 regarding the use of medical cannabis or hemp; and (2) the market demand and supply in
720.29 this state for products made from hemp that can be used for medicinal purposes.

720.30 (b) The commissioner may submit medical research based on the data collected under
720.31 sections 152.22 to 152.37 to any federal agency with regulatory or enforcement authority
720.32 over medical cannabis to demonstrate the effectiveness of medical cannabis for treating a
720.33 qualifying medical condition.

721.1 Sec. 59. Minnesota Statutes 2018, section 152.27, subdivision 2, is amended to read:

721.2 Subd. 2. **Commissioner duties.** (a) The commissioner shall:

721.3 (1) give notice of the program to health care practitioners in the state who are eligible
721.4 to serve as health care practitioners and explain the purposes and requirements of the
721.5 program;

721.6 (2) allow each health care practitioner who meets or agrees to meet the program's
721.7 requirements and who requests to participate, to be included in the registry program to
721.8 collect data for the patient registry;

721.9 (3) provide explanatory information and assistance to each health care practitioner in
721.10 understanding the nature of therapeutic use of medical cannabis within program requirements;

721.11 (4) create and provide a certification to be used by a health care practitioner for the
721.12 practitioner to certify whether a patient has been diagnosed with a qualifying medical
721.13 condition and include in the certification an option for the practitioner to certify whether
721.14 the patient, in the health care practitioner's medical opinion, is developmentally or physically
721.15 disabled and, as a result of that disability, the patient is ~~unable to self-administer medication~~
721.16 requires assistance in administering medical cannabis or ~~acquire~~ obtaining medical cannabis
721.17 from a distribution facility;

721.18 (5) supervise the participation of the health care practitioner in conducting patient
721.19 treatment and health records reporting in a manner that ensures stringent security and
721.20 record-keeping requirements and that prevents the unauthorized release of private data on
721.21 individuals as defined by section 13.02;

721.22 (6) develop safety criteria for patients with a qualifying medical condition as a
721.23 requirement of the patient's participation in the program, to prevent the patient from
721.24 undertaking any task under the influence of medical cannabis that would constitute negligence
721.25 or professional malpractice on the part of the patient; and

721.26 (7) conduct research and studies based on data from health records submitted to the
721.27 registry program and submit reports on intermediate or final research results to the legislature
721.28 and major scientific journals. The commissioner may contract with a third party to complete
721.29 the requirements of this clause. Any reports submitted must comply with section 152.28,
721.30 subdivision 2.

721.31 (b) If the commissioner wishes to add a delivery method under section 152.22, subdivision
721.32 6, or a qualifying medical condition under section 152.22, subdivision 14, the commissioner
721.33 must notify the chairs and ranking minority members of the legislative policy committees

722.1 having jurisdiction over health and public safety of the addition and the reasons for its
722.2 addition, including any written comments received by the commissioner from the public
722.3 and any guidance received from the task force on medical cannabis research, by January
722.4 15 of the year in which the commissioner wishes to make the change. The change shall be
722.5 effective on August 1 of that year, unless the legislature by law provides otherwise.

722.6 Sec. 60. Minnesota Statutes 2018, section 152.27, subdivision 3, is amended to read:

722.7 Subd. 3. **Patient application.** (a) The commissioner shall develop a patient application
722.8 for enrollment into the registry program. The application shall be available to the patient
722.9 and given to health care practitioners in the state who are eligible to serve as health care
722.10 practitioners. The application must include:

722.11 (1) the name, mailing address, and date of birth of the patient;

722.12 (2) the name, mailing address, and telephone number of the patient's health care
722.13 practitioner;

722.14 (3) the name, mailing address, and date of birth of the patient's designated caregiver, if
722.15 any, or the patient's parent ~~or~~ legal guardian, or spouse if the parent ~~or~~ legal guardian, or
722.16 spouse will be acting as a caregiver;

722.17 (4) a copy of the certification from the patient's health care practitioner that is dated
722.18 within 90 days prior to submitting the application which certifies that the patient has been
722.19 diagnosed with a qualifying medical condition and, if applicable, that, in the health care
722.20 practitioner's medical opinion, the patient is developmentally or physically disabled and,
722.21 as a result of that disability, the patient ~~is unable to self-administer medication~~ requires
722.22 assistance in administering medical cannabis or ~~acquire~~ obtaining medical cannabis from
722.23 a distribution facility; and

722.24 (5) all other signed affidavits and enrollment forms required by the commissioner under
722.25 sections 152.22 to 152.37, including, but not limited to, the disclosure form required under
722.26 paragraph (c).

722.27 (b) The commissioner shall require a patient to resubmit a copy of the certification from
722.28 the patient's health care practitioner on a yearly basis and shall require that the recertification
722.29 be dated within 90 days of submission.

722.30 (c) The commissioner shall develop a disclosure form and require, as a condition of
722.31 enrollment, all patients to sign a copy of the disclosure. The disclosure must include:

723.1 (1) a statement that, notwithstanding any law to the contrary, the commissioner, or an
 723.2 employee of any state agency, may not be held civilly or criminally liable for any injury,
 723.3 loss of property, personal injury, or death caused by any act or omission while acting within
 723.4 the scope of office or employment under sections 152.22 to 152.37; and

723.5 (2) the patient's ~~acknowledgement~~ acknowledgment that enrollment in the patient registry
 723.6 program is conditional on the patient's agreement to meet all of the requirements of sections
 723.7 152.22 to 152.37.

723.8 Sec. 61. Minnesota Statutes 2018, section 152.27, subdivision 4, is amended to read:

723.9 Subd. 4. **Registered designated caregiver.** (a) The commissioner shall register a
 723.10 designated caregiver for a patient if the patient's health care practitioner has certified that
 723.11 the patient, in the health care practitioner's medical opinion, is developmentally or physically
 723.12 disabled and, as a result of that disability, the patient ~~is unable to self-administer medication~~
 723.13 ~~or acquire~~ requires assistance in administering medical cannabis or obtaining medical
 723.14 cannabis from a distribution facility and the caregiver has agreed, in writing, to be the
 723.15 patient's designated caregiver. As a condition of registration as a designated caregiver, the
 723.16 commissioner shall require the person to:

723.17 (1) be at least ~~21~~ 18 years of age;

723.18 (2) agree to only possess ~~any~~ the patient's medical cannabis for purposes of assisting the
 723.19 patient; and

723.20 (3) agree that if the application is approved, the person will not be a registered designated
 723.21 caregiver for more than one patient, unless the patients reside in the same residence.

723.22 (b) The commissioner shall conduct a criminal background check on the designated
 723.23 caregiver prior to registration to ensure that the person does not have a conviction for a
 723.24 disqualifying felony offense. Any cost of the background check shall be paid by the person
 723.25 seeking registration as a designated caregiver. A designated caregiver must have the criminal
 723.26 background check renewed every two years.

723.27 (c) Nothing in sections 152.22 to 152.37 shall be construed to prevent a person registered
 723.28 as a designated caregiver from also being enrolled in the registry program as a patient and
 723.29 possessing and using medical cannabis as a patient.

723.30 Sec. 62. Minnesota Statutes 2018, section 152.27, subdivision 5, is amended to read:

723.31 Subd. 5. **Parents ~~or~~, legal guardians, and spouses.** A parent ~~or~~, legal guardian, or
 723.32 spouse of a patient may act as the caregiver to the patient without having to register as a

724.1 designated caregiver. The parent ~~or~~₂ legal guardian, or spouse shall follow all of the
724.2 requirements of parents ~~and~~₂ legal guardians, and spouses listed in sections 152.22 to 152.37.
724.3 Nothing in sections 152.22 to 152.37 limits any legal authority a parent ~~or~~₂ legal guardian,
724.4 or spouse may have for the patient under any other law.

724.5 Sec. 63. Minnesota Statutes 2018, section 152.27, subdivision 6, is amended to read:

724.6 Subd. 6. **Patient enrollment.** (a) After receipt of a patient's application, application fees,
724.7 and signed disclosure, the commissioner shall enroll the patient in the registry program and
724.8 issue the patient and patient's registered designated caregiver or parent ~~or~~₂ legal guardian,
724.9 or spouse, if applicable, a registry verification. The commissioner shall approve or deny a
724.10 patient's application for participation in the registry program within 30 days after the
724.11 commissioner receives the patient's application and application fee. The commissioner may
724.12 approve applications up to 60 days after the receipt of a patient's application and application
724.13 fees until January 1, 2016. A patient's enrollment in the registry program shall only be
724.14 denied if the patient:

724.15 (1) does not have certification from a health care practitioner that the patient has been
724.16 diagnosed with a qualifying medical condition;

724.17 (2) has not signed and returned the disclosure form required under subdivision 3,
724.18 paragraph (c), to the commissioner;

724.19 (3) does not provide the information required;

724.20 (4) has previously been removed from the registry program for violations of section
724.21 152.30 or 152.33; or

724.22 (5) provides false information.

724.23 (b) The commissioner shall give written notice to a patient of the reason for denying
724.24 enrollment in the registry program.

724.25 (c) Denial of enrollment into the registry program is considered a final decision of the
724.26 commissioner and is subject to judicial review under the Administrative Procedure Act
724.27 pursuant to chapter 14.

724.28 (d) A patient's enrollment in the registry program may only be revoked upon the death
724.29 of the patient or if a patient violates a requirement under section 152.30 or 152.33.

724.30 (e) The commissioner shall develop a registry verification to provide to the patient, the
724.31 health care practitioner identified in the patient's application, and to the manufacturer. The
724.32 registry verification shall include:

725.1 (1) the patient's name and date of birth;

725.2 (2) the patient registry number assigned to the patient; and

725.3 ~~(3) the patient's qualifying medical condition as provided by the patient's health care~~
725.4 ~~practitioner in the certification; and~~

725.5 ~~(4)~~ (3) the name and date of birth of the patient's registered designated caregiver, if any,
725.6 or the name of the patient's parent ~~or~~₂ legal guardian, or spouse if the parent ~~or~~₂ legal guardian,
725.7 or spouse will be acting as a caregiver.

725.8 Sec. 64. Minnesota Statutes 2018, section 152.28, subdivision 1, is amended to read:

725.9 Subdivision 1. **Health care practitioner duties.** (a) Prior to a patient's enrollment in
725.10 the registry program, a health care practitioner shall:

725.11 (1) determine, in the health care practitioner's medical judgment, whether a patient suffers
725.12 from a qualifying medical condition, and, if so determined, provide the patient with a
725.13 certification of that diagnosis;

725.14 (2) determine whether a patient is developmentally or physically disabled and, as a result
725.15 of that disability, the patient ~~is unable to self-administer medication or acquire~~ requires
725.16 assistance in administering medical cannabis or obtaining medical cannabis from a
725.17 distribution facility, and, if so determined, include that determination on the patient's
725.18 certification of diagnosis;

725.19 (3) advise patients, registered designated caregivers, and parents ~~or~~₂ legal guardians, or
725.20 spouses who are acting as caregivers of the existence of any nonprofit patient support groups
725.21 or organizations;

725.22 (4) provide explanatory information from the commissioner to patients with qualifying
725.23 medical conditions, including disclosure to all patients about the experimental nature of
725.24 therapeutic use of medical cannabis; the possible risks, benefits, and side effects of the
725.25 proposed treatment; the application and other materials from the commissioner; and provide
725.26 patients with the Tennessee warning as required by section 13.04, subdivision 2; and

725.27 (5) agree to continue treatment of the patient's qualifying medical condition and report
725.28 medical findings to the commissioner.

725.29 (b) Upon notification from the commissioner of the patient's enrollment in the registry
725.30 program, the health care practitioner shall:

725.31 (1) participate in the patient registry reporting system under the guidance and supervision
725.32 of the commissioner;

726.1 (2) report health records of the patient throughout the ongoing treatment of the patient
 726.2 to the commissioner in a manner determined by the commissioner and in accordance with
 726.3 subdivision 2;

726.4 (3) determine, on a yearly basis, if the patient continues to suffer from a qualifying
 726.5 medical condition and, if so, issue the patient a new certification of that diagnosis; and

726.6 (4) otherwise comply with all requirements developed by the commissioner.

726.7 (c) A health care practitioner may conduct a patient assessment to issue a recertification
 726.8 as required under paragraph (b), clause (3), via telemedicine as defined under section
 726.9 62A.671, subdivision 9.

726.10 ~~(e)~~ (d) Nothing in this section requires a health care practitioner to participate in the
 726.11 registry program.

726.12 Sec. 65. Minnesota Statutes 2018, section 152.29, subdivision 1, is amended to read:

726.13 Subdivision 1. **Manufacturer; requirements.** (a) A manufacturer shall operate ~~four~~
 726.14 eight distribution facilities, which may include the manufacturer's single location for
 726.15 cultivation, harvesting, manufacturing, packaging, and processing but is not required to
 726.16 include that location. ~~A manufacturer is required to begin distribution of medical cannabis~~
 726.17 ~~from at least one distribution facility by July 1, 2015. All distribution facilities must be~~
 726.18 ~~operational and begin distribution of medical cannabis by July 1, 2016. The distribution~~
 726.19 ~~facilities shall be located~~ The commissioner shall designate the geographical service areas
 726.20 to be served by each manufacturer based on geographical need throughout the state to
 726.21 improve patient access. ~~A manufacturer shall disclose the proposed locations for the~~
 726.22 ~~distribution facilities to the commissioner during the registration process.~~ A manufacturer
 726.23 shall not have more than two distribution facilities in each geographical service area assigned
 726.24 to the manufacturer by the commissioner. A manufacturer shall operate only one location
 726.25 where all cultivation, harvesting, manufacturing, packaging, and processing shall be
 726.26 conducted. ~~Any~~ This location may be one of the manufacturer's distribution facility sites.
 726.27 The additional distribution facilities may dispense medical cannabis and medical cannabis
 726.28 products but may not contain any medical cannabis in a form other than those forms allowed
 726.29 under section 152.22, subdivision 6, and the manufacturer shall not conduct any cultivation,
 726.30 harvesting, manufacturing, packaging, or processing at ~~an additional~~ the other distribution
 726.31 facility ~~site~~ sites. Any distribution facility operated by the manufacturer is subject to all of
 726.32 the requirements applying to the manufacturer under sections 152.22 to 152.37, including,
 726.33 but not limited to, security and distribution requirements.

727.1 (b) A manufacturer may acquire hemp from a hemp grower. A manufacturer may
 727.2 manufacture or process hemp into an allowable form of medical cannabis under section
 727.3 152.22, subdivision 6. Hemp acquired by a manufacturer under this paragraph is subject to
 727.4 the same quality control program, security and testing requirements, and other requirements
 727.5 that apply to medical cannabis plant material under sections 152.22 to 152.37 and Minnesota
 727.6 Rules, chapter 4770.

727.7 ~~(b)~~ (c) A medical cannabis manufacturer shall contract with a laboratory approved by
 727.8 the commissioner, subject to any additional requirements set by the commissioner, for
 727.9 purposes of testing medical cannabis manufactured by the medical cannabis manufacturer
 727.10 as to content, contamination, and consistency to verify the medical cannabis meets the
 727.11 requirements of section 152.22, subdivision 6. The cost of laboratory testing shall be paid
 727.12 by the manufacturer.

727.13 ~~(c)~~ (d) The operating documents of a manufacturer must include:

727.14 (1) procedures for the oversight of the manufacturer and procedures to ensure accurate
 727.15 record keeping; ~~and~~

727.16 (2) procedures for the implementation of appropriate security measures to deter and
 727.17 prevent the theft of medical cannabis or hemp and unauthorized entrance into areas containing
 727.18 medical cannabis; ~~or hemp~~; and

727.19 (3) procedures for the transportation and delivery of hemp from hemp growers to
 727.20 manufacturers.

727.21 ~~(d)~~ (e) A manufacturer shall implement security requirements, including requirements
 727.22 for the transportation and delivery of hemp from hemp growers to manufacturers, protection
 727.23 of each location by a fully operational security alarm system, facility access controls,
 727.24 perimeter intrusion detection systems, and a personnel identification system.

727.25 ~~(e)~~ (f) A manufacturer shall not share office space with, refer patients to a health care
 727.26 practitioner, or have any financial relationship with a health care practitioner.

727.27 ~~(f)~~ (g) A manufacturer shall not permit any person to consume medical cannabis on the
 727.28 property of the manufacturer.

727.29 ~~(g)~~ (h) A manufacturer is subject to reasonable inspection by the commissioner.

727.30 ~~(h)~~ (i) For purposes of sections 152.22 to 152.37, a medical cannabis manufacturer is
 727.31 not subject to the Board of Pharmacy licensure or regulatory requirements under chapter
 727.32 151.

728.1 ~~(j)~~ (j) A medical cannabis manufacturer may not employ any person who is under 21
728.2 years of age or who has been convicted of a disqualifying felony offense. An employee of
728.3 a medical cannabis manufacturer must submit a completed criminal history records check
728.4 consent form, a full set of classifiable fingerprints, and the required fees for submission to
728.5 the Bureau of Criminal Apprehension before an employee may begin working with the
728.6 manufacturer. The bureau must conduct a Minnesota criminal history records check and
728.7 the superintendent is authorized to exchange the fingerprints with the Federal Bureau of
728.8 Investigation to obtain the applicant's national criminal history record information. The
728.9 bureau shall return the results of the Minnesota and federal criminal history records checks
728.10 to the commissioner.

728.11 ~~(k)~~ (k) A manufacturer may not operate in any location, whether for distribution or
728.12 cultivation, harvesting, manufacturing, packaging, or processing, within 1,000 feet of a
728.13 public or private school existing before the date of the manufacturer's registration with the
728.14 commissioner.

728.15 ~~(l)~~ (l) A manufacturer shall comply with reasonable restrictions set by the commissioner
728.16 relating to signage, marketing, display, and advertising of medical cannabis.

728.17 (m) Before a manufacturer acquires hemp from a hemp grower, the manufacturer must
728.18 verify that the hemp grower has a valid license issued by the commissioner of agriculture
728.19 under chapter 18K.

728.20 Sec. 66. Minnesota Statutes 2018, section 152.29, subdivision 2, is amended to read:

728.21 Subd. 2. **Manufacturer; production.** (a) A manufacturer of medical cannabis shall
728.22 provide a reliable and ongoing supply of all medical cannabis needed for the registry program
728.23 through cultivation by the manufacturer and through the purchase of hemp from hemp
728.24 growers.

728.25 (b) All cultivation, and harvesting performed by the manufacturer, and all manufacturing,
728.26 packaging, and processing of medical cannabis and hemp, must take place in an enclosed,
728.27 locked facility at a physical address provided to the commissioner during the registration
728.28 process.

728.29 (c) A manufacturer must process and prepare any medical cannabis plant material or
728.30 hemp plant material into a form allowable under section 152.22, subdivision 6, prior to
728.31 distribution of any medical cannabis.

729.1 Sec. 67. Minnesota Statutes 2018, section 152.29, subdivision 3, is amended to read:

729.2 Subd. 3. **Manufacturer; distribution.** (a) A manufacturer shall require that employees
729.3 licensed as pharmacists pursuant to chapter 151 be the only employees to give final approval
729.4 for the distribution of medical cannabis to a patient. A manufacturer may transport medical
729.5 cannabis or medical cannabis products that have been cultivated, harvested, manufactured,
729.6 packaged, and processed by that manufacturer to another registered manufacturer for the
729.7 other manufacturer to distribute.

729.8 (b) A manufacturer may ~~dispense~~ distribute medical cannabis products, whether or not
729.9 the products have been manufactured by ~~the~~ that manufacturer, ~~but is not required to dispense~~
729.10 ~~medical cannabis products.~~

729.11 (c) Prior to distribution of any medical cannabis, the manufacturer shall:

729.12 (1) verify that the manufacturer has received the registry verification from the
729.13 commissioner for that individual patient;

729.14 (2) verify that the person requesting the distribution of medical cannabis is the patient,
729.15 the patient's registered designated caregiver, or the patient's parent ~~or~~, legal guardian, or
729.16 spouse listed in the registry verification using the procedures described in section 152.11,
729.17 subdivision 2d;

729.18 (3) assign a tracking number to any medical cannabis distributed from the manufacturer;

729.19 (4) ensure that any employee of the manufacturer licensed as a pharmacist pursuant to
729.20 chapter 151 has consulted with the patient to determine the proper dosage for the individual
729.21 patient after reviewing the ranges of chemical compositions of the medical cannabis and
729.22 the ranges of proper dosages reported by the commissioner. For purposes of this clause, a
729.23 consultation may be conducted remotely using a videoconference, so long as the employee
729.24 providing the consultation is able to confirm the identity of the patient, the consultation
729.25 occurs while the patient is at a distribution facility, and the consultation adheres to patient
729.26 privacy requirements that apply to health care services delivered through telemedicine;

729.27 (5) properly package medical cannabis in compliance with the United States Poison
729.28 Prevention Packing Act regarding child-resistant packaging and exemptions for packaging
729.29 for elderly patients, and label distributed medical cannabis with a list of all active ingredients
729.30 and individually identifying information, including:

729.31 (i) the patient's name and date of birth;

729.32 (ii) the name and date of birth of the patient's registered designated caregiver or, if listed
729.33 on the registry verification, the name of the patient's parent or legal guardian, if applicable;

- 730.1 (iii) the patient's registry identification number;
- 730.2 (iv) the chemical composition of the medical cannabis; and
- 730.3 (v) the dosage; and
- 730.4 (6) ensure that the medical cannabis distributed contains a maximum of a ~~30-day~~ 90-day
- 730.5 supply of the dosage determined for that patient.

730.6 (d) A manufacturer shall require any employee of the manufacturer who is transporting

730.7 medical cannabis or medical cannabis products to a distribution facility or to another

730.8 registered manufacturer to carry identification showing that the person is an employee of

730.9 the manufacturer.

730.10 Sec. 68. Minnesota Statutes 2018, section 152.29, subdivision 3a, is amended to read:

730.11 Subd. 3a. **Transportation of medical cannabis or hemp; staffing.** A medical cannabis

730.12 manufacturer may staff a transport motor vehicle with only one employee if the medical

730.13 cannabis manufacturer is transporting medical cannabis or hemp to either a certified

730.14 laboratory for the purpose of testing or a facility for the purpose of disposal. If the medical

730.15 cannabis manufacturer is transporting medical cannabis or hemp for any other purpose or

730.16 destination, the transport motor vehicle must be staffed with a minimum of two employees

730.17 as required by rules adopted by the commissioner.

730.18 Sec. 69. Minnesota Statutes 2018, section 152.31, is amended to read:

730.19 **152.31 DATA PRACTICES.**

730.20 (a) Government data in patient files maintained by the commissioner and the health care

730.21 practitioner, and data submitted to or by a medical cannabis manufacturer, are private data

730.22 on individuals, as defined in section 13.02, subdivision 12, or nonpublic data, as defined in

730.23 section 13.02, subdivision 9, but may be used for purposes of complying with chapter 13

730.24 and complying with a request from the legislative auditor or the state auditor in the

730.25 performance of official duties. The provisions of section 13.05, subdivision 11, apply to a

730.26 registration agreement entered between the commissioner and a medical cannabis

730.27 manufacturer under section 152.25.

730.28 (b) Not public data maintained by the commissioner may not be used for any purpose

730.29 not provided for in sections 152.22 to 152.37, and may not be combined or linked in any

730.30 manner with any other list, dataset, or database.

731.1 (c) The commissioner may execute data sharing arrangements with the commissioner
731.2 of agriculture to verify licensing, inspection, and compliance information related to hemp
731.3 growers under chapter 18K.

731.4 Sec. 70. Minnesota Statutes 2018, section 152.32, subdivision 2, is amended to read:

731.5 Subd. 2. **Criminal and civil protections.** (a) Subject to section 152.23, the following
731.6 are not violations under this chapter:

731.7 (1) use or possession of medical cannabis or medical cannabis products by a patient
731.8 enrolled in the registry program, or possession by a registered designated caregiver or the
731.9 parent ~~or~~ legal guardian, or spouse of a patient if the parent ~~or~~ legal guardian, or spouse
731.10 is listed on the registry verification;

731.11 (2) possession, dosage determination, or sale of medical cannabis or medical cannabis
731.12 products by a medical cannabis manufacturer, employees of a manufacturer, a laboratory
731.13 conducting testing on medical cannabis, or employees of the laboratory; and

731.14 (3) possession of medical cannabis or medical cannabis products by any person while
731.15 carrying out the duties required under sections 152.22 to 152.37.

731.16 (b) Medical cannabis obtained and distributed pursuant to sections 152.22 to 152.37 and
731.17 associated property is not subject to forfeiture under sections 609.531 to 609.5316.

731.18 (c) The commissioner, the commissioner's staff, the commissioner's agents or contractors,
731.19 and any health care practitioner are not subject to any civil or disciplinary penalties by the
731.20 Board of Medical Practice, the Board of Nursing, or by any business, occupational, or
731.21 professional licensing board or entity, solely for the participation in the registry program
731.22 under sections 152.22 to 152.37. A pharmacist licensed under chapter 151 is not subject to
731.23 any civil or disciplinary penalties by the Board of Pharmacy when acting in accordance
731.24 with the provisions of sections 152.22 to 152.37. Nothing in this section affects a professional
731.25 licensing board from taking action in response to violations of any other section of law.

731.26 (d) Notwithstanding any law to the contrary, the commissioner, the governor of
731.27 Minnesota, or an employee of any state agency may not be held civilly or criminally liable
731.28 for any injury, loss of property, personal injury, or death caused by any act or omission
731.29 while acting within the scope of office or employment under sections 152.22 to 152.37.

731.30 (e) Federal, state, and local law enforcement authorities are prohibited from accessing
731.31 the patient registry under sections 152.22 to 152.37 except when acting pursuant to a valid
731.32 search warrant.

732.1 (f) Notwithstanding any law to the contrary, neither the commissioner nor a public
732.2 employee may release data or information about an individual contained in any report,
732.3 document, or registry created under sections 152.22 to 152.37 or any information obtained
732.4 about a patient participating in the program, except as provided in sections 152.22 to 152.37.

732.5 (g) No information contained in a report, document, or registry or obtained from a patient
732.6 under sections 152.22 to 152.37 may be admitted as evidence in a criminal proceeding
732.7 unless independently obtained or in connection with a proceeding involving a violation of
732.8 sections 152.22 to 152.37.

732.9 (h) Notwithstanding section 13.09, any person who violates paragraph (e) or (f) is guilty
732.10 of a gross misdemeanor.

732.11 (i) An attorney may not be subject to disciplinary action by the Minnesota Supreme
732.12 Court or professional responsibility board for providing legal assistance to prospective or
732.13 registered manufacturers or others related to activity that is no longer subject to criminal
732.14 penalties under state law pursuant to sections 152.22 to 152.37.

732.15 (j) Possession of a registry verification or application for enrollment in the program by
732.16 a person entitled to possess or apply for enrollment in the registry program does not constitute
732.17 probable cause or reasonable suspicion, nor shall it be used to support a search of the person
732.18 or property of the person possessing or applying for the registry verification, or otherwise
732.19 subject the person or property of the person to inspection by any governmental agency.

732.20 Sec. 71. Minnesota Statutes 2018, section 152.33, subdivision 1, is amended to read:

732.21 Subdivision 1. **Intentional diversion; criminal penalty.** In addition to any other
732.22 applicable penalty in law, a manufacturer or an agent of a manufacturer who intentionally
732.23 transfers medical cannabis to a person other than another registered manufacturer, a patient,
732.24 a registered designated caregiver or, if listed on the registry verification, a parent ~~or~~ legal
732.25 guardian, or spouse of a patient is guilty of a felony punishable by imprisonment for not
732.26 more than two years or by payment of a fine of not more than \$3,000, or both. A person
732.27 convicted under this subdivision may not continue to be affiliated with the manufacturer
732.28 and is disqualified from further participation under sections 152.22 to 152.37.

732.29 Sec. 72. Minnesota Statutes 2018, section 152.33, subdivision 2, is amended to read:

732.30 Subd. 2. **Diversion by patient, registered designated caregiver, ~~or parent~~, legal**
732.31 **guardian, or patient's spouse; criminal penalty.** In addition to any other applicable penalty
732.32 in law, a patient, registered designated caregiver or, if listed on the registry verification, a

733.1 parent ~~or~~ legal guardian, or spouse of a patient who intentionally sells or otherwise transfers
 733.2 medical cannabis to a person other than a patient, designated registered caregiver or, if listed
 733.3 on the registry verification, a parent ~~or~~ legal guardian, or spouse of a patient is guilty of a
 733.4 felony punishable by imprisonment for not more than two years or by payment of a fine of
 733.5 not more than \$3,000, or both.

733.6 Sec. 73. Minnesota Statutes 2018, section 152.34, is amended to read:

733.7 **152.34 HEALTH CARE FACILITIES.**

733.8 (a) Health care facilities licensed under chapter 144A, hospice providers licensed under
 733.9 chapter 144A, boarding care homes or supervised living facilities licensed under section
 733.10 144.50, assisted living facilities, ~~and~~ facilities owned, controlled, managed, or under common
 733.11 control with hospitals licensed under chapter 144, and other health facilities licensed by the
 733.12 commissioner of health, may adopt reasonable restrictions on the use of medical cannabis
 733.13 by a patient enrolled in the registry program who resides at or is actively receiving treatment
 733.14 or care at the facility. The restrictions may include a provision that the facility will not store
 733.15 or maintain the patient's supply of medical cannabis, that the facility is not responsible for
 733.16 providing the medical cannabis for patients, and that medical cannabis be used only in a
 733.17 place specified by the facility.

733.18 (b) Any employee or agent of a facility listed in this section or a person licensed under
 733.19 chapter 144E is not subject to violations under this chapter for possession of medical cannabis
 733.20 while carrying out employment duties, including providing or supervising care to a registered
 733.21 patient, or distribution of medical cannabis to a registered patient who resides at or is actively
 733.22 receiving treatment or care at the facility with which the employee or agent is affiliated.
 733.23 Nothing in this section shall require the facilities to adopt such restrictions and no facility
 733.24 shall unreasonably limit a patient's access to or use of medical cannabis to the extent that
 733.25 use is authorized by the patient under sections 152.22 to 152.37.

733.26 Sec. 74. Minnesota Statutes 2018, section 152.36, subdivision 2, is amended to read:

733.27 Subd. 2. **Impact assessment.** The task force shall hold hearings to evaluate the impact
 733.28 of the use of medical cannabis and hemp and Minnesota's activities involving medical
 733.29 cannabis and hemp, including, but not limited to:

- 733.30 (1) program design and implementation;
- 733.31 (2) the impact on the health care provider community;
- 733.32 (3) patient experiences;

- 734.1 (4) the impact on the incidence of substance abuse;
- 734.2 (5) access to and quality of medical cannabis, hemp, and medical cannabis products;
- 734.3 (6) the impact on law enforcement and prosecutions;
- 734.4 (7) public awareness and perception; and
- 734.5 (8) any unintended consequences.

734.6 Sec. 75. Minnesota Statutes 2018, section 171.171, is amended to read:

734.7 **171.171 SUSPENSION; ILLEGAL PURCHASE OF ALCOHOL OR TOBACCO.**

734.8 The commissioner shall suspend for a period of 90 days the license of a person who:

734.9 (1) is under the age of 21 years and is convicted of purchasing or attempting to purchase
 734.10 an alcoholic beverage in violation of section 340A.503 if the person used a license, Minnesota
 734.11 identification card, or any type of false identification to purchase or attempt to purchase the
 734.12 alcoholic beverage;

734.13 (2) is convicted under section 171.22, subdivision 1, clause (2), or 340A.503, subdivision
 734.14 2, clause (3), of lending or knowingly permitting a person under the age of 21 years to use
 734.15 the person's license, Minnesota identification card, or other type of identification to purchase
 734.16 or attempt to purchase an alcoholic beverage; or

734.17 ~~(3) is under the age of 18 years and is found by a court to have committed a petty
 734.18 misdemeanor under section 609.685, subdivision 3, if the person used a license, Minnesota
 734.19 identification card, or any type of false identification to purchase or attempt to purchase the
 734.20 tobacco product; or~~

734.21 ~~(4)~~ (3) is convicted under section 171.22, subdivision 1, clause (2), of lending or
 734.22 knowingly permitting a person under the age of ~~18~~ 21 years to use the person's license,
 734.23 Minnesota identification card, or other type of identification to purchase or attempt to
 734.24 purchase a ~~tobacco product~~ tobacco, a tobacco-related device, an electronic delivery device,
 734.25 as defined in section 609.685, subdivision 1; or a nicotine or lobelia delivery product, as
 734.26 described in section 609.6855, subdivision 1.

734.27 Sec. 76. Minnesota Statutes 2018, section 214.25, subdivision 2, is amended to read:

734.28 Subd. 2. **Commissioner of health data.** (a) All data collected or maintained as part of
 734.29 the commissioner of health's duties under Minnesota Statutes 2018, sections 214.19, 214.23,
 734.30 and 214.24, shall be classified as investigative data under section 13.39, except that inactive

735.1 investigative data shall be classified as private data under section 13.02, subdivision 12, or
 735.2 nonpublic data under section 13.02, subdivision 9, in the case of data not on individuals.

735.3 ~~(b) Notwithstanding section 13.05, subdivision 9, data addressed in this subdivision~~
 735.4 ~~shall not be disclosed except as provided in this subdivision or section 13.04; except that~~
 735.5 ~~the commissioner may disclose to the boards under section 214.23.~~

735.6 ~~(c) The commissioner may disclose data addressed under this subdivision as necessary:~~
 735.7 ~~to identify, establish, implement, and enforce a monitoring plan; to investigate a regulated~~
 735.8 ~~person; to alert persons who may be threatened by illness as evidenced by epidemiologic~~
 735.9 ~~data; to control or prevent the spread of HIV, HBV, or HCV disease; or to diminish an~~
 735.10 ~~imminent threat to the public health.~~

735.11 **EFFECTIVE DATE.** This section is effective on January 1, 2020, and no new cases
 735.12 shall be investigated under this subdivision after June 1, 2019.

735.13 Sec. 77. Minnesota Statutes 2018, section 461.12, subdivision 2, is amended to read:

735.14 Subd. 2. **Administrative penalties for sales and furnishing; licensees.** If a licensee or
 735.15 employee of a licensee sells, gives, or otherwise furnishes tobacco, tobacco-related devices,
 735.16 electronic delivery devices, or nicotine or lobelia delivery products to a person under the
 735.17 age of ~~18~~ 21 years, or violates any other provision of this chapter, the licensee shall be
 735.18 charged an administrative penalty of ~~\$75~~ \$300 for the first violation. An administrative
 735.19 penalty of ~~\$200~~ \$600 must be imposed for a second violation at the same location within
 735.20 ~~24~~ 36 months after the initial violation. For a third or any subsequent violation at the same
 735.21 location within ~~24~~ 36 months after the initial violation, an administrative penalty of ~~\$250~~
 735.22 \$1,000 must be imposed, and the licensee's authority to sell tobacco, tobacco-related devices,
 735.23 electronic delivery devices, or nicotine or lobelia delivery products at that location must be
 735.24 suspended for not less than seven days and may be revoked. No suspension, revocation, or
 735.25 other penalty may take effect until the licensee has received notice, served personally or by
 735.26 mail, of the alleged violation and an opportunity for a hearing before a person authorized
 735.27 by the licensing authority to conduct the hearing. A decision that a violation has occurred
 735.28 must be in writing.

735.29 Sec. 78. Minnesota Statutes 2018, section 461.12, subdivision 3, is amended to read:

735.30 Subd. 3. **Administrative penalty for sales and furnishing; individuals.** An individual
 735.31 who sells, gives, or otherwise furnishes tobacco, tobacco-related devices, electronic delivery
 735.32 devices, or nicotine or lobelia delivery products to a person under the age of ~~18~~ 21 years
 735.33 ~~must~~ may be charged an administrative penalty of \$50. No penalty may be imposed until

736.1 the individual has received notice, served personally or by mail, of the alleged violation
 736.2 and an opportunity for a hearing before a person authorized by the licensing authority to
 736.3 conduct the hearing. A decision that a violation has occurred must be in writing.

736.4 Sec. 79. Minnesota Statutes 2018, section 461.12, subdivision 4, is amended to read:

736.5 Subd. 4. ~~Minors~~ **Alternative penalties for use of false identification; persons under**
 736.6 **age 21.** The licensing authority shall consult with interested persons, as applicable, including
 736.7 but not limited to educators, parents, ~~children~~ guardians, persons under the age of 21 years,
 736.8 and representatives of the court system to develop alternative penalties for ~~minors~~ persons
 736.9 under the age of 21 years who purchase, ~~possess, and consume~~ or attempt to purchase,
 736.10 tobacco, tobacco-related devices, electronic delivery devices, or nicotine or lobelia delivery
 736.11 products using a driver's license, permit, Minnesota identification card, or any other type
 736.12 of false identification to misrepresent the person's age, in violation of section 609.685 or
 736.13 609.6855. The licensing authority and the interested persons shall consider a variety of
 736.14 alternative civil ~~options~~ penalties, including, but not limited to, ~~tobacco-free~~ tobacco-free
 736.15 education; tobacco-cessation programs; notice to schools; and parents, or guardians;
 736.16 community service; and ~~other~~ court diversion programs. Alternative civil penalties developed
 736.17 under this subdivision shall not include fines or monetary penalties.

736.18 Sec. 80. Minnesota Statutes 2018, section 461.12, subdivision 5, is amended to read:

736.19 Subd. 5. **Compliance checks.** (a) A licensing authority shall conduct unannounced
 736.20 compliance checks at least once each calendar year at each location where tobacco,
 736.21 tobacco-related devices, electronic delivery devices, or nicotine or lobelia delivery products
 736.22 are sold to test compliance with sections 609.685 and 609.6855. Compliance checks
 736.23 conducted under this subdivision must involve ~~minors~~ persons ~~over the age of 15~~ at least
 736.24 17 years of age, but under the age of ~~18~~ 21, who, with the prior written consent of a parent
 736.25 or guardian if the person is under the age of 18, attempt to purchase tobacco, tobacco-related
 736.26 devices, electronic delivery devices, or nicotine or lobelia delivery products under the direct
 736.27 supervision of a law enforcement officer or an employee of the licensing authority. The age
 736.28 requirements for persons participating in compliance checks under this subdivision shall
 736.29 not affect the age requirements in federal law for persons participating in federally required
 736.30 compliance checks of these locations.

736.31 (b) By January 15 of each year, a licensing authority must report the following
 736.32 information to the commissioner of human services:

737.1 (1) the total number of current licensees overseen by the licensing authority and the total
 737.2 number of compliance checks performed by the licensing authority in the preceding calendar
 737.3 year as required under paragraph (a); and

737.4 (2) the following information for each violation found in a retail compliance check
 737.5 required under paragraph (a) that was performed by the licensing authority in the preceding
 737.6 calendar year:

737.7 (i) the name of the licensing authority;

737.8 (ii) the date of the compliance check at which the violations were found;

737.9 (iii) the name and physical address of the licensee; and

737.10 (iv) the number of violations of sections 609.685 and 609.6855 by that licensee in the
 737.11 past 36 months.

737.12 The licensing authority may also report to the commissioner, a list of the products purchased
 737.13 during the compliance check and the penalty assessed on the licensee by the licensing
 737.14 authority. The commissioner shall compile all reports received from licensing authorities,
 737.15 make publicly available the information reported to the commissioner under this paragraph
 737.16 for the most recent five-year period, make publicly available the most recent list of licensees
 737.17 provided to the commissioner under subdivision 8, paragraph (b), and update the publicly
 737.18 available information at least annually.

737.19 Sec. 81. Minnesota Statutes 2018, section 461.12, subdivision 6, is amended to read:

737.20 Subd. 6. **Defense.** It is an affirmative defense to the charge of selling tobacco,
 737.21 tobacco-related devices, electronic delivery devices, or nicotine or lobelia delivery products
 737.22 to a person under the age of ~~18~~ 21 years in violation of subdivision 2 or 3 that the licensee
 737.23 or individual making the sale relied in good faith upon proof of age as described in section
 737.24 340A.503, subdivision 6.

737.25 Sec. 82. Minnesota Statutes 2018, section 461.12, subdivision 8, is amended to read:

737.26 Subd. 8. **Notice to commissioner; information shared with commissioner of human**
 737.27 **services.** (a) The licensing authority under this section shall, within 30 days of the issuance
 737.28 of a license, inform the commissioner of revenue of the licensee's name, address, trade
 737.29 name, and the effective and expiration dates of the license. The commissioner of revenue
 737.30 must also be informed of a license renewal, transfer, cancellation, suspension, or revocation
 737.31 during the license period.

738.1 (b) The commissioner of revenue shall, by January 15 of each year, provide the
 738.2 commissioner of human services with a list of current licensees and shall provide the
 738.3 following information for each licensee: name, address, trade name, and effective date and
 738.4 expiration date of the license.

738.5 Sec. 83. Minnesota Statutes 2018, section 461.18, is amended to read:

738.6 **461.18 BAN ON SELF-SERVICE SALE OF PACKS SALES; EXCEPTIONS.**

738.7 Subdivision 1. **Except in adult-only facilities for persons 21 years of age and older.** (a)
 738.8 No person shall offer for sale tobacco or tobacco-related devices, or electronic delivery
 738.9 devices as defined in section 609.685, subdivision 1, or nicotine or lobelia delivery products
 738.10 as described in section 609.6855, in open displays which are accessible to the public without
 738.11 the intervention of a store employee.

738.12 (b) [~~Expired August 28, 1997~~]

738.13 (c) [~~Expired~~]

738.14 (d) (b) This subdivision shall not apply to retail stores ~~which~~ that have an entrance door
 738.15 opening directly to the outside and that derive at least 90 percent of their gross revenue from
 738.16 the sale of tobacco and, tobacco-related devices, and electronic delivery devices as defined
 738.17 in section 609.685, subdivision 1, and where the retailer ensures that no person younger
 738.18 than 18 years of age under the age of 21 years is present, or permitted to enter, at any time.

738.19 Subd. 2. **Vending machine sales prohibited.** No person shall sell tobacco products,
 738.20 electronic delivery devices, or nicotine or lobelia delivery products from vending machines.
 738.21 This subdivision does not apply to vending machines in facilities that cannot be entered at
 738.22 any time by persons ~~younger than 18~~ under the age of 21 years of age.

738.23 Subd. 3. **Federal regulations for cartons, multipacks.** Code of Federal Regulations,
 738.24 title 21, part ~~897.16(e)~~ 1140.16(c), as amended from time to time, is incorporated by reference
 738.25 with respect to cartons and other multipack units.

738.26 Sec. 84. **[461.22] AGE VERIFICATION AND SIGNAGE REQUIRED.**

738.27 Subdivision 1. **Signage.** At each location where tobacco, tobacco-related devices,
 738.28 electronic delivery devices, or nicotine or lobelia delivery products are sold, the licensee
 738.29 shall display a sign in plain view to provide public notice that selling any of these products
 738.30 to any person under the age of 21 is illegal and subject to penalties. The notice shall be
 738.31 placed in a conspicuous location in the licensed establishment and shall be readily visible
 738.32 to any person who is purchasing or attempting to purchase these products. The sign shall

739.1 provide notice that all persons responsible for selling these products must verify, by means
 739.2 of photographic identification containing the bearer's date of birth, the age of any person
 739.3 under 30 years of age.

739.4 Subd. 2. **Age verification.** At each location where tobacco, tobacco-related devices,
 739.5 electronic delivery devices, or nicotine or lobelia delivery products are sold, the licensee
 739.6 shall verify, by means of government-issued photographic identification containing the
 739.7 bearer's date of birth, that the purchaser or person attempting to make the purchase is at
 739.8 least 21 years of age. Verification is not required if the purchaser or person attempting to
 739.9 make the purchase is 30 years of age or older. It shall not constitute a defense to a violation
 739.10 of this subdivision that the person appeared to be 30 years of age or older.

739.11 Sec. 85. Minnesota Statutes 2018, section 609.685, is amended to read:

739.12 **609.685 SALE OF TOBACCO TO ~~CHILDREN~~ PERSONS UNDER AGE 21.**

739.13 Subdivision 1. **Definitions.** For the purposes of this section, the following terms shall
 739.14 have the meanings respectively ascribed to them in this section.

739.15 (a) "Tobacco" means cigarettes and any product containing, made, or derived from
 739.16 tobacco that is intended for human consumption, whether chewed, smoked, absorbed,
 739.17 dissolved, inhaled, snorted, sniffed, or ingested by any other means, or any component,
 739.18 part, or accessory of a tobacco product including but not limited to cigars; cheroots; stogies;
 739.19 perique; granulated, plug cut, crimp cut, ready rubbed, and other smoking tobacco; snuff;
 739.20 snuff flour; cavendish; plug and twist tobacco; fine cut and other chewing tobaccos; shorts;
 739.21 refuse scraps, clippings, cuttings and sweepings of tobacco; and other kinds and forms of
 739.22 tobacco. Tobacco excludes any ~~tobacco product that has been approved by the United States~~
 739.23 ~~Food and Drug Administration for sale as a tobacco-cessation product, as a~~
 739.24 ~~tobacco-dependence product, or for other medical purposes, and is being marketed and sold~~
 739.25 ~~solely for such an approved purpose.~~ drugs, devices, or combination products, as those terms
 739.26 are defined in the Federal Food, Drug, and Cosmetic Act, that are authorized for sale by the
 739.27 United States Food and Drug Administration.

739.28 (b) "Tobacco-related devices" means cigarette papers or pipes for smoking or other
 739.29 devices intentionally designed or intended to be used in a manner which enables the chewing,
 739.30 sniffing, smoking, or inhalation of ~~vapers~~ aerosol or vapor of tobacco or tobacco products.
 739.31 Tobacco-related devices include components of tobacco-related devices which may be
 739.32 marketed or sold separately.

740.1 (c) "Electronic delivery device" means any product containing or delivering nicotine,
 740.2 lobelia, or any other substance, whether natural or synthetic, intended for human consumption
 740.3 ~~that can be used by a person to simulate smoking in the delivery of nicotine or any other~~
 740.4 ~~substance~~ through inhalation of aerosol or vapor from the product. Electronic delivery
 740.5 devices includes but is not limited to devices manufactured, marketed, or sold as electronic
 740.6 cigarettes, electronic cigars, electronic pipe, vape pens, modes, tank systems, or under any
 740.7 other product name or descriptor. Electronic delivery device includes any component part
 740.8 of a product, whether or not marketed or sold separately. Electronic delivery device ~~does~~
 740.9 ~~not include any product that has been approved or certified by the United States Food and~~
 740.10 ~~Drug Administration for sale as a tobacco-cessation product, as a tobacco-dependence~~
 740.11 ~~product, or for other medical purposes, and is marketed and sold for such an approved~~
 740.12 ~~purpose.~~ excludes drugs, devices, or combination products, as those terms are defined in
 740.13 the Federal Food, Drug, and Cosmetic Act, that are authorized for sale by the United States
 740.14 Food and Drug Administration.

740.15 Subd. 1a. **Penalty to sell or furnish.** (a) ~~Whoever~~ Any person 21 years of age or older
 740.16 who sells, gives, or otherwise furnishes tobacco, tobacco-related devices, or electronic
 740.17 delivery devices to a person under the age of ~~18~~ 21 years is guilty of a petty misdemeanor
 740.18 for the first violation. Whoever violates this subdivision a subsequent time within five years
 740.19 of a previous conviction under this subdivision is guilty of a ~~gross~~ misdemeanor.

740.20 (b) It is an affirmative defense to a charge under this subdivision if the defendant proves
 740.21 by a preponderance of the evidence that the defendant reasonably and in good faith relied
 740.22 on proof of age as described in section 340A.503, subdivision 6.

740.23 Subd. 2. ~~Other offenses~~ **Use of false identification.** (a) ~~Whoever furnishes tobacco,~~
 740.24 ~~tobacco-related devices, or electronic delivery devices to a person under the age of 18 years~~
 740.25 ~~is guilty of a misdemeanor for the first violation. Whoever violates this paragraph a~~
 740.26 ~~subsequent time is guilty of a gross misdemeanor.~~

740.27 ~~(b)~~ A person under the age of ~~18~~ 21 years who purchases or attempts to purchase tobacco,
 740.28 tobacco-related devices, or electronic delivery devices and who uses a driver's license,
 740.29 permit, Minnesota identification card, or any type of false identification to misrepresent the
 740.30 person's age, ~~is guilty of a misdemeanor~~ shall only be subject to an alternative civil penalty,
 740.31 in accordance with subdivision 2a.

740.32 Subd. 2a. **Alternative penalties.** Law enforcement and court system representatives
 740.33 shall consult, as applicable, with interested persons, including but not limited to parents,
 740.34 guardians, educators, and persons under the age of 21 years, to develop alternative civil

741.1 penalties for persons under the age of 21 years who violate this section. Consulting
 741.2 participants shall consider a variety of alternative civil penalties including but not limited
 741.3 to tobacco-free education programs, community service, court diversion programs, and
 741.4 tobacco cessation programs, and for persons under the age of 18 years, notice to schools
 741.5 and to parents or guardians. Alternative civil penalties developed under this subdivision
 741.6 shall not include fines or monetary penalties.

741.7 ~~Subd. 3. **Petty misdemeanor.** Except as otherwise provided in subdivision 2, whoever~~
 741.8 ~~possesses, smokes, chews, or otherwise ingests, purchases, or attempts to purchase tobacco,~~
 741.9 ~~tobacco-related devices, or electronic delivery devices and is under the age of 18 years is~~
 741.10 ~~guilty of a petty misdemeanor.~~

741.11 Subd. 4. **Effect on local ordinances.** Nothing in subdivisions 1 to ~~3~~ 2a shall supersede
 741.12 or preclude the continuation or adoption of any local ordinance which provides for more
 741.13 stringent regulation of the subject matter in subdivisions 1 to ~~3~~ 2a.

741.14 Subd. 5. **Exceptions.** (a) Notwithstanding subdivision ~~2~~ 1a, an Indian may furnish
 741.15 tobacco to an Indian under the age of ~~18~~ 21 years if the tobacco is furnished as part of a
 741.16 traditional Indian spiritual or cultural ceremony. For purposes of this paragraph, an Indian
 741.17 is a person who is a member of an Indian tribe as defined in section 260.755, subdivision
 741.18 12.

741.19 (b) The penalties in this section do not apply to a person under the age of ~~18~~ 21 years
 741.20 who purchases or attempts to purchase tobacco, tobacco-related devices, or electronic
 741.21 delivery devices while under the direct supervision of a responsible adult for training,
 741.22 education, research, or enforcement purposes.

741.23 Subd. 6. **Seizure of false identification.** A ~~retailer~~ licensee may seize a form of
 741.24 identification listed in section 340A.503, subdivision 6, if the ~~retailer~~ licensee has reasonable
 741.25 grounds to believe that the form of identification has been altered or falsified or is being
 741.26 used to violate any law. A ~~retailer~~ licensee that seizes a form of identification as authorized
 741.27 under this subdivision shall deliver it to a law enforcement agency within 24 hours of seizing
 741.28 it.

741.29 Sec. 86. Minnesota Statutes 2018, section 609.6855, is amended to read:

741.30 **609.6855 SALE OF NICOTINE DELIVERY PRODUCTS TO CHILDREN**
 741.31 **PERSONS UNDER AGE 21.**

741.32 Subdivision 1. **Penalty to sell or furnish.** (a) ~~Whoever~~ Any person 21 years of age or
 741.33 older who sells, gives, or otherwise furnishes to a person under the age of ~~18~~ 21 years a

742.1 product containing or delivering nicotine or lobelia, whether natural or synthetic, intended
 742.2 for human consumption, or any part of such a product, that is not tobacco or an electronic
 742.3 delivery device as defined by section 609.685, is guilty of a petty misdemeanor for the first
 742.4 violation. Whoever violates this subdivision a subsequent time within five years of a previous
 742.5 conviction under this subdivision is guilty of a ~~gross~~ misdemeanor.

742.6 (b) It is an affirmative defense to a charge under this subdivision if the defendant proves
 742.7 by a preponderance of the evidence that the defendant reasonably and in good faith relied
 742.8 on proof of age as described in section 340A.503, subdivision 6.

742.9 (c) Notwithstanding paragraph (a), a product containing or delivering nicotine or lobelia
 742.10 intended for human consumption, whether natural or synthetic, or any part of such a product,
 742.11 that is not tobacco or an electronic delivery device as defined by section 609.685, may be
 742.12 sold to persons under the age of ~~18~~ 21 if the product ~~has been approved or otherwise certified~~
 742.13 ~~for legal sale by the United States Food and Drug Administration for tobacco use cessation,~~
 742.14 ~~harm reduction, or for other medical purposes, and is being marketed and sold solely for~~
 742.15 ~~that approved purpose~~ is a drug, device, or combination product, as those terms are defined
 742.16 in the Federal Food, Drug, and Cosmetic Act, that are authorized for sale by the United
 742.17 States Food and Drug Administration.

742.18 Subd. 2. ~~Other offense~~ Use of false identification. A person under the age of ~~18~~ 21
 742.19 years who purchases or attempts to purchase a product containing or delivering nicotine or
 742.20 lobelia intended for human consumption, or any part of such a product, that is not tobacco
 742.21 or an electronic delivery device as defined by section 609.685, and who uses a driver's
 742.22 license, permit, Minnesota identification card, or any type of false identification to
 742.23 misrepresent the person's age, ~~is guilty of a misdemeanor~~ shall only be subject to an
 742.24 alternative civil penalty in accordance with subdivision 3. No penalty shall apply to a person
 742.25 under the age of 21 years who purchases or attempts to purchase these products while under
 742.26 the direct supervision of a responsible adult for training, education, research, or enforcement
 742.27 purposes.

742.28 Subd. 3. ~~Petty misdemeanor~~ Alternative penalties. ~~Except as otherwise provided in~~
 742.29 ~~subdivisions 1 and 2, whoever is under the age of 18 years and possesses, purchases, or~~
 742.30 ~~attempts to purchase a product containing or delivering nicotine or lobelia intended for~~
 742.31 ~~human consumption, or any part of such a product, that is not tobacco or an electronic~~
 742.32 ~~delivery device as defined by section 609.685, is guilty of a petty misdemeanor.~~ Law
 742.33 enforcement and court system representatives shall consult, as applicable, with interested
 742.34 persons, including but not limited to parents, guardians, educators, and persons under the
 742.35 age of 21 years, to develop alternative civil penalties for persons under the age of 21 years

743.1 who violate this section. Consulting participants shall consider a variety of alternative civil
743.2 penalties including but not limited to tobacco-free education programs, community service,
743.3 court diversion programs, and tobacco cessation programs, and for persons under the age
743.4 of 18 years, notice to schools and to parents or guardians. Alternative civil penalties
743.5 developed under this subdivision shall not include fines or monetary penalties.

743.6 Sec. 87. **REVISOR INSTRUCTION.**

743.7 The revisor of statutes shall correct any internal cross-references to sections 214.17 to
743.8 214.25 that occur as a result of the repealed language and may make changes necessary to
743.9 correct punctuation, grammar, or structure of the remaining text and preserve its meaning.

743.10 Sec. 88. **REPEALER.**

743.11 (a) Minnesota Statutes 2018, sections 144A.45, subdivision 6; and 144A.481, are repealed.

743.12 (b) Minnesota Statutes 2018, sections 214.17; 214.18; 214.19; 214.20; 214.21; 214.22;
743.13 214.23; and 214.24, are repealed on January 1, 2020, and no new cases shall be investigated
743.14 under these sections after June 1, 2019.

743.15 **ARTICLE 13**

743.16 **HEALTH COVERAGE**

743.17 Section 1. Minnesota Statutes 2018, section 62A.021, is amended by adding a subdivision
743.18 to read:

743.19 Subd. 1a. **Loss ratio standards.** (a) Health plans issued on the individual market must
743.20 return to enrollees in the form of aggregate benefits not including anticipated refunds or
743.21 credits, at least 80 percent of the aggregate amount of premiums earned; calculated on the
743.22 basis of incurred claims experience or incurred health care expenses where coverage is
743.23 provided by a health maintenance organization on a service rather than reimbursement basis
743.24 and earned premiums for the period and according to accepted actuarial principles and
743.25 practices.

743.26 (b) Health plans issued on the small employer market, as defined in section 62L.02,
743.27 subdivision 27, must return to enrollees in the form of aggregate benefits not including
743.28 anticipated refunds or credits, at least 80 percent of the aggregate amount of premiums
743.29 earned; calculated on the basis of incurred claims experience or incurred health care expenses
743.30 where coverage is provided by a health maintenance organization on a service rather than

744.1 reimbursement basis and earned premiums for the period and according to accepted actuarial
744.2 principles and practices.

744.3 (c) Health plans issued to large groups, meaning groups with 51 or more covered persons,
744.4 must return to enrollees in the form of aggregate benefits not including anticipated refunds
744.5 or credits, at least 85 percent of the aggregate amount of premiums earned; calculated on
744.6 the basis of incurred claims experience or incurred health care expenses where coverage is
744.7 provided by a health maintenance organization on a service rather than reimbursement basis
744.8 and earned premiums for the period and according to accepted actuarial principles and
744.9 practices.

744.10 (d) A health carrier must submit to the commissioner a report, in a form and manner
744.11 determined by the commissioner, evidencing compliance with this section. Information in
744.12 the report must be aggregated and separated by individual, small employer, and large group
744.13 market. The form must be submitted to the commissioner by June 1 of the year following
744.14 the last calendar year during which the health carrier offered individual, small employer,
744.15 or large group health plans.

744.16 (e) The commissioner shall review reports for actuarial reasonableness, soundness, and
744.17 compliance with this section. If the report does not meet these requirements, the
744.18 commissioner shall notify the health carrier in writing of the deficiency. The health carrier
744.19 shall have 30 days from the date of the commissioner's notice to file an amended report that
744.20 complies with this section. If the health carrier fails to file an amended report, the
744.21 commissioner shall order the health carrier to issue a rebate calculated pursuant to subdivision
744.22 2a.

744.23 (f) A health plan that does not comply with the loss ratio requirements of this section is
744.24 an unfair or deceptive act or practice in the business of insurance and is subject to the
744.25 penalties in sections 72A.17 to 72A.32.

744.26 (g) The commissioners of commerce and health shall each annually issue a public report
744.27 listing, by health carrier, the actual loss ratios experienced in the individual, small employer,
744.28 and large group markets in this state by the health carriers that the commissioners respectively
744.29 regulate. The commissioners shall coordinate release of these reports so as to release them
744.30 as a joint report or as separate reports issued the same day. The report or reports shall be
744.31 released no later than June 1 for loss ratios experienced for the preceding calendar year.
744.32 Health carriers shall provide to the commissioners any information requested by the
744.33 commissioners for purposes of this paragraph.

744.34 **EFFECTIVE DATE.** This section is effective the day following final enactment.

745.1 Sec. 2. Minnesota Statutes 2018, section 62A.021, is amended by adding a subdivision to
745.2 read:

745.3 Subd. 2a. **Rebate.** (a) A health carrier must issue a rebate to each enrollee if the health
745.4 carrier's loss ratio does not meet or exceed the minimum required by subdivision 1a.

745.5 (b) The rebate must be in the amount of the aggregate amount of premiums earned,
745.6 multiplied by the difference between the loss ratio the health carrier had for the prior calendar
745.7 year and the loss ratio required under subdivision 1a.

745.8 (c) A health carrier must issue the rebate under paragraph (b) by August 1 of the year
745.9 following the prior calendar year during which individual, small employee, or large group
745.10 health plans were offered.

745.11 (d) The rebate must be paid in the form of a lump-sum check or lump-sum reimbursement
745.12 to persons who are no longer enrolled in the health plan. The rebate may be paid either as
745.13 a lump-sum check, a lump-sum reimbursement, or a direct deduction to the current plan
745.14 year's premiums for current enrollees.

745.15 **EFFECTIVE DATE.** This section is effective the day following final enactment.

745.16 Sec. 3. Minnesota Statutes 2018, section 62A.021, is amended by adding a subdivision to
745.17 read:

745.18 Subd. 3a. **Minnesota premium security plan and loss ratio calculations.** A health
745.19 carrier, when demonstrating compliance with the requirements of this section, shall subtract
745.20 from incurred claims or incurred health expenses all reinsurance payments applied for or
745.21 received under section 62E.23. The commissioner, in reviewing this information, shall
745.22 verify that health carriers have complied with the requirements of this subdivision.

745.23 **EFFECTIVE DATE.** This section is effective the day following final enactment.

745.24 Sec. 4. Minnesota Statutes 2018, section 62A.25, subdivision 2, is amended to read:

745.25 **Subd. 2. Required coverage.** (a) Every policy, plan, certificate or contract to which this
745.26 section applies shall provide benefits for reconstructive surgery when such service is
745.27 incidental to or follows surgery resulting from injury, sickness or other diseases of the
745.28 involved part or when such service is performed on a covered dependent child because of
745.29 congenital disease or anomaly which has resulted in a functional defect as determined by
745.30 the attending physician.

746.1 (b) The coverage limitations on reconstructive surgery in paragraph (a) do not apply to
746.2 reconstructive breast surgery: (1) following mastectomies; or (2) if the patient has been
746.3 diagnosed with ectodermal dysplasia and has congenitally absent breast tissue or nipples.
746.4 ~~In these cases, Coverage for reconstructive surgery must be provided if the mastectomy is~~
746.5 ~~medically necessary as determined by the attending physician.~~

746.6 (c) Reconstructive surgery benefits include all stages of reconstruction ~~of the breast on~~
746.7 ~~which the mastectomy has been performed,~~ including surgery and reconstruction of the
746.8 other breast to produce a symmetrical appearance, and prosthesis and physical complications
746.9 at all stages ~~of a mastectomy,~~ including lymphedemas, in a manner determined in consultation
746.10 with the attending physician and patient. Coverage may be subject to annual deductible,
746.11 co-payment, and coinsurance provisions as may be deemed appropriate and as are consistent
746.12 with those established for other benefits under the plan or coverage. Coverage may not:

746.13 (1) deny to a patient eligibility, or continued eligibility, to enroll or to renew coverage
746.14 under the terms of the plan, solely for the purpose of avoiding the requirements of this
746.15 section; and

746.16 (2) penalize or otherwise reduce or limit the reimbursement of an attending provider, or
746.17 provide monetary or other incentives to an attending provider to induce the provider to
746.18 provide care to an individual participant or beneficiary in a manner inconsistent with this
746.19 section.

746.20 Written notice of the availability of the coverage must be delivered to the participant upon
746.21 enrollment and annually thereafter.

746.22 **EFFECTIVE DATE.** This section is effective January 1, 2020, and applies to health
746.23 plans offered, issued, or sold on or after that date.

746.24 Sec. 5. Minnesota Statutes 2018, section 62A.28, subdivision 2, is amended to read:

746.25 Subd. 2. **Required coverage.** Every policy, plan, certificate, or contract referred to in
746.26 subdivision 1 ~~issued or renewed after August 1, 1987,~~ must provide coverage for scalp hair
746.27 prostheses worn for hair loss suffered as a result of alopecia areata or ectodermal dysplasias.

746.28 The coverage required by this section is subject to the co-payment, coinsurance,
746.29 deductible, and other enrollee cost-sharing requirements that apply to similar types of items
746.30 under the policy, plan, certificate, or contract and may be limited to one prosthesis per
746.31 benefit year.

746.32 **EFFECTIVE DATE.** This section is effective January 1, 2020, and applies to health
746.33 plans offered, issued, or sold on or after that date.

747.1 Sec. 6. Minnesota Statutes 2018, section 62A.30, is amended by adding a subdivision to
747.2 read:

747.3 Subd. 4. **Mammograms.** (a) For purposes of subdivision 2, coverage for a preventive
747.4 mammogram screening (1) includes digital breast tomosynthesis for enrollees at risk for
747.5 breast cancer, and (2) is covered as a preventive item or service, as described under section
747.6 62Q.46.

747.7 (b) For purposes of this subdivision, "digital breast tomosynthesis" means a radiologic
747.8 procedure that involves the acquisition of projection images over the stationary breast to
747.9 produce cross-sectional digital three-dimensional images of the breast. "At risk for breast
747.10 cancer" means:

747.11 (1) having a family history with one or more first- or second-degree relatives with breast
747.12 cancer;

747.13 (2) testing positive for BRCA1 or BRCA2 mutations;

747.14 (3) having heterogeneously dense breasts or extremely dense breasts based on the Breast
747.15 Imaging Reporting and Data System established by the American College of Radiology; or

747.16 (4) having a previous diagnosis of breast cancer.

747.17 (c) This subdivision does not apply to coverage provided through a public health care
747.18 program under chapter 256B or 256L.

747.19 (d) Nothing in this subdivision limits the coverage of digital breast tomosynthesis in a
747.20 policy, plan, certificate, or contract referred to in subdivision 1 that is in effect prior to
747.21 January 1, 2020.

747.22 (e) Nothing in this subdivision prohibits a policy, plan, certificate, or contract referred
747.23 to in subdivision 1 from covering digital breast tomosynthesis for an enrollee who is not at
747.24 risk for breast cancer.

747.25 **EFFECTIVE DATE.** This section is effective January 1, 2020, and applies to health
747.26 plans issued, sold, or renewed on or after that date.

747.27 **Sec. 7. [62A.3096] COVERAGE FOR ECTODERMAL DYSPLASIAS.**

747.28 Subdivision 1. **Definition.** For purposes of this chapter, "ectodermal dysplasias" means
747.29 a genetic disorder involving the absence or deficiency of tissues and structures derived from
747.30 the embryonic ectoderm.

748.1 Subd. 2. Coverage. A health plan must provide coverage for the treatment of ectodermal
 748.2 dysplasias.

748.3 Subd. 3. Dental coverage. (a) A health plan must provide coverage for dental treatments
 748.4 related to ectodermal dysplasias. Covered dental treatments must include but are not limited
 748.5 to bone grafts, dental implants, orthodontia, dental prosthodontics, and dental maintenance.

748.6 (b) If a dental treatment is eligible for coverage under a dental insurance plan or other
 748.7 health plan, the coverage under this subdivision is secondary.

748.8 Subd. 4. Reimbursement. The commissioner of commerce shall reimburse health carriers
 748.9 for coverage under this section at the medical assistance rate.

748.10 EFFECTIVE DATE. This section is effective January 1, 2020, and applies to health
 748.11 plans offered, issued, or sold on or after that date.

748.12 Sec. 8. [62A.3097] PEDIATRIC AUTOIMMUNE NEUROPSYCHIATRIC
 748.13 DISORDERS ASSOCIATED WITH STREPTOCOCCAL INFECTIONS (PANDAS)
 748.14 AND PEDIATRIC ACUTE-ONSET NEUROPSYCHIATRIC SYNDROME (PANS)
 748.15 TREATMENT; COVERAGE.

748.16 Subdivision 1. Definitions. (a) The definitions in this subdivision apply to this section.

748.17 (b) "Pediatric acute-onset neuropsychiatric syndrome" means a class of acute-onset
 748.18 obsessive compulsive or tic disorders or other behavioral changes presenting in children
 748.19 and adolescents that are not otherwise explained by another known neurologic or medical
 748.20 disorder.

748.21 (c) "Pediatric autoimmune neuropsychiatric disorders associated with streptococcal
 748.22 infections" means a condition in which a streptococcal infection in a child or adolescent
 748.23 causes the abrupt onset of clinically significant obsessions, compulsions, tics, or other
 748.24 neuropsychiatric symptoms or behavioral changes, or a relapsing and remitting course of
 748.25 symptom severity.

748.26 Subd. 2. Scope of coverage. This section applies to all health plans that provide coverage
 748.27 to Minnesota residents.

748.28 Subd. 3. Required coverage. Every health plan included in subdivision 2 must provide
 748.29 coverage for treatment for pediatric autoimmune neuropsychiatric disorders associated with
 748.30 streptococcal infections (PANDAS) and for treatment for pediatric acute-onset
 748.31 neuropsychiatric syndrome (PANS). Treatments that must be covered under this section
 748.32 must be recommended by the insured's licensed health care professional and include but

749.1 are not limited to antibiotics, medication and behavioral therapies to manage neuropsychiatric
749.2 symptoms, plasma exchange, and immunoglobulin.

749.3 Subd. 4. **Reimbursement.** The commissioner of commerce shall reimburse health carriers
749.4 for coverage under this section at the medical assistance rate.

749.5 **EFFECTIVE DATE.** This section is effective January 1, 2020, and applies to health
749.6 plans offered, sold, issued, or renewed on or after that date.

749.7 **Sec. 9. [62C.045] APPLICATION OF OTHER LAWS.**

749.8 Chapter 317B and Laws 2017, First Special Session chapter 6, article 5, section 11, as
749.9 amended by this act, apply to service plan corporations operating under this chapter.

749.10 **Sec. 10.** Minnesota Statutes 2018, section 62D.02, subdivision 4, is amended to read:

749.11 **Subd. 4. Health maintenance organization.** "Health maintenance organization" means
749.12 a ~~foreign or domestic~~ nonprofit corporation organized under chapter 317A, or a local
749.13 governmental unit as defined in subdivision 11, controlled and operated as provided in
749.14 sections 62D.01 to 62D.30, which provides, either directly or through arrangements with
749.15 providers or other persons, comprehensive health maintenance services, or arranges for the
749.16 provision of these services, to enrollees on the basis of a fixed prepaid sum without regard
749.17 to the frequency or extent of services furnished to any particular enrollee.

749.18 **Sec. 11.** Minnesota Statutes 2018, section 62D.03, subdivision 1, is amended to read:

749.19 **Subdivision 1. Certificate of authority required.** Notwithstanding any law of this state
749.20 to the contrary, any ~~foreign or domestic~~ nonprofit corporation organized to do so or a local
749.21 governmental unit may apply to the commissioner of health for a certificate of authority to
749.22 establish and operate a health maintenance organization in compliance with sections 62D.01
749.23 to 62D.30. No person shall establish or operate a health maintenance organization in this
749.24 state, nor sell or offer to sell, or solicit offers to purchase or receive advance or periodic
749.25 consideration in conjunction with a health maintenance organization or health maintenance
749.26 contract unless the organization has a certificate of authority under sections 62D.01 to
749.27 62D.30.

749.28 **Sec. 12. [62D.046] APPLICATION OF OTHER LAW.**

749.29 Chapter 317B applies to nonprofit health maintenance organizations operating under
749.30 this chapter.

750.1 Sec. 13. Minnesota Statutes 2018, section 62D.05, subdivision 1, is amended to read:

750.2 Subdivision 1. **Authority granted.** Any nonprofit corporation or local governmental
750.3 unit may, upon obtaining a certificate of authority as required in sections 62D.01 to 62D.30,
750.4 operate as a health maintenance organization.

750.5 Sec. 14. Minnesota Statutes 2018, section 62D.06, subdivision 1, is amended to read:

750.6 Subdivision 1. **Governing body composition; enrollee advisory body.** The governing
750.7 body of any health maintenance organization which is a nonprofit corporation may include
750.8 enrollees, providers, or other individuals; provided, however, that after a health maintenance
750.9 organization which is a nonprofit corporation has been authorized under sections 62D.01
750.10 to 62D.30 for one year, at least 40 percent of the governing body shall be composed of
750.11 enrollees and members elected by the enrollees and members from among the enrollees and
750.12 members. For purposes of this section, "member" means a consumer who receives health
750.13 care services through a self-insured contract that is administered by the health maintenance
750.14 organization or its related third-party administrator. The number of members elected to the
750.15 governing body shall not exceed the number of enrollees elected to the governing body. An
750.16 enrollee or member elected to the governing board may not be a person:

750.17 (1) whose occupation involves, or before retirement involved, the administration of
750.18 health activities or the provision of health services;

750.19 (2) who is or was employed by a health care facility as a licensed health professional;
750.20 or

750.21 (3) who has or had a direct substantial financial or managerial interest in the rendering
750.22 of a health service, other than the payment of a reasonable expense reimbursement or
750.23 compensation as a member of the board of a health maintenance organization.

750.24 After a health maintenance organization which is a local governmental unit has been
750.25 authorized under sections 62D.01 to 62D.30 for one year, an enrollee advisory body shall
750.26 be established. The enrollees who make up this advisory body shall be elected by the enrollees
750.27 from among the enrollees.

750.28 Sec. 15. Minnesota Statutes 2018, section 62D.12, is amended by adding a subdivision to
750.29 read:

750.30 Subd. 8a. **Net earnings.** All net earnings of a nonprofit health maintenance organization
750.31 must be devoted to the nonprofit purposes of the health maintenance organization in providing
750.32 comprehensive health care. A nonprofit health maintenance organization must not provide

751.1 for the payment, whether directly or indirectly, of any part of its net earnings to any person
 751.2 for a purpose other than providing comprehensive health care, except that the health
 751.3 maintenance organization may make payments to providers or other persons based on the
 751.4 efficient provision of services or as incentives to provide quality care. The commissioner
 751.5 of health shall, pursuant to this chapter, revoke the certificate of authority of any nonprofit
 751.6 health maintenance organization in violation of this subdivision.

751.7 **EFFECTIVE DATE.** This section is effective the day following final enactment.

751.8 Sec. 16. Minnesota Statutes 2018, section 62D.124, subdivision 1, is amended to read:

751.9 Subdivision 1. **Emergency care; primary care; mental health services; general**
 751.10 **hospital services.** (a) Within the health maintenance organization's service area, the
 751.11 maximum travel distance or time shall be the lesser of 30 miles or 30 minutes to the nearest
 751.12 provider of each of the following services: primary care services, mental health services,
 751.13 and general hospital services. The health maintenance organization must designate which
 751.14 method is used.

751.15 (b) Emergency care must be available to enrollees 24 hours a day, 7 days a week.
 751.16 Appointment wait times for primary care services must not exceed 45 calendar days from
 751.17 the date of the enrollee's request for routine and preventive care and 48 hours for urgent
 751.18 care. Appointment wait times for mental health services and substance use disorder treatment
 751.19 services must not exceed 15 calendar days from the date of the enrollee's request for routine
 751.20 care and 24 hours for urgent care.

751.21 Sec. 17. Minnesota Statutes 2018, section 62D.124, subdivision 2, is amended to read:

751.22 Subd. 2. **Other health services.** (a) Within a health maintenance organization's service
 751.23 area, the maximum travel distance or time shall be the lesser of 60 miles or 60 minutes to
 751.24 the nearest provider of specialty physician services, ancillary services, specialized hospital
 751.25 services, and all other health services not listed in subdivision 1. The health maintenance
 751.26 organization must designate which method is used.

751.27 (b) Appointment wait times for nonurgent specialty care must not exceed 60 calendar
 751.28 days from the date of the enrollee's request.

751.29 (c) Appointment wait time for dental, optometry, laboratory, and x-ray services must
 751.30 not exceed 45 calendar days from the date of the enrollee's request for regular appointments
 751.31 and 48 hours for urgent care. For purposes of this paragraph, regular appointments for dental
 751.32 care means preventive care and initial appointments for restorative care.

752.1 Sec. 18. Minnesota Statutes 2018, section 62D.124, subdivision 3, is amended to read:

752.2 Subd. 3. **Exception Waiver.** ~~The commissioner shall grant an exception to the~~
752.3 ~~requirements of this section according to Minnesota Rules, part 4685.1010, subpart 4, if the~~
752.4 ~~health maintenance organization can demonstrate with specific data that the requirement~~
752.5 ~~of subdivision 1 or 2 is not feasible in a particular service area or part of a service area. (a)~~
752.6 A health maintenance organization may apply to the commissioner of health for a waiver
752.7 of the requirements in subdivision 1 or 2 if it is unable to meet those requirements. A waiver
752.8 application must be submitted on a form provided by the commissioner, must be accompanied
752.9 by an application fee of \$1,000 per county per year, for each application to waive the
752.10 requirements in subdivision 1 or 2 for one or more provider types in that county, and must:

752.11 (1) demonstrate with specific data that the requirements of subdivision 1 or 2 are not
752.12 feasible in a particular service area or part of a service area; and

752.13 (2) include specific information as to the steps that were and will be taken to address
752.14 network inadequacy, and for steps that will be taken prospectively to address network
752.15 inadequacy, the time frame within which those steps will be taken.

752.16 (b) Using the guidelines and standards established under section 62K.10, subdivision 5,
752.17 paragraph (b), the commissioner shall review each waiver request and shall approve a waiver
752.18 only if:

752.19 (1) the standards for approval established by the commissioner are satisfied; and

752.20 (2) the steps that were and will be taken to address the network inadequacy and the time
752.21 frame for implementing these steps satisfy the standards established by the commissioner.

752.22 (c) If, in its waiver application, a health maintenance organization demonstrates to the
752.23 commissioner that there are no providers of a specific type or specialty in a county, the
752.24 commissioner may approve a waiver in which the health maintenance organization is allowed
752.25 to address network inadequacy in that county by providing for patient access to providers
752.26 of that type or specialty via telemedicine, as defined in section 62A.671, subdivision 9.

752.27 (d) A waiver shall automatically expire after three years. Upon or prior to expiration of
752.28 a waiver, a health maintenance organization unable to meet the requirements in subdivision
752.29 1 or 2 must submit a new waiver application under paragraph (a) and must also submit
752.30 evidence of steps the organization took to address the network inadequacy. When the
752.31 commissioner reviews a waiver application for a network adequacy requirement which has
752.32 been waived for the organization for the most recent three-year period, the commissioner
752.33 shall also examine the steps the organization took during that three-year period to address

753.1 network inadequacy, and shall only approve a subsequent waiver application if it satisfies
753.2 the requirements in paragraph (b), demonstrates that the organization took the steps it
753.3 proposed to address network inadequacy, and explains why the organization continues to
753.4 be unable to satisfy the requirements in subdivision 1 or 2.

753.5 (e) Application fees collected under this subdivision shall be deposited in the state
753.6 government special revenue fund in the state treasury.

753.7 Sec. 19. Minnesota Statutes 2018, section 62D.124, is amended by adding a subdivision
753.8 to read:

753.9 Subd. 6. **Complaints alleging violation of network adequacy requirements;**
753.10 **investigation.** Enrollees of a health maintenance organization may file a complaint with
753.11 the commissioner that the health maintenance organization is not in compliance with the
753.12 requirements of subdivision 1 or 2, using the process established under section 62K.105,
753.13 subdivision 1. The commissioner shall investigate all complaints received under this
753.14 subdivision and may use the program established under section 62K.105, subdivision 2, to
753.15 investigate complaints.

753.16 Sec. 20. Minnesota Statutes 2018, section 62D.124, is amended by adding a subdivision
753.17 to read:

753.18 Subd. 7. **Provider network notifications.** A health maintenance organization must
753.19 provide on the organization's website the provider network for each product offered by the
753.20 organization, and must update the organization's website at least once a month with any
753.21 changes to the organization's provider network, including provider changes from in-network
753.22 status to out-of-network status. A health maintenance organization must also provide on
753.23 the organization's website, for each product offered by the organization, a list of the current
753.24 waivers of the requirements in subdivision 1 or 2, in a format that is easily accessed and
753.25 searchable by enrollees and prospective enrollees.

753.26 Sec. 21. Minnesota Statutes 2018, section 62D.17, subdivision 1, is amended to read:

753.27 Subdivision 1. **Administrative penalty.** The commissioner of health may, for any
753.28 violation of statute or rule applicable to a health maintenance organization, or in lieu of
753.29 suspension or revocation of a certificate of authority under section 62D.15, levy an
753.30 administrative penalty in an amount up to \$25,000 for each violation. In the case of contracts
753.31 or agreements made pursuant to section 62D.05, subdivisions 2 to 4, each contract or
753.32 agreement entered into or implemented in a manner which violates sections 62D.01 to

754.1 62D.30 shall be considered a separate violation. The commissioner shall impose an
 754.2 administrative penalty of at least \$100 per day that a provider network in a county violates
 754.3 section 62D.124, subdivision 1 or 2, and may take other enforcement action authorized in
 754.4 law but shall not also impose an administrative penalty under section 62K.105, subdivision
 754.5 3, for a violation. In determining the level of an administrative penalty, the commissioner
 754.6 shall consider the following factors:

- 754.7 (1) the number of enrollees affected by the violation;
- 754.8 (2) the effect of the violation on enrollees' health and access to health services;
- 754.9 (3) if only one enrollee is affected, the effect of the violation on that enrollee's health;
- 754.10 (4) whether the violation is an isolated incident or part of a pattern of violations; and
- 754.11 (5) the economic benefits derived by the health maintenance organization or a
 754.12 participating provider by virtue of the violation.

754.13 Reasonable notice in writing to the health maintenance organization shall be given of
 754.14 the intent to levy the penalty and the reasons therefor, and the health maintenance
 754.15 organization may have 15 days within which to file a written request for an administrative
 754.16 hearing and review of the commissioner of health's determination. Such administrative
 754.17 hearing shall be subject to judicial review pursuant to chapter 14. If an administrative penalty
 754.18 is levied, the commissioner must divide 50 percent of the amount among any enrollees
 754.19 affected by the violation, unless the commissioner certifies in writing that the division and
 754.20 distribution to enrollees would be too administratively complex or that the number of
 754.21 enrollees affected by the penalty would result in a distribution of less than \$50 per enrollee.

754.22 Sec. 22. Minnesota Statutes 2018, section 62D.19, is amended to read:

754.23 **62D.19 UNREASONABLE EXPENSES.**

754.24 No health maintenance organization shall incur or pay for any expense of any nature
 754.25 which is unreasonably high in relation to the value of the service or goods provided. The
 754.26 commissioner of health shall implement and enforce this section by rules adopted under
 754.27 this section.

754.28 In an effort to achieve the stated purposes of sections 62D.01 to 62D.30, in order to
 754.29 safeguard the underlying nonprofit status of nonprofit health maintenance organizations,
 754.30 and to ensure that the payment of health maintenance organization money to major
 754.31 participating entities results in a corresponding benefit to the health maintenance organization
 754.32 and its enrollees, when determining whether an organization has incurred an unreasonable

755.1 expense in relation to a major participating entity, due consideration shall be given to, in
755.2 addition to any other appropriate factors, whether the officers and trustees of the health
755.3 maintenance organization have acted with good faith and in the best interests of the health
755.4 maintenance organization in entering into, and performing under, a contract under which
755.5 the health maintenance organization has incurred an expense. The commissioner has standing
755.6 to sue, on behalf of a health maintenance organization, officers or trustees of the health
755.7 maintenance organization who have breached their fiduciary duty in entering into and
755.8 performing such contracts.

755.9 Sec. 23. Minnesota Statutes 2018, section 62D.30, subdivision 8, is amended to read:

755.10 Subd. 8. **Rural demonstration project.** (a) The commissioner may permit demonstration
755.11 projects to allow health maintenance organizations to extend coverage to a health
755.12 improvement and purchasing coalition located in rural Minnesota, comprised of the health
755.13 maintenance organization and members from a geographic area. For purposes of this
755.14 subdivision, rural is defined as greater Minnesota excluding the seven-county metropolitan
755.15 area of Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington. The coalition
755.16 must be designed in such a way that members will:

755.17 (1) become better informed about health care trends and cost increases;

755.18 (2) be actively engaged in the design of health benefit options that will meet the needs
755.19 of their community;

755.20 (3) pool their insurance risk;

755.21 (4) purchase these products from the health maintenance organization involved in the
755.22 demonstration project; and

755.23 (5) actively participate in health improvement decisions for their community.

755.24 (b) The commissioner must consider the following when approving applications for
755.25 rural demonstration projects:

755.26 (1) the extent of consumer involvement in development of the project;

755.27 (2) the degree to which the project is likely to reduce the number of uninsured or to
755.28 maintain existing coverage; and

755.29 (3) a plan to evaluate and report to the commissioner and legislature as prescribed by
755.30 paragraph (e).

755.31 (c) For purposes of this subdivision, the commissioner must waive compliance with the
755.32 following statutes and rules: the cost-sharing restrictions under section 62D.095, subdivisions

756.1 2, 3, and 4, and Minnesota Rules, part 4685.0801, subparts 1 to 7; for a period of at least
756.2 two years, participation in government programs under section 62D.04, subdivision 5, in
756.3 the counties of the demonstration project if that compliance would have been required solely
756.4 due to participation in the demonstration project and shall continue to waive this requirement
756.5 beyond two years if the enrollment in the demonstration project is less than 10,000 enrollees;
756.6 small employer marketing under section 62L.05, subdivisions 1 to 3; and small employer
756.7 geographic premium variations under section 62L.08, subdivision 4. The commissioner
756.8 shall approve enrollee cost-sharing features desired by the coalition that appropriately share
756.9 costs between employers, individuals, and the health maintenance organization.

756.10 (d) The health maintenance organization may make the starting date of the project
756.11 contingent upon a minimum number of enrollees as cited in the application, provide for an
756.12 initial term of contract with the purchasers of a minimum of three years, and impose a
756.13 reasonable penalty for employers who withdraw early from the project. For purposes of this
756.14 subdivision, loss ratios are to be determined as if the policies issued under this section are
756.15 considered individual or small employer policies pursuant to section 62A.021, subdivision
756.16 ~~1, paragraph (f)~~ 1a. The health maintenance organization may consider businesses of one
756.17 to be a small employer under section 62L.02, subdivision 26. The health maintenance
756.18 organization may limit enrollment and establish enrollment criteria for businesses of one.
756.19 Health improvement and purchasing coalitions under this subdivision are not associations
756.20 under section 62L.045, subdivision 1, paragraph (a).

756.21 (e) The health improvement and purchasing coalition must report to the commissioner
756.22 and legislature annually on the progress of the demonstration project and, to the extent
756.23 possible, any significant findings in the criteria listed in clauses (1), (2), and (3) for the final
756.24 report. The coalition must submit a final report five years from the starting date of the
756.25 project. The final report must detail significant findings from the project and must include,
756.26 to the extent available, but should not be limited to, information on the following:

756.27 (1) the extent to which the project had an impact on the number of uninsured in the
756.28 project area;

756.29 (2) the effect on health coverage premiums for groups in the project's geographic area,
756.30 including those purchasing health coverage outside the health improvement and purchasing
756.31 coalition; and

756.32 (3) the degree to which health care consumers were involved in the development and
756.33 implementation of the demonstration project.

757.1 (f) The commissioner must limit the number of demonstration projects under this
757.2 subdivision to five projects.

757.3 (g) Approval of the application for the demonstration project is deemed to be in
757.4 compliance with section 62E.06, subdivisions 1, paragraph (a), 2, and 3.

757.5 (h) Subdivisions 2 to 7 apply to demonstration projects under this subdivision. Waivers
757.6 permitted under subdivision 1 do not apply to demonstration projects under this subdivision.

757.7 (i) If a demonstration project under this subdivision works in conjunction with a
757.8 purchasing alliance formed under chapter 62T, that chapter will apply to the purchasing
757.9 alliance except to the extent that chapter 62T is inconsistent with this subdivision.

757.10 Sec. 24. Minnesota Statutes 2018, section 62E.02, subdivision 3, is amended to read:

757.11 Subd. 3. **Health maintenance organization.** "Health maintenance organization" means
757.12 a nonprofit corporation licensed and operated as provided in chapter 62D.

757.13 Sec. 25. Minnesota Statutes 2018, section 62K.075, is amended to read:

757.14 **62K.075 PROVIDER NETWORK NOTIFICATIONS.**

757.15 (a) A health carrier must provide on the carrier's website the provider network for each
757.16 product offered by the carrier, and must update the carrier's website at least once a month
757.17 with any changes to the carrier's provider network, including provider changes from
757.18 in-network status to out-of-network status. A health carrier must also provide on the carrier's
757.19 website, for each product offered by the carrier, a list of the current waivers of the
757.20 requirements in section 62K.10, subdivision 2 or 3, in a format that is easily accessed and
757.21 searchable by enrollees and prospective enrollees.

757.22 (b) Upon notification from an enrollee, a health carrier must reprocess any claim for
757.23 services provided by a provider whose status has changed from in-network to out-of-network
757.24 as an in-network claim if the service was provided after the network change went into effect
757.25 but before the change was posted as required under paragraph (a) unless the health carrier
757.26 notified the enrollee of the network change prior to the service being provided. This paragraph
757.27 does not apply if the health carrier is able to verify that the health carrier's website displayed
757.28 the correct provider network status on the health carrier's website at the time the service
757.29 was provided.

757.30 (c) The limitations of section 62Q.56, subdivision 2a, shall apply to payments required
757.31 by paragraph (b).

758.1 Sec. 26. Minnesota Statutes 2018, section 62K.10, subdivision 2, is amended to read:

758.2 Subd. 2. **Emergency care; primary care; mental health services; general hospital**
758.3 **services.** (a) The maximum travel distance or time shall be the lesser of 30 miles or 30
758.4 minutes to the nearest provider of each of the following services: primary care services,
758.5 mental health services, and general hospital services.

758.6 (b) Emergency care must be available to enrollees 24 hours a day, 7 days a week. A
758.7 provider network must comply with the access standards for appointment wait times specified
758.8 in section 62D.124, subdivision 1, paragraph (b), for primary care services, mental health
758.9 services, and substance use disorder treatment services.

758.10 Sec. 27. Minnesota Statutes 2018, section 62K.10, subdivision 3, is amended to read:

758.11 Subd. 3. **Other health services.** (a) The maximum travel distance or time shall be the
758.12 lesser of 60 miles or 60 minutes to the nearest provider of specialty physician services,
758.13 ancillary services, specialized hospital services, and all other health services not listed in
758.14 subdivision 2.

758.15 (b) A provider network must comply with the access standards for appointment wait
758.16 times specified in section 62D.124, subdivision 2, paragraph (b), for nonurgent specialty
758.17 care.

758.18 (c) A provider network must comply with the access standards for appointment wait
758.19 times specified in section 62D.124, subdivision 2, paragraph (c), for dental, optometry,
758.20 laboratory, and x-ray services.

758.21 Sec. 28. Minnesota Statutes 2018, section 62K.10, subdivision 4, is amended to read:

758.22 Subd. 4. **Network adequacy.** Each designated provider network must include a sufficient
758.23 number and type of providers, including providers that specialize in mental health and
758.24 substance use disorder services, to ensure that covered services are available to all enrollees
758.25 without unreasonable delay. In determining network adequacy, the commissioner of health
758.26 shall ensure that a provider network is sufficient to satisfy the access standards for emergency
758.27 care and appointment wait times in subdivisions 2 and 3 and shall also consider availability
758.28 of services, including the following:

758.29 (1) primary care physician services are available and accessible 24 hours per day, seven
758.30 days per week, within the network area;

759.1 (2) a sufficient number of primary care physicians have hospital admitting privileges at
759.2 one or more participating hospitals within the network area so that necessary admissions
759.3 are made on a timely basis consistent with generally accepted practice parameters;

759.4 (3) specialty physician service is available through the network or contract arrangement;

759.5 (4) mental health and substance use disorder treatment providers are available and
759.6 accessible through the network or contract arrangement;

759.7 (5) to the extent that primary care services are provided through primary care providers
759.8 other than physicians, and to the extent permitted under applicable scope of practice in state
759.9 law for a given provider, these services shall be available and accessible; and

759.10 (6) the network has available, either directly or through arrangements, appropriate and
759.11 sufficient personnel, physical resources, and equipment to meet the projected needs of
759.12 enrollees for covered health care services.

759.13 Sec. 29. Minnesota Statutes 2018, section 62K.10, subdivision 5, is amended to read:

759.14 Subd. 5. **Waiver.** (a) A health carrier or preferred provider organization may apply to
759.15 the commissioner of health for a waiver of the requirements in subdivision 2 or 3 if it is
759.16 unable to meet the statutory requirements. A waiver application must be submitted on a
759.17 form provided by the commissioner, must be accompanied by an application fee of \$1,000
759.18 for each application to waive the requirements in subdivision 2 or 3 for one or more provider
759.19 types per county, and must:

759.20 (1) demonstrate with specific data that the requirement of subdivision 2 or 3 is not
759.21 feasible in a particular service area or part of a service area; and

759.22 (2) include specific information as to the steps that were and will be taken to address
759.23 the network inadequacy, and for steps that will be taken prospectively to address network
759.24 inadequacy, the time frame within which those steps will be taken.

759.25 (b) The commissioner shall establish guidelines for evaluating waiver applications,
759.26 standards governing approval or denial of a waiver application, and standards for steps that
759.27 health carriers must take to address the network inadequacy and allow the health carrier to
759.28 meet network adequacy requirements within a reasonable time period. The commissioner
759.29 shall review each waiver application using these guidelines and standards and shall approve
759.30 a waiver application only if:

759.31 (1) the standards for approval established by the commissioner are satisfied; and

760.1 (2) the steps that were and will be taken to address the network inadequacy and the time
760.2 frame for taking these steps satisfy the standards established by the commissioner.

760.3 (c) If, in its waiver application, a health carrier demonstrates to the commissioner that
760.4 there are no providers of a specific type or specialty in a county, the commissioner may
760.5 approve a waiver in which the health carrier is allowed to address network inadequacy in
760.6 that county by providing for patient access to providers of that type or specialty via
760.7 telemedicine, as defined in section 62A.671, subdivision 9.

760.8 (d) The waiver shall automatically expire after four years. If a renewal of the waiver is
760.9 sought, the commissioner of health shall take into consideration steps that have been taken
760.10 to address network adequacy. one year. Upon or prior to expiration of a waiver, a health
760.11 carrier unable to meet the requirements in subdivision 2 or 3 must submit a new waiver
760.12 application under paragraph (a) and must also submit evidence of steps the carrier took to
760.13 address the network inadequacy. When the commissioner reviews a waiver application for
760.14 a network adequacy requirement which has been waived for the carrier for the most recent
760.15 one-year period, the commissioner shall also examine the steps the carrier took during that
760.16 one-year period to address network inadequacy, and shall only approve a subsequent waiver
760.17 application that satisfies the requirements in paragraph (b), demonstrates that the carrier
760.18 took the steps it proposed to address network inadequacy, and explains why the carrier
760.19 continues to be unable to satisfy the requirements in subdivision 2 or 3.

760.20 (e) Application fees collected under this subdivision shall be deposited in the state
760.21 government special revenue fund in the state treasury.

760.22 **Sec. 30. [62K.105] NETWORK ADEQUACY COMPLAINTS AND**
760.23 **INVESTIGATIONS.**

760.24 Subdivision 1. **Complaints.** The commissioner shall establish a clear, easily accessible
760.25 process for accepting complaints from enrollees regarding health carrier compliance with
760.26 section 62K.10, subdivision 2, 3, or 4. Using this process, an enrollee may file a complaint
760.27 with the commissioner that a health carrier is not in compliance with the requirements of
760.28 section 62K.10, subdivision 2, 3, or 4. The commissioner shall investigate all complaints
760.29 received under this subdivision.

760.30 Subd. 2. **Commissioner investigations of provider networks.** The commissioner shall
760.31 establish a program to examine health carrier compliance with the requirements in section
760.32 62K.10, subdivisions 2, 3, and 4. Under this program, department employees or contractors
760.33 shall seek to make appointments with a range of provider types in a carrier's designated
760.34 provider network to determine whether covered services are available to enrollees within

761.1 the required appointment times, and shall examine whether the carrier's network complies
761.2 with the maximum distance or travel time requirements for specific provider types. The
761.3 commissioner shall develop a schedule to ensure that all health carriers are periodically
761.4 examined under this program, and shall also use this program to investigate enrollee
761.5 complaints filed under subdivision 1.

761.6 Subd. 3. **Administrative penalties.** The commissioner shall impose on a health carrier
761.7 an administrative penalty of at least \$100 per day that a provider network violates section
761.8 62K.10, subdivision 2, 3, or 4, in a county. The commissioner may also take other
761.9 enforcement actions authorized in law for a violation, except that if the commissioner
761.10 imposes an administrative penalty under this subdivision, the commissioner shall not also
761.11 impose an administrative penalty under section 62D.17, subdivision 1. The commissioner
761.12 shall use the factors in section 62D.17, subdivision 1, to determine the amount of the
761.13 administrative penalty, and the procedures in section 62D.17, subdivision 1, apply to
761.14 administrative penalties imposed under this subdivision.

761.15 Sec. 31. Minnesota Statutes 2018, section 62Q.01, is amended by adding a subdivision to
761.16 read:

761.17 Subd. 6b. **Nonquantitative treatment limitations or NQTLs.** "Nonquantitative treatment
761.18 limitations" or "NQTLs" means processes, strategies, or evidentiary standards, or other
761.19 factors that are not expressed numerically, but otherwise limit the scope or duration of
761.20 benefits for treatment. NQTLs include but are not limited to:

761.21 (1) medical management standards limiting or excluding benefits based on (i) medical
761.22 necessity or medical appropriateness, or (ii) whether the treatment is experimental or
761.23 investigative;

761.24 (2) formulary design for prescription drugs;

761.25 (3) health plans with multiple network tiers;

761.26 (4) criteria and parameters for provider inclusion in provider networks, including
761.27 credentialing standards and reimbursement rates;

761.28 (5) health plan methods for determining usual, customary, and reasonable charges;

761.29 (6) fail-first or step therapy protocols;

761.30 (7) exclusions based on failure to complete a course of treatment;

762.1 (8) restrictions based on geographic location, facility type, provider specialty, and other
 762.2 criteria that limit the scope or duration of benefits for services provided under the health
 762.3 plan;

762.4 (9) in- and out-of-network geographic limitations;

762.5 (10) standards for providing access to out-of-network providers;

762.6 (11) limitations on inpatient services for situations where the enrollee is a threat to self
 762.7 or others;

762.8 (12) exclusions for court-ordered and involuntary holds;

762.9 (13) experimental treatment limitations;

762.10 (14) service coding;

762.11 (15) exclusions for services provided by clinical social workers; and

762.12 (16) provider reimbursement rates, including rates of reimbursement for mental health
 762.13 and substance use disorder services in primary care.

762.14 **Sec. 32. [62Q.1841] PROHIBITION ON USE OF STEP THERAPY FOR**
 762.15 **METASTATIC CANCER.**

762.16 Subdivision 1. **Definitions.** (a) For purposes of this section, the following definitions
 762.17 apply.

762.18 (b) "Health plan" has the meaning given in section 62Q.01, subdivision 3. Health plan
 762.19 includes health coverage provided by a county-based purchasing plan participating in a
 762.20 public program under chapter 256B or 256L or an integrated health partnership under section
 762.21 256B.0755.

762.22 (c) "Stage four advanced metastatic cancer" means cancer that has spread from the
 762.23 primary or original site of the cancer to nearby tissues, lymph nodes, or other parts of the
 762.24 body.

762.25 (d) "Step therapy protocol" has the meaning given in section 62Q.184, subdivision 1.

762.26 Subd. 2. **Prohibition on use of step therapy protocols.** A health plan that provides
 762.27 coverage for the treatment of stage four advanced metastatic cancer or associated conditions
 762.28 must not limit or exclude coverage for a drug approved by the United States Food and Drug
 762.29 Administration that is on the health plan's prescription drug formulary by mandating that
 762.30 an enrollee with stage four advanced metastatic cancer or associated conditions follow a
 762.31 step therapy protocol if the use of the approved drug is consistent with:

- 763.1 (1) a United States Food and Drug Administration-approved indication; and
 763.2 (2) a clinical practice guideline published by the National Comprehensive Care Network.

763.3 **EFFECTIVE DATE.** This section is effective January 1, 2020, and applies to health
 763.4 plans offered, issued, or renewed on or after that date.

763.5 Sec. 33. Minnesota Statutes 2018, section 62Q.47, is amended to read:

763.6 **62Q.47 ALCOHOLISM, MENTAL HEALTH, AND CHEMICAL DEPENDENCY**
 763.7 **SERVICES.**

763.8 (a) All health plans, as defined in section 62Q.01, that provide coverage for alcoholism,
 763.9 mental health, or chemical dependency services, must comply with the requirements of this
 763.10 section.

763.11 (b) Cost-sharing requirements and benefit or service limitations for outpatient mental
 763.12 health and outpatient chemical dependency and alcoholism services, except for persons
 763.13 placed in chemical dependency services under Minnesota Rules, parts 9530.6600 to
 763.14 9530.6655, must not place a greater financial burden on the insured or enrollee, or be more
 763.15 restrictive than those requirements and limitations for outpatient medical services.

763.16 (c) Cost-sharing requirements and benefit or service limitations for inpatient hospital
 763.17 mental health and inpatient hospital and residential chemical dependency and alcoholism
 763.18 services, except for persons placed in chemical dependency services under Minnesota Rules,
 763.19 parts 9530.6600 to 9530.6655, must not place a greater financial burden on the insured or
 763.20 enrollee, or be more restrictive than those requirements and limitations for inpatient hospital
 763.21 medical services.

763.22 (d) A health plan must not impose an NQTL with respect to mental health and substance
 763.23 use disorders in any classification of benefits unless, under the terms of the plan as written
 763.24 and in operation, any processes, strategies, evidentiary standards, or other factors used in
 763.25 applying the NQTL to mental health and substance use disorders in the classification are
 763.26 comparable to, and are applied no more stringently than, the processes, strategies, evidentiary
 763.27 standards, or other factors used in applying the NQTL with respect to medical and surgical
 763.28 benefits in the same classification.

763.29 ~~(d)~~ (e) All health plans must meet the requirements of the federal Mental Health Parity
 763.30 Act of 1996, Public Law 104-204; Paul Wellstone and Pete Domenici Mental Health Parity
 763.31 and Addiction Equity Act of 2008; the Affordable Care Act; and any amendments to, and
 763.32 federal guidance or regulations issued under, those acts.

764.1 (f) The commissioner, in consultation with advocates, providers, and health plan
764.2 companies, may require information from health plan companies to confirm that mental
764.3 health parity is being implemented. Information required may include comparisons between
764.4 mental health and substance use disorder treatment against other health care conditions for
764.5 other issues, including wait times, prior authorizations, provider credentialing and
764.6 reimbursement, drug formularies, use of out-of-network providers, out-of-pocket costs,
764.7 medical necessity, network adequacy, claim denials, adoption of coverage for new treatments,
764.8 in-home services, rehabilitation services, and other information the commissioner deems
764.9 appropriate.

764.10 (g) Regardless of the care provider's professional license, if the care is consistent with
764.11 the provider's scope of practice and the health plan's credentialing and contracting provisions,
764.12 mental health therapy visits and medication maintenance visits are considered primary care
764.13 visits for the purposes of applying any patient cost-sharing requirements imposed by the
764.14 health plan. Beginning June 1, 2021, and each year thereafter, the commissioner of commerce,
764.15 in consultation with the commissioner of health, must issue an updated report to the
764.16 legislature. The report must:

764.17 (1) describe how the commissioners review health plan compliance with United States
764.18 Code, title 42, section 18031(j), and any federal regulations or guidance relating to
764.19 compliance and oversight;

764.20 (2) describe how the commissioners review compliance with this section and section
764.21 62Q.53;

764.22 (3) identify enforcement actions taken during the preceding 12-month period regarding
764.23 compliance with parity for mental health and substance use disorders benefits under state
764.24 and federal law and summarize the results of such market conduct examinations. The
764.25 summary must include:

764.26 (i) the number of formal enforcement actions taken;

764.27 (ii) the benefit classifications examined in each enforcement action;

764.28 (iii) the subject matter of each enforcement action, including quantitative and
764.29 nonquantitative treatment limitations; and

764.30 (iv) a description of how individually identifiable information will be excluded from
764.31 the reports, consistent with state and federal privacy protections;

765.1 (4) detail any corrective actions the commissioners have taken to ensure health plan
765.2 compliance with this section and section 62Q.53, and United States Code, title 42, section
765.3 18031(j);

765.4 (5) detail the approach taken by the commissioners relating to informing the public about
765.5 alcoholism, mental health, or chemical dependency parity protections under state and federal
765.6 law; and

765.7 (6) be written in nontechnical, readily understandable language and must be made
765.8 available to the public by, among other means as the commissioners find appropriate, posting
765.9 the report on department websites.

765.10 **Sec. 34. [62Q.521] COVERAGE OF CONTRACEPTIVE METHODS AND**
765.11 **SERVICES.**

765.12 Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.

765.13 (b) "Closely held for-profit entity" means an entity that:

765.14 (1) is not a nonprofit entity;

765.15 (2) has more than 50 percent of the value of its ownership interest owned directly or
765.16 indirectly by five or fewer individuals, or has an ownership structure that is substantially
765.17 similar; and

765.18 (3) has no publicly traded ownership interest, having any class of common equity
765.19 securities required to be registered under United States Code, title 15, section 781.

765.20 For purposes of this paragraph:

765.21 (i) ownership interests owned by a corporation, partnership, estate, or trust are considered
765.22 owned proportionately by that entity's shareholders, partners, or beneficiaries;

765.23 (ii) ownership interests owned by a nonprofit entity are considered owned by a single
765.24 owner;

765.25 (iii) ownership interests owned by an individual are considered owned, directly or
765.26 indirectly, by or for the individual's family. For purposes of this item, "family" means
765.27 brothers and sisters, including half-brothers and half-sisters, a spouse, ancestors, and lineal
765.28 descendants; and

765.29 (iv) if an individual or entity holds an option to purchase an ownership interest, the
765.30 individual or entity is considered to be the owner of those ownership interests.

766.1 (c) "Contraceptive method" means a drug, device, or other product approved by the Food
766.2 and Drug Administration to prevent unintended pregnancy.

766.3 (d) "Contraceptive service" means consultation, examination, procedures, and medical
766.4 services related to the prevention of unintended pregnancy. This includes but is not limited
766.5 to voluntary sterilization procedures, patient education, counseling on contraceptives, and
766.6 follow-up services related to contraceptive methods or services, management of side effects,
766.7 counseling for continued adherence, and device insertion or removal.

766.8 (e) "Eligible organization" means an organization that opposes providing coverage for
766.9 some or all contraceptive methods or services on account of religious objections and that
766.10 is:

766.11 (1) organized as a nonprofit entity and holds itself as a religious organization; or

766.12 (2) organized and operates as a closely held for-profit entity, and the organization's
766.13 highest governing body has adopted, under the organization's applicable rules of governance
766.14 and consistent with state law, a resolution or similar action establishing that it objects to
766.15 covering some or all contraceptive methods or services on account of the owners' sincerely
766.16 held religious beliefs.

766.17 (f) "Medical necessity" includes but is not limited to considerations such as severity of
766.18 side effects, difference in permanence and reversibility of a contraceptive method or service,
766.19 and ability to adhere to the appropriate use of the contraceptive method or service, as
766.20 determined by the attending provider.

766.21 (g) "Religious organization" means an organization that is organized and operates as a
766.22 nonprofit entity and meets the requirements of section 6033(a)(3)(A)(i) or (iii) of the Internal
766.23 Revenue Code of 1986, as amended.

766.24 (h) "Therapeutic equivalent version" means a drug, device, or product that can be expected
766.25 to have the same clinical effect and safety profile when administered to a patient under the
766.26 conditions specified in the labeling, and that:

766.27 (1) is approved as safe and effective;

766.28 (2) is a pharmaceutical equivalent, (i) containing identical amounts of the same active
766.29 drug ingredient in the same dosage form and route of administration, and (ii) meeting
766.30 compendial or other applicable standards of strength, quality, purity, and identity;

766.31 (3) is bioequivalent in that:

767.1 (i) the drug, device, or product does not present a known or potential bioequivalence
767.2 problem and meet an acceptable in vitro standard; or

767.3 (ii) if the drug, device, or product does present a known or potential bioequivalence
767.4 problem, it is shown to meet an appropriate bioequivalence standard;

767.5 (4) is adequately labeled; and

767.6 (5) is manufactured in compliance with current manufacturing practice regulations.

767.7 Subd. 2. Required coverage; cost sharing prohibited. (a) A health plan must provide
767.8 coverage for contraceptive methods and services.

767.9 (b) A health plan company must not impose cost-sharing requirements, including co-pays,
767.10 deductibles, or co-insurance, for contraceptive methods or services.

767.11 (c) Notwithstanding paragraph (b), a health plan that is a high-deductible health plan in
767.12 conjunction with a health savings account must include cost-sharing for contraceptive
767.13 methods and services at the minimum level necessary to preserve the enrollee's ability to
767.14 make tax exempt contributions and withdrawals from the health savings account, as provided
767.15 by section 223 of the Internal Revenue Code of 1986, as amended.

767.16 (d) A health plan company must not impose any referral requirements, restrictions, or
767.17 delays for contraceptive methods or services.

767.18 (e) A health plan must include at least one of each type of Food and Drug Administration
767.19 approved contraceptive method in its formulary. If more than one therapeutic equivalent
767.20 version of a contraceptive method is approved, a health plan must include at least one
767.21 therapeutic equivalent version in its formulary, but is not required to include all therapeutic
767.22 equivalent versions.

767.23 (f) For each health plan, a health plan company must list the contraceptive methods and
767.24 services that are covered without cost-sharing in a manner that is easily accessible to
767.25 enrollees, health care providers, and representatives of health care providers. The list for
767.26 each health plan must be promptly updated to reflect changes to the coverage.

767.27 (g) If an enrollee's attending provider recommends a particular contraceptive method or
767.28 service based on a determination of medical necessity for that enrollee, the health plan must
767.29 cover that contraceptive method or service without cost-sharing. The health plan company
767.30 issuing the health plan must defer to the attending provider's determination that the particular
767.31 contraceptive method or service is medically necessary for the enrollee.

768.1 Subd. 3. **Religious employers; exempt** (a) A religious employer is not required to cover
768.2 contraceptive methods or services if the employer has religious objections to the coverage.
768.3 A religious employer that chooses to not provide coverage for contraceptive methods and
768.4 services must notify employees as part of the hiring process and total employees at least 30
768.5 days before:

768.6 (1) an employee enrolls in the health plan; or

768.7 (2) the effective date of the health plan, whichever occurs first.

768.8 (b) If the religious employer provides coverage for some contraceptive methods or
768.9 services, the notice must provide a list of the contraceptive methods or services the employer
768.10 refuses to cover.

768.11 Subd. 4. **Accommodation for eligible organizations.** (a) A health plan established or
768.12 maintained by an eligible organization complies with the requirements of subdivision 2 to
768.13 provide coverage of contraceptive methods and services if the eligible organization provides
768.14 notice to any health plan company the eligible organization contracts with that it is an eligible
768.15 organization and that the eligible organization has a religious objection to coverage for all
768.16 or a subset of contraceptive methods or services.

768.17 (b) The notice from an eligible organization to a health plan company under paragraph
768.18 (a) must include the name of the eligible organization, a statement that it objects to coverage
768.19 for some or all of contraceptive methods or services, including a list of the contraceptive
768.20 methods or services the eligible organization objects to, if applicable, and the health plan
768.21 name. The notice must be executed by a person authorized to provide notice on behalf of
768.22 the eligible organization.

768.23 (c) An eligible organization must provide a copy of the notice under paragraph (b) to
768.24 prospective employees as part of the hiring process and total employees at least 30 days
768.25 before:

768.26 (1) an employee enrolls in the health plan; or

768.27 (2) the effective date of the health plan, whichever occurs first.

768.28 (d) A health plan company that receives a copy of the notice under paragraph (a) with
768.29 respect to a health plan established or maintained by an eligible organization must:

768.30 (1) expressly exclude coverage for some or all contraceptive methods or services from
768.31 the health plan; and

769.1 (2) provide separate payments for any contraceptive methods or services required to be
769.2 covered under subdivision 2 for enrollees as long as the enrollee remains enrolled in the
769.3 health plan.

769.4 (e) The health plan company must not impose any cost-sharing requirements, including
769.5 co-pays, deductibles, or co-insurance, or directly or indirectly impose any premium, fee, or
769.6 other charge for contraceptive services or methods on the eligible organization, health plan,
769.7 or enrollee.

769.8 (f) On January 1, 2021, and every year thereafter a health plan company must notify the
769.9 commissioner, in a manner to be determined by the commissioner, regarding the number
769.10 of eligible organizations granted an accommodation under this subdivision.

769.11 **EFFECTIVE DATE.** This section is effective January 1, 2021, and applies to coverage
769.12 offered, sold, issued, or renewed on or after that date.

769.13 Sec. 35. **[62Q.522] COVERAGE FOR PRESCRIPTION CONTRACEPTIVES;**
769.14 **SUPPLY REQUIREMENTS.**

769.15 Subdivision 1. **Scope of coverage.** Except as otherwise provided in section 62Q.521,
769.16 subdivision 3, all health plans that provide prescription coverage must comply with the
769.17 requirements of this section.

769.18 Subd. 2. **Definition.** For purposes of this section, "prescription contraceptive" means
769.19 any drug or device that requires a prescription and is approved by the Food and Drug
769.20 Administration to prevent pregnancy. Prescription contraceptive does not include an
769.21 emergency contraceptive drug that prevents pregnancy when administered after sexual
769.22 contact.

769.23 Subd. 3. **Required coverage.** (a) Health plan coverage for a prescription contraceptive
769.24 must provide a 12-month supply for any prescription contraceptive, regardless of whether
769.25 the enrollee was covered by the health plan at the time of the first dispensing.

769.26 (b) The prescribing health care provider must determine the appropriate number of
769.27 months to prescribe the prescription contraceptives for, up to 12 months.

769.28 **EFFECTIVE DATE.** This section is effective January 1, 2021, and applies to coverage
769.29 offered, sold, issued, or renewed on or after that date.

770.1 Sec. 36. Minnesota Statutes 2018, section 256B.0625, subdivision 13, is amended to read:

770.2 Subd. 13. **Drugs.** (a) Medical assistance covers drugs, except for fertility drugs when
770.3 specifically used to enhance fertility, if prescribed by a licensed practitioner and dispensed
770.4 by a licensed pharmacist, by a physician enrolled in the medical assistance program as a
770.5 dispensing physician, or by a physician, physician assistant, or a nurse practitioner employed
770.6 by or under contract with a community health board as defined in section 145A.02,
770.7 subdivision 5, for the purposes of communicable disease control.

770.8 (b) The dispensed quantity of a prescription drug must not exceed a 34-day supply,
770.9 unless authorized by the commissioner or as provided in paragraph (g).

770.10 (c) For the purpose of this subdivision and subdivision 13d, an "active pharmaceutical
770.11 ingredient" is defined as a substance that is represented for use in a drug and when used in
770.12 the manufacturing, processing, or packaging of a drug becomes an active ingredient of the
770.13 drug product. An "excipient" is defined as an inert substance used as a diluent or vehicle
770.14 for a drug. The commissioner shall establish a list of active pharmaceutical ingredients and
770.15 excipients which are included in the medical assistance formulary. Medical assistance covers
770.16 selected active pharmaceutical ingredients and excipients used in compounded prescriptions
770.17 when the compounded combination is specifically approved by the commissioner or when
770.18 a commercially available product:

770.19 (1) is not a therapeutic option for the patient;

770.20 (2) does not exist in the same combination of active ingredients in the same strengths
770.21 as the compounded prescription; and

770.22 (3) cannot be used in place of the active pharmaceutical ingredient in the compounded
770.23 prescription.

770.24 (d) Medical assistance covers the following over-the-counter drugs when prescribed by
770.25 a licensed practitioner or by a licensed pharmacist who meets standards established by the
770.26 commissioner, in consultation with the board of pharmacy: antacids, acetaminophen, family
770.27 planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults
770.28 with documented vitamin deficiencies, vitamins for children under the age of seven and
770.29 pregnant or nursing women, and any other over-the-counter drug identified by the
770.30 commissioner, in consultation with the formulary committee, as necessary, appropriate, and
770.31 cost-effective for the treatment of certain specified chronic diseases, conditions, or disorders,
770.32 and this determination shall not be subject to the requirements of chapter 14. A pharmacist
770.33 may prescribe over-the-counter medications as provided under this paragraph for purposes
770.34 of receiving reimbursement under Medicaid. When prescribing over-the-counter drugs under

771.1 this paragraph, licensed pharmacists must consult with the recipient to determine necessity,
771.2 provide drug counseling, review drug therapy for potential adverse interactions, and make
771.3 referrals as needed to other health care professionals. Over-the-counter medications must
771.4 be dispensed in a quantity that is the lowest of: (1) the number of dosage units contained in
771.5 the manufacturer's original package; (2) the number of dosage units required to complete
771.6 the patient's course of therapy; or (3) if applicable, the number of dosage units dispensed
771.7 from a system using retrospective billing, as provided under subdivision 13e, paragraph
771.8 (b).

771.9 (e) Effective January 1, 2006, medical assistance shall not cover drugs that are coverable
771.10 under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and
771.11 Modernization Act of 2003, Public Law 108-173, section 1860D-2(e), for individuals eligible
771.12 for drug coverage as defined in the Medicare Prescription Drug, Improvement, and
771.13 Modernization Act of 2003, Public Law 108-173, section 1860D-1(a)(3)(A). For these
771.14 individuals, medical assistance may cover drugs from the drug classes listed in United States
771.15 Code, title 42, section 1396r-8(d)(2), subject to this subdivision and subdivisions 13a to
771.16 13g, except that drugs listed in United States Code, title 42, section 1396r-8(d)(2)(E), shall
771.17 not be covered.

771.18 (f) Medical assistance covers drugs acquired through the federal 340B Drug Pricing
771.19 Program and dispensed by 340B covered entities and ambulatory pharmacies under common
771.20 ownership of the 340B covered entity. Medical assistance does not cover drugs acquired
771.21 through the federal 340B Drug Pricing Program and dispensed by 340B contract pharmacies.

771.22 (g) Medical assistance coverage for a prescription contraceptive must provide a 12-month
771.23 supply for any prescription contraceptive, regardless of whether the enrollee was covered
771.24 by medical assistance or the health plan at the time of the first dispensing. The prescribing
771.25 health care provider must determine the appropriate number of months to prescribe the
771.26 prescription contraceptives for, up to 12 months.

771.27 For purposes of this paragraph, "prescription contraceptive" means any drug or device that
771.28 requires a prescription and is approved by the Food and Drug Administration to prevent
771.29 pregnancy. Prescription contraceptive does not include an emergency contraceptive drug
771.30 approved to prevent pregnancy when administered after sexual contact. For purposes of this
771.31 paragraph, "health plan" has the meaning provided in section 62Q.01, subdivision 3.

771.32 **EFFECTIVE DATE.** This section applies to medical assistance and MinnesotaCare
771.33 coverage effective January 1, 2021.

772.1 Sec. 37. Minnesota Statutes 2018, section 256B.0625, subdivision 13f, is amended to read:

772.2 Subd. 13f. **Prior authorization.** (a) The Formulary Committee shall review and
772.3 recommend drugs which require prior authorization. The Formulary Committee shall
772.4 establish general criteria to be used for the prior authorization of brand-name drugs for
772.5 which generically equivalent drugs are available, but the committee is not required to review
772.6 each brand-name drug for which a generically equivalent drug is available.

772.7 (b) Prior authorization may be required by the commissioner before certain formulary
772.8 drugs are eligible for payment. The Formulary Committee may recommend drugs for prior
772.9 authorization directly to the commissioner. The commissioner may also request that the
772.10 Formulary Committee review a drug for prior authorization. Before the commissioner may
772.11 require prior authorization for a drug:

772.12 (1) the commissioner must provide information to the Formulary Committee on the
772.13 impact that placing the drug on prior authorization may have on the quality of patient care
772.14 and on program costs, information regarding whether the drug is subject to clinical abuse
772.15 or misuse, and relevant data from the state Medicaid program if such data is available;

772.16 (2) the Formulary Committee must review the drug, taking into account medical and
772.17 clinical data and the information provided by the commissioner; and

772.18 (3) the Formulary Committee must hold a public forum and receive public comment for
772.19 an additional 15 days.

772.20 The commissioner must provide a 15-day notice period before implementing the prior
772.21 authorization.

772.22 (c) Except as provided in subdivision 13j, prior authorization shall not be required or
772.23 utilized for any atypical antipsychotic drug prescribed for the treatment of mental illness
772.24 if:

772.25 (1) there is no generically equivalent drug available; and

772.26 (2) the drug was initially prescribed for the recipient prior to July 1, 2003; or

772.27 (3) the drug is part of the recipient's current course of treatment.

772.28 This paragraph applies to any multistate preferred drug list or supplemental drug rebate
772.29 program established or administered by the commissioner. Prior authorization shall
772.30 automatically be granted for 60 days for brand name drugs prescribed for treatment of mental
772.31 illness within 60 days of when a generically equivalent drug becomes available, provided

773.1 that the brand name drug was part of the recipient's course of treatment at the time the
773.2 generically equivalent drug became available.

773.3 (d) Prior authorization shall not be required or utilized for any antihemophilic factor
773.4 drug prescribed for the treatment of hemophilia and blood disorders where there is no
773.5 generically equivalent drug available if the prior authorization is used in conjunction with
773.6 any supplemental drug rebate program or multistate preferred drug list established or
773.7 administered by the commissioner.

773.8 (e) The commissioner may require prior authorization for brand name drugs whenever
773.9 a generically equivalent product is available, even if the prescriber specifically indicates
773.10 "dispense as written-brand necessary" on the prescription as required by section 151.21,
773.11 subdivision 2.

773.12 (f) Notwithstanding this subdivision, the commissioner may automatically require prior
773.13 authorization, for a period not to exceed 180 days, for any drug that is approved by the
773.14 United States Food and Drug Administration on or after July 1, 2005. The 180-day period
773.15 begins no later than the first day that a drug is available for shipment to pharmacies within
773.16 the state. The Formulary Committee shall recommend to the commissioner general criteria
773.17 to be used for the prior authorization of the drugs, but the committee is not required to
773.18 review each individual drug. In order to continue prior authorizations for a drug after the
773.19 180-day period has expired, the commissioner must follow the provisions of this subdivision.

773.20 (g) Any step therapy protocol requirements established by the commissioner must comply
773.21 with section 62Q.1841.

773.22 **EFFECTIVE DATE.** This section is effective January 1, 2020.

773.23 Sec. 38. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision
773.24 to read:

773.25 **Subd. 66. Coverage for treatment of pediatric autoimmune neuropsychiatric**
773.26 **disorders associated with streptococcal infections (PANDAS) and pediatric acute-onset**
773.27 **neuropsychiatric syndrome (PANS).** Medical assistance covers treatment of pediatric
773.28 autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS)
773.29 and pediatric acute-onset neuropsychiatric syndrome (PANS). Coverage shall be developed
773.30 in collaboration with the Health Services Policy Committee established under subdivision
773.31 3c.

774.1 Sec. 39. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision
774.2 to read:

774.3 Subd. 67. Ectodermal dysplasias. Medical assistance covers the following services for
774.4 the treatment of ectodermal dysplasias:

774.5 (1) scalp hair prosthesis;

774.6 (2) breast reconstruction surgery; and

774.7 (3) dental services, including bone grafts, dental implants, orthodontia, dental
774.8 prosthodontics, and dental maintenance.

774.9 **EFFECTIVE DATE.** This section is effective January 1, 2020.

774.10 Sec. 40. Minnesota Statutes 2018, section 256B.69, is amended by adding a subdivision
774.11 to read:

774.12 Subd. 6e. Access standards; appointment wait times. Managed care and county-based
774.13 purchasing plans must comply with the access standards for emergency care and appointment
774.14 wait times specified in section 62D.124, subdivisions 1, paragraph (b), and 2, paragraphs
774.15 (b) and (c).

774.16 **EFFECTIVE DATE.** This section is effective for managed care and county-based
774.17 purchasing contracts entered into on or after January 1, 2020.

774.18 Sec. 41. Minnesota Statutes 2018, section 256L.121, subdivision 3, is amended to read:

774.19 Subd. 3. **Coordination with state-administered health programs.** The commissioner
774.20 shall coordinate the administration of the MinnesotaCare program with medical assistance
774.21 to maximize efficiency and improve the continuity of care. This includes, but is not limited
774.22 to:

774.23 (1) establishing geographic areas for MinnesotaCare that are consistent with the
774.24 geographic areas of the medical assistance program, within which participating entities may
774.25 offer health plans;

774.26 (2) requiring, as a condition of participation in MinnesotaCare, participating entities to
774.27 also participate in the medical assistance program;

774.28 (3) complying with sections 256B.69, subdivision 3a; 256B.692, subdivision 1; and
774.29 256B.694, when contracting with MinnesotaCare participating entities;

775.1 (4) providing MinnesotaCare enrollees, to the extent possible, with the option to remain
 775.2 in the same health plan and provider network, if they later become eligible for medical
 775.3 assistance or coverage through MNsure and if, in the case of becoming eligible for medical
 775.4 assistance, the enrollee's MinnesotaCare health plan is also a medical assistance health plan
 775.5 in the enrollee's county of residence; ~~and~~

775.6 (5) establishing requirements and criteria for selection that ensure that covered health
 775.7 care services will be coordinated with local public health services, social services, long-term
 775.8 care services, mental health services, and other local services affecting enrollees' health,
 775.9 access, and quality of care; and

775.10 (6) complying with the appointment wait time standards specified in section 62D.124,
 775.11 subdivisions 1, paragraph (b), and 2, paragraphs (b) and (c).

775.12 **EFFECTIVE DATE.** This section is effective for managed care, county-based
 775.13 purchasing, and participating entity contracts entered into on or after January 1, 2020.

775.14 Sec. 42. Minnesota Statutes 2018, section 317A.811, is amended by adding a subdivision
 775.15 to read:

775.16 **Subd. 1a. Nonprofit health care entity; notice and approval required.** In addition to
 775.17 the requirements of subdivision 1, a nonprofit health care entity as defined in section 317B.01,
 775.18 subdivision 12, is subject to the notice and approval requirements for certain transactions
 775.19 under chapter 317B.

775.20 Sec. 43. **[317B.01] NONPROFIT HEALTH CARE ENTITY CONVERSIONS;**
 775.21 **DEFINITIONS.**

775.22 **Subdivision 1. Application.** The definitions in this section apply to this chapter.

775.23 **Subd. 2. Commissioner.** "Commissioner" means the commissioner of commerce for a
 775.24 nonprofit health care entity that is a nonprofit health service plan corporation operating
 775.25 under chapter 62C, or the commissioner of health for a nonprofit health care entity that is
 775.26 a nonprofit health maintenance organization operating under chapter 62D.

775.27 **Subd. 3. Conversion benefit entity.** "Conversion benefit entity" means a foundation,
 775.28 corporation, limited liability company, trust, partnership, or other entity that receives, in
 775.29 connection with a conversion transaction, the value of any public benefit assets, in accordance
 775.30 with section 317B.02, subdivision 7.

776.1 Subd. 4. **Conversion transaction or transaction.** "Conversion transaction" or
776.2 "transaction" means a transaction otherwise permitted by applicable law in which a nonprofit
776.3 health care entity:

776.4 (1) merges, consolidates, converts, or transfers all or a material amount of its assets to
776.5 any entity except a corporation that is also exempt under United States Code, title 26, section
776.6 501(c)(3);

776.7 (2) makes a series of separate transfers within a 24-month period that in the aggregate
776.8 constitute a transfer of all or a material amount of the nonprofit health care entity's assets
776.9 to any entity except a corporation that is also exempt under United States Code, title 26,
776.10 section 501(c)(3); or

776.11 (3) adds or substitutes one or more members that effectively transfers the control,
776.12 responsibility for, or governance of the nonprofit health care entity to any entity except a
776.13 corporation that is also exempt under United States Code, title 26, section 501(c)(3).

776.14 Subd. 5. **Corporation.** "Corporation" has the meaning given in section 317A.011,
776.15 subdivision 6, and also includes a nonprofit limited liability company organized under
776.16 section 322C.1101.

776.17 Subd. 6. **Director.** "Director" has the meaning given in section 317A.011, subdivision
776.18 7.

776.19 Subd. 7. **Family member.** "Family member" means a spouse, parent, child, spouse of
776.20 a child, brother, sister, or spouse of a brother or sister.

776.21 Subd. 8. **Full and fair value.** "Full and fair value" means the amount that the public
776.22 benefit assets of the nonprofit health care entity would be worth if the assets were equal to
776.23 stock in the nonprofit health care entity, if the nonprofit health care entity was a for-profit
776.24 corporation, and if the nonprofit health care entity had 100 percent of its stock authorized
776.25 by the corporation and available for purchase without transfer restrictions. The valuation
776.26 shall consider market value, investment or earning value, net asset value, goodwill, the
776.27 amount of donations received, and a control premium, if any.

776.28 Subd. 9. **Key employee.** "Key employee" means a person, regardless of title, who:

776.29 (1) has responsibilities, power, or influence over an organization similar to those of an
776.30 officer or director;

776.31 (2) manages a discrete segment or activity of the organization that represents ten percent
776.32 or more of the activities, assets, income, or expenses of the organization, as compared to
776.33 the organization as a whole; or

777.1 (3) has or shares authority to control or determine ten percent or more of the organization's
777.2 capital expenditures, operating budget, or compensation for employees.

777.3 Subd. 10. **Material amount.** "Material amount" means the lesser of ten percent of a
777.4 nonprofit health care entity's total net admitted assets as of December 31 of the preceding
777.5 year, or \$10,000,000.

777.6 Subd. 11. **Member.** "Member" has the meaning given in section 317A.011, subdivision
777.7 12.

777.8 Subd. 12. **Nonprofit health care entity.** "Nonprofit health care entity" means a nonprofit
777.9 health service plan corporation operating under chapter 62C, a nonprofit health maintenance
777.10 organization operating under chapter 62D, a corporation that can effectively exercise control
777.11 over a nonprofit health service plan corporation or a nonprofit health maintenance
777.12 organization, or any other entity that is effectively controlled by a corporation operating a
777.13 nonprofit health service plan corporation or a nonprofit health maintenance organization.

777.14 Subd. 13. **Officer.** "Officer" has the meaning given in section 317A.011, subdivision
777.15 15.

777.16 Subd. 14. **Public benefit assets.** "Public benefit assets" means the entirety of a nonprofit
777.17 health care entity's assets, whether tangible or intangible, including but not limited to its
777.18 goodwill and anticipated future revenue.

777.19 Subd. 15. **Related organization.** "Related organization" has the meaning given in section
777.20 317A.011, subdivision 18.

777.21 Sec. 44. **[317B.02] NONPROFIT HEALTH CARE ENTITY CONVERSION**
777.22 **TRANSACTIONS; REVIEW, NOTICE, APPROVAL.**

777.23 Subdivision 1. **Certain conversion transactions prohibited.** A nonprofit health care
777.24 entity shall not enter into a conversion transaction if a person who has been an officer,
777.25 director, or key employee of the nonprofit health care entity or of a related organization, or
777.26 a family member of such a person:

777.27 (1) has received or will receive any type of compensation or other financial benefit,
777.28 directly or indirectly, in connection with the conversion transaction;

777.29 (2) has held or will hold, whether guaranteed or contingent, an ownership stake, stock,
777.30 securities, investment, or other financial interest in an entity to which the nonprofit health
777.31 care entity transfers public benefit assets in connection with the conversion transaction;

778.1 (3) has received or will receive any type of compensation or other financial benefit from
778.2 an entity to which the nonprofit health care entity transfers public benefit assets in connection
778.3 with a conversion transaction;

778.4 (4) has held or will hold, whether guaranteed or contingent, an ownership stake, stock,
778.5 securities, investment, or other financial interest in an entity that has or will have a business
778.6 relationship with an entity to which the nonprofit health care entity transfers public benefit
778.7 assets in connection with the conversion transaction; or

778.8 (5) has received or will receive any type of compensation or other financial benefit from
778.9 an entity that has or will have a business relationship with an entity to which the nonprofit
778.10 health care entity transfers public benefit assets in connection with the conversion transaction.

778.11 Subd. 2. **Attorney general notice required.** (a) Before entering into a conversion
778.12 transaction, a nonprofit health care entity must notify the attorney general according to
778.13 section 317A.811. In addition to the elements listed in section 317A.811, subdivision 1, the
778.14 notice required by this subdivision must also include an itemization of the nonprofit health
778.15 care entity's public benefit assets and the valuation the nonprofit health care entity attributes
778.16 to those assets; a proposed plan for the distribution of the value of those assets to a conversion
778.17 benefit entity that meets the requirements of subdivision 4; and other information from the
778.18 nonprofit health care entity or the proposed conversion benefit entity that the attorney general
778.19 reasonably considers necessary to review the proposed conversion transaction under
778.20 subdivision 3.

778.21 (b) At the time the nonprofit health care entity provides the attorney general with the
778.22 notice and other information required under this subdivision, the nonprofit health care entity
778.23 must also provide a copy of the notice and other information required under this subdivision
778.24 to the commissioner. If the attorney general requests additional information from a nonprofit
778.25 health care entity in connection with its review of a proposed conversion transaction, the
778.26 nonprofit health care entity must also provide a copy of this information to the commissioner,
778.27 at the time this information is provided to the attorney general.

778.28 Subd. 3. **Review elements.** (a) The attorney general may approve, conditionally approve,
778.29 or disapprove a proposed conversion transaction under this section. In determining whether
778.30 to approve, conditionally approve, or disapprove a proposed transaction, the attorney general,
778.31 in consultation with the commissioner, shall consider any factors the attorney general
778.32 considers relevant in evaluating whether the proposed transaction is in the public interest,
778.33 including whether:

- 779.1 (1) the proposed transaction complies with chapters 317A and 501B and other applicable
779.2 laws;
- 779.3 (2) the proposed transaction involves or constitutes a breach of charitable trust;
- 779.4 (3) the nonprofit health care entity will receive full and fair value for its public benefit
779.5 assets;
- 779.6 (4) the value of the public benefit assets to be transferred has been manipulated in a
779.7 manner that causes or has caused the value of the assets to decrease;
- 779.8 (5) the proceeds of the proposed transaction will be used in a manner consistent with
779.9 the public benefit for which the assets are held by the nonprofit health care entity;
- 779.10 (6) the proposed transaction will result in a breach of fiduciary duty, as determined by
779.11 the attorney general, including whether:
- 779.12 (i) conflicts of interest exist related to payments to or benefits conferred upon officers,
779.13 directors, or key employees of the nonprofit health care entity or a related organization;
- 779.14 (ii) the nonprofit health care entity's directors exercised reasonable care and due diligence
779.15 in deciding to pursue the transaction, in selecting the entity with which to pursue the
779.16 transaction, and in negotiating the terms and conditions of the transaction; and
- 779.17 (iii) the nonprofit health care entity's directors considered all reasonably viable
779.18 alternatives, including any competing offers for its public benefit assets, or alternative
779.19 transactions;
- 779.20 (7) the transaction will result in financial benefit to a person, including owners, directors,
779.21 officers, or key employees of the nonprofit health care entity or of the entity to which the
779.22 nonprofit health care entity proposes to transfer public benefit assets;
- 779.23 (8) the conversion benefit entity meets the requirements in subdivision 4; and
- 779.24 (9) the attorney general and the commissioner have been provided with sufficient
779.25 information by the nonprofit health care entity to adequately evaluate the proposed transaction
779.26 and its effects on the public and enrollees, provided the attorney general or commissioner
779.27 has notified the nonprofit health care entity or the proposed conversion benefit entity if the
779.28 information provided is insufficient and has provided the nonprofit health care entity or
779.29 proposed conversion benefit entity with a reasonable opportunity to remedy that insufficiency.
- 779.30 (b) In addition to the elements in paragraph (a), the attorney general shall also consider
779.31 public comments received under subdivision 5 regarding the proposed conversion transaction

780.1 and the proposed transaction's likely effect on the availability, accessibility, and affordability
780.2 of health care services to the public.

780.3 (c) In deciding whether to approve, conditionally approve, or disapprove a transaction,
780.4 the attorney general must consult with the commissioner.

780.5 Subd. 4. **Conversion benefit entity requirements.** (a) A conversion benefit entity shall:

780.6 (1) be an existing or new, domestic, nonprofit corporation operating under chapter 317A
780.7 and exempt under United States Code, title 26, section 501(c)(3);

780.8 (2) have in place procedures and policies to prohibit conflicts of interest, including but
780.9 not limited to conflicts of interest relating to any grant-making activities that may benefit:

780.10 (i) the directors, officers, or key employees of the conversion benefit entity;

780.11 (ii) any entity to which the nonprofit health care entity transfers public benefit assets in
780.12 connection with a conversion transaction; or

780.13 (iii) any directors, officers, or key employees of an entity to which the nonprofit health
780.14 care entity transfers public benefit assets in connection with a conversion transaction;

780.15 (3) operate to benefit the health of the people of this state; and

780.16 (4) have in place procedures and policies that prohibit:

780.17 (i) an officer, director, or key employee of the nonprofit health care entity from serving
780.18 as an officer, director, or key employee of the conversion benefit entity for the five-year
780.19 period following the conversion transaction;

780.20 (ii) an officer, director, or key employee of the nonprofit health care entity or of the
780.21 conversion benefit entity from directly or indirectly benefiting from the conversion
780.22 transaction; and

780.23 (iii) elected or appointed public officials from serving as an officer, director, or key
780.24 employee of the conversion benefit entity.

780.25 (b) A conversion benefit entity shall not make grants or payments or otherwise provide
780.26 financial benefit to an entity to which a nonprofit health care entity transfers public benefit
780.27 assets as part of a conversion transaction, or to a related organization of the entity to which
780.28 the nonprofit health care entity transfers public benefit assets as part of a conversion
780.29 transaction.

781.1 (c) No person who has been an officer, director, or key employee of an entity that has
781.2 received public benefit assets in connection with a conversion transaction may serve as an
781.3 officer, director, or key employee of the conversion benefit entity.

781.4 (d) The attorney general must review and approve the governance structure of a
781.5 conversion benefit entity before the conversion benefit entity receives the value of public
781.6 benefit assets from a nonprofit health care entity. In order to be approved by the attorney
781.7 general under this paragraph, the conversion benefit entity's governance must be broadly
781.8 based in the community served by the nonprofit health care entity and must be independent
781.9 of the entity to which the nonprofit health care entity transfers public benefit assets as part
781.10 of the conversion transaction. As part of the review of the conversion benefit entity's
781.11 governance, the attorney general shall hold a public hearing. If the attorney general finds
781.12 it necessary, a portion of the value of the public benefit assets shall be used to develop a
781.13 community-based plan for use by the conversion benefit entity.

781.14 (e) The attorney general shall establish a community advisory committee for a conversion
781.15 benefit entity receiving the value of public benefit assets. The members of the community
781.16 advisory committee must be selected to represent the diversity of the community previously
781.17 served by the nonprofit health care entity. The community advisory committee shall:

781.18 (1) provide a slate of three nominees for each vacancy on the governing board of the
781.19 conversion benefit entity, from which the remaining board members shall select new members
781.20 to the board;

781.21 (2) provide the governing board with guidance on the health needs of the community
781.22 previously served by the nonprofit health care entity; and

781.23 (3) promote dialogue and information sharing between the conversion benefit entity and
781.24 the community previously served by the nonprofit health care entity.

781.25 **Subd. 5. Hearing; public comment; maintenance of record.** (a) Before issuing a
781.26 decision under subdivision 6, the attorney general shall hold one or more hearings and solicit
781.27 public comments regarding the proposed conversion transaction. No later than 45 days after
781.28 the attorney general receives notice of a proposed conversion transaction, the attorney
781.29 general shall hold at least one public hearing in the area served by the nonprofit health care
781.30 entity, and shall hold as many hearings as necessary in various parts of the state to ensure
781.31 that each community in the nonprofit health care entity's service area has an opportunity to
781.32 provide comments on the conversion transaction. Any person may appear and speak at the
781.33 hearing, file written comments, or file exhibits for the hearing. At least 14 days before the
781.34 hearing, the attorney general shall provide written notice of the hearing through posting on

782.1 the attorney general's website, publication in one or more newspapers of general circulation,
782.2 and notice by means of a public listserv or through other means to all persons who request
782.3 notice from the attorney general of such hearings. A public hearing is not required if the
782.4 waiting period under subdivision 6 is waived or is shorter than 45 days in duration. The
782.5 attorney general may also solicit public comments through other means.

782.6 (b) The attorney general shall develop and maintain a summary of written and oral public
782.7 comments made at a hearing and otherwise received by the attorney general, shall record
782.8 all questions posed during the public hearing or received by the attorney general, and shall
782.9 require answers from the appropriate parties. The summary materials, questions, and answers
782.10 shall be maintained on the attorney general's website, and the attorney general must provide
782.11 a copy of these materials at no cost to any person who requests them.

782.12 Subd. 6. **Approval required; period for approval or disapproval; extension.** (a)
782.13 Notwithstanding the time periods in section 15.99 or 317A.811, a nonprofit health care
782.14 entity shall not enter into a conversion transaction until:

782.15 (1) 150 days after the entity has given written notice to the attorney general, unless the
782.16 attorney general waives all or a part of the waiting period. The attorney general shall establish
782.17 guidelines for when the attorney general may waive all or part of the waiting period, and
782.18 must provide public notice if the attorney general waives all or part of the waiting period;
782.19 and

782.20 (2) the nonprofit health care entity obtains approval of the transaction from the attorney
782.21 general, or obtains conditional approval from the attorney general and satisfies the required
782.22 conditions.

782.23 (b) During the waiting period, the attorney general shall decide whether to approve,
782.24 conditionally approve, or disapprove the conversion transaction and shall notify the nonprofit
782.25 health care entity in writing of the attorney general's decision. If the transaction is
782.26 disapproved, the notice must include the reasons for the decision. If the transaction is
782.27 conditionally approved, the notice must specify the conditions that must be met and the
782.28 reasons for these conditions. The attorney general may extend the waiting period for an
782.29 additional 90 days by notifying the nonprofit health care entity of the extension in writing.

782.30 (c) The time periods under this subdivision shall be suspended while a request from the
782.31 attorney general for additional information is outstanding.

782.32 Subd. 7. **Transfer of value of assets required.** If a proposed conversion transaction is
782.33 approved or conditionally approved by the attorney general, the nonprofit health care entity

783.1 shall transfer the entirety of the full and fair value of its public benefit assets to one or more
783.2 conversion benefit entities as part of the transaction.

783.3 Subd. 8. **Assessment of costs.** (a) The nonprofit health care entity must reimburse the
783.4 attorney general or a state agency for all reasonable and actual costs incurred by the attorney
783.5 general or the state agency in reviewing the proposed conversion transaction and in exercising
783.6 enforcement remedies under this section. Costs incurred may include attorney fees at the
783.7 rate at which the attorney general bills state agencies; costs for retaining actuarial, valuation,
783.8 or other experts and consultants; and administrative costs. In order to receive reimbursement
783.9 under this subdivision, the attorney general or state agency must provide the nonprofit health
783.10 care entity with a statement of costs incurred.

783.11 (b) The nonprofit health care entity must remit the total amount listed on the statement
783.12 to the attorney general or state agency within 30 days after the statement date, unless the
783.13 entity disputes some or all of the submitted costs. The nonprofit health care entity may
783.14 dispute the submitted costs by bringing an action in district court to have the court determine
783.15 the amount of the reasonable and actual costs that must be remitted.

783.16 (c) Money remitted to the attorney general or state agency under this subdivision shall
783.17 be deposited in the general fund in the state treasury and is appropriated to the attorney
783.18 general or state agency, as applicable, to reimburse the attorney general or state agency for
783.19 costs paid or incurred under this section.

783.20 Subd. 9. **Challenge to disapproval or conditional approval.** If the attorney general
783.21 disapproves or conditionally approves a conversion transaction, a nonprofit health care
783.22 entity may bring an action in district court to challenge the disapproval, or any condition
783.23 of a conditional approval, as applicable. To prevail in such an action, the nonprofit health
783.24 care entity must clearly establish that the disapproval, or each condition being challenged,
783.25 as applicable, is arbitrary and capricious and unnecessary to protect the public interest.

783.26 Subd. 10. **Penalties; remedies.** The attorney general is authorized to bring an action to
783.27 unwind a conversion transaction entered into in violation of this section and to recover the
783.28 amount of any financial benefit received or held in violation of subdivision 1. In addition
783.29 to this recovery, the officers, directors, and key employees of each entity that is a party to,
783.30 and who materially participated in, the transaction entered into in violation of this section,
783.31 may be subject to a civil penalty of up to the greater of the entirety of any financial benefit
783.32 each officer, director, or key employee derived from the transaction or \$1,000,000, as
783.33 determined by the court. The attorney general is authorized to enforce this section under
783.34 section 8.31.

784.1 Subd. 11. **Relation to other law.** (a) This section is in addition to, and does not affect
 784.2 or limit any power, remedy, or responsibility of a health maintenance organization, a service
 784.3 plan corporation, a conversion benefit entity, the attorney general, the commissioner of
 784.4 commerce, or commissioner of health under chapter 62C, 62D, 317A, or 501B, or other
 784.5 law.

784.6 (b) Nothing in this section authorizes a nonprofit health care entity to enter into a
 784.7 conversion transaction not otherwise permitted under chapter 317A or 501B or other law.

784.8 Sec. 45. Laws 2017, First Special Session chapter 6, article 5, section 11, is amended to
 784.9 read:

784.10 Sec. 11. **MORATORIUM ON CONVERSION TRANSACTIONS.**

784.11 (a) Notwithstanding Laws 2017, chapter 2, article 2, a nonprofit ~~health~~ service plan
 784.12 corporation operating under Minnesota Statutes, chapter 62C, ~~or~~; a nonprofit health
 784.13 maintenance organization operating under Minnesota Statutes, chapter 62D, as of January
 784.14 1, 2017~~;~~; or a direct or indirect parent, subsidiary, or other affiliate of such an entity, may
 784.15 only merge or consolidate with; ~~or~~ convert~~;~~; or transfer, as part of a single transaction or a
 784.16 series of transactions within a 24-month period, all or a ~~substantial portion~~ material amount
 784.17 of its assets to an entity that is a corporation organized under Minnesota Statutes, chapter
 784.18 317A. For purposes of this section, "material amount" means the lesser of ten percent of
 784.19 such an entity's total net admitted assets as of December 31 of the preceding year, or
 784.20 \$10,000,000.

784.21 (b) Paragraph (a) does not apply if the nonprofit service plan corporation or nonprofit
 784.22 health maintenance organization files an intent to dissolve due to insolvency of the
 784.23 corporation in accordance with Minnesota Statutes, chapter 317A, or insolvency proceedings
 784.24 are commenced under Minnesota Statutes, chapter 60B.

784.25 (c) Nothing in this section shall be construed to authorize a nonprofit health maintenance
 784.26 organization or a nonprofit ~~health~~ service plan corporation to engage in any transaction or
 784.27 activities not otherwise permitted under state law.

784.28 (d) This section expires July 1, ~~2019~~ 2029.

784.29 **EFFECTIVE DATE.** This section is effective the day following final enactment.

784.30 Sec. 46. **FINDINGS.**

784.31 The Legislature of the state of Minnesota finds and declares that:

785.1 (1) nonprofit health care entities hold their assets in trust, and those assets are irrevocably
785.2 dedicated, as a condition of their tax-exempt status, to the specific charitable purpose set
785.3 forth in the articles of incorporation of the entities;

785.4 (2) the public is the beneficiary of that trust;

785.5 (3) nonprofit health care entities have a substantial and beneficial effect on the quality
785.6 of life of the people of Minnesota;

785.7 (4) transfers of assets by nonprofit health care entities to for-profit entities directly affect
785.8 the charitable uses of those assets and may adversely affect the public as the beneficiary of
785.9 the charitable assets;

785.10 (5) it is in the best interest of the public to ensure that the public interest is fully protected
785.11 whenever the assets or operations of a nonprofit health care entity are transferred, directly
785.12 or indirectly, from a charitable trust to a for-profit or mutual benefit entity; and

785.13 (6) the attorney general's approval of any transfers of assets or operations by a nonprofit
785.14 health care entity is necessary to ensure the protection of these trusts.

785.15 **Sec. 47. REPORT; DENIALS OF COVERAGE FOR TREATMENT FOR**
785.16 **PEDIATRIC AUTOIMMUNE NEUROPSYCHIATRIC DISORDERS ASSOCIATED**
785.17 **WITH STREPTOCOCCAL INFECTIONS (PANDAS) AND PEDIATRIC**
785.18 **ACUTE-ONSET NEUROPSYCHIATRIC SYNDROME (PANS).**

785.19 Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.

785.20 (b) "Health carrier" has the meaning given in Minnesota Statutes, section 62A.011,
785.21 subdivision 2.

785.22 (c) "Health plan" has the meaning given in Minnesota Statutes, section 62A.011,
785.23 subdivision 3.

785.24 (d) "Pediatric acute-onset neuropsychiatric syndrome" and "pediatric autoimmune
785.25 neuropsychiatric disorders associated with streptococcal infections" have the meanings
785.26 given in Minnesota Statutes, section 62A.3097, subdivision 1.

785.27 Subd. 2. **Report required.** (a) A health carrier that offers a health plan providing coverage
785.28 to Minnesota residents must report the following to the commissioner of health by October
785.29 1, 2019:

785.30 (1) the number of times the health carrier has denied coverage for treatment for pediatric
785.31 autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS)
785.32 or for treatment for pediatric acute-onset neuropsychiatric syndrome (PANS); and

786.1 (2) for each denial of coverage, the specific treatment for which coverage was denied.

786.2 (b) The commissioner of health must compile the information submitted under this
786.3 subdivision into a single report and must post that report to the department's website on or
786.4 before November 1, 2019. The posted report must identify each reporting health carrier and
786.5 must specify, for each carrier, the number of coverage denials for each specific treatment.

786.6 **EFFECTIVE DATE.** This section is effective the day following final enactment.

786.7 Sec. 48. **REVISOR INSTRUCTION.**

786.8 The revisor of statutes shall codify Laws 2017, First Special Session chapter 6, article
786.9 5, section 11, as amended by this act, in Minnesota Statutes, chapter 62D.

786.10 Sec. 49. **REPEALER.**

786.11 Minnesota Statutes 2018, section 62A.021, subdivisions 1 and 3, are repealed effective
786.12 the day following final enactment.

786.13

ARTICLE 14

786.14

RESIDENT RIGHTS AND CONSUMER PROTECTIONS

786.15 Section 1. **[144.6512] RETALIATION IN NURSING HOMES PROHIBITED.**

786.16 Subdivision 1. **Definitions.** For the purposes of this section:

786.17 (1) "nursing home" means a facility licensed as a nursing home under chapter 144A;

786.18 and

786.19 (2) "resident" means a person residing in a nursing home.

786.20 Subd. 2. **Retaliation prohibited.** A nursing home or agent of the nursing home may not
786.21 retaliate against a resident or employee if the resident, employee, or any person acting on
786.22 behalf of the resident:

786.23 (1) files a complaint or grievance, makes an inquiry, or asserts any right;

786.24 (2) indicates an intention to file a complaint or grievance, make an inquiry, or assert any
786.25 right;

786.26 (3) files or indicates an intention to file a maltreatment report, whether mandatory or
786.27 voluntary, under section 626.557;

786.28 (4) seeks assistance from or reports a reasonable suspicion of a crime or systemic
786.29 problems or concerns to the administrator or manager of the nursing home, the Office of

787.1 Ombudsman for Long-Term Care, a regulatory or other government agency, or a legal or
787.2 advocacy organization;

787.3 (5) advocates or seeks advocacy assistance for necessary or improved care or services
787.4 or enforcement of rights under this section or other law;

787.5 (6) takes or indicates an intention to take civil action;

787.6 (7) participates or indicates an intention to participate in any investigation or
787.7 administrative or judicial proceeding;

787.8 (8) contracts or indicates an intention to contract to receive services from a service
787.9 provider of the resident's choice other than the nursing home; or

787.10 (9) places or indicates an intention to place a camera or electronic monitoring device in
787.11 the resident's private space as provided under section 144J.05.

787.12 Subd. 3. **Retaliation against a resident.** For purposes of this section, to retaliate against
787.13 a resident includes but is not limited to any of the following actions taken or threatened by
787.14 a nursing home or an agent of the nursing home against a resident, or any person with a
787.15 familial, personal, legal, or professional relationship with the resident:

787.16 (1) the discharge, eviction, transfer, or termination of services;

787.17 (2) the imposition of discipline, punishment, or a sanction or penalty;

787.18 (3) any form of discrimination;

787.19 (4) restriction or prohibition of access:

787.20 (i) of the resident to the nursing home or visitors; or

787.21 (ii) to the resident by a family member or a person with a personal, legal, or professional
787.22 relationship with the resident;

787.23 (5) the imposition of involuntary seclusion or withholding food, care, or services;

787.24 (6) restriction of any of the rights granted to residents under state or federal law;

787.25 (7) restriction or reduction of access to or use of amenities, care, services, privileges, or
787.26 living arrangements;

787.27 (8) an arbitrary increase in charges or fees;

787.28 (9) removing, tampering with, or deprivation of technology, communication, or electronic
787.29 monitoring devices; or

788.1 (10) any oral or written communication of false information about a person advocating
788.2 on behalf of the resident.

788.3 Subd. 4. **Retaliation against an employee.** For purposes of this section, to retaliate
788.4 against an employee includes but is not limited to any of the following actions taken or
788.5 threatened by the nursing home or an agent of the nursing home against an employee:

788.6 (1) discharge or transfer;

788.7 (2) demotion or refusal to promote;

788.8 (3) reduction in compensation, benefits, or privileges;

788.9 (4) the unwarranted imposition of discipline, punishment, or a sanction or penalty; or

788.10 (5) any form of discrimination.

788.11 Subd. 5. **Rebuttable presumption of retaliation.** (a) Except as provided in paragraphs
788.12 (b), (c), and (d), there is a rebuttable presumption that any action described in subdivision
788.13 3 or 4 and taken within 90 days of an initial action described in subdivision 2 is retaliatory.

788.14 (b) The presumption does not apply to actions described in subdivision 3, clause (4), if
788.15 a good faith report of maltreatment pursuant to section 626.557 is made by the nursing home
788.16 or agent of the nursing home against the visitor, family member, or other person with a
788.17 personal, legal, or professional relationship that is subject to the restriction or prohibition
788.18 of access.

788.19 (c) The presumption does not apply to any oral or written communication described in
788.20 subdivision 3, clause (10), that is associated with a good faith report of maltreatment pursuant
788.21 to section 626.557 made by the nursing home or agent of the nursing home against the
788.22 person advocating on behalf of the resident.

788.23 (d) The presumption does not apply to a termination of a contract of admission, as that
788.24 term is defined under section 144.6501, subdivision 1, for a reason permitted under state
788.25 or federal law.

788.26 Subd. 6. **Remedy.** A resident who meets the criteria under section 325F.71, subdivision
788.27 1, has a cause of action under section 325F.71, subdivision 4, for the violation of this section,
788.28 unless the resident otherwise has a cause of action under section 626.557, subdivision 17.

788.29 **EFFECTIVE DATE.** This section is effective August 1, 2019.

788.30 Sec. 2. **[144G.07] RETALIATION PROHIBITED.**

788.31 Subdivision 1. **Definitions.** For the purposes of this section and section 144G.08:

789.1 (1) "facility" means a housing with services establishment registered under section
789.2 144D.02 and operating under title protection under this chapter; and

789.3 (2) "resident" means a resident of a facility.

789.4 Subd. 2. **Retaliation prohibited.** A facility or agent of the facility may not retaliate
789.5 against a resident or employee if the resident, employee, or any person on behalf of the
789.6 resident:

789.7 (1) files a complaint or grievance, makes an inquiry, or asserts any right;

789.8 (2) indicates an intention to file a complaint or grievance, make an inquiry, or assert any
789.9 right;

789.10 (3) files or indicates an intention to file a maltreatment report, whether mandatory or
789.11 voluntary, under section 626.557;

789.12 (4) seeks assistance from or reports a reasonable suspicion of a crime or systemic
789.13 problems or concerns to the administrator or manager of the facility, the Office of
789.14 Ombudsman for Long-Term Care, a regulatory or other government agency, or a legal or
789.15 advocacy organization;

789.16 (5) advocates or seeks advocacy assistance for necessary or improved care or services
789.17 or enforcement of rights under this section or other law;

789.18 (6) takes or indicates an intention to take civil action;

789.19 (7) participates or indicates an intention to participate in any investigation or
789.20 administrative or judicial proceeding;

789.21 (8) contracts or indicates an intention to contract to receive services from a service
789.22 provider of the resident's choice other than the facility; or

789.23 (9) places or indicates an intention to place a camera or electronic monitoring device in
789.24 the resident's private space as provided under section 144J.05.

789.25 Subd. 3. **Retaliation against a resident.** For purposes of this section, to retaliate against
789.26 a resident includes but is not limited to any of the following actions taken or threatened by
789.27 a facility or an agent of the facility against a resident, or any person with a familial, personal,
789.28 legal, or professional relationship with the resident:

789.29 (1) the discharge, eviction, transfer, or termination of services;

789.30 (2) the imposition of discipline, punishment, or a sanction or penalty;

789.31 (3) any form of discrimination;

- 790.1 (4) restriction or prohibition of access:
- 790.2 (i) of the resident to the facility or visitors; or
- 790.3 (ii) to the resident by a family member or a person with a personal, legal, or professional
- 790.4 relationship with the resident;
- 790.5 (5) the imposition of involuntary seclusion or withholding food, care, or services;
- 790.6 (6) restriction of any of the rights granted to residents under state or federal law;
- 790.7 (7) restriction or reduction of access to or use of amenities, care, services, privileges, or
- 790.8 living arrangements;
- 790.9 (8) an arbitrary increase in charges or fees;
- 790.10 (9) removing, tampering with, or deprivation of technology, communication, or electronic
- 790.11 monitoring devices; or
- 790.12 (10) any oral or written communication of false information about a person advocating
- 790.13 on behalf of the resident.

790.14 Subd. 4. **Retaliation against an employee.** For purposes of this section, to retaliate

790.15 against an employee includes but is not limited to any of the following actions taken or

790.16 threatened by the facility or an agent of the facility against an employee:

- 790.17 (1) discharge or transfer;
- 790.18 (2) demotion or refusal to promote;
- 790.19 (3) reduction in compensation, benefits, or privileges;
- 790.20 (4) the unwarranted imposition of discipline, punishment, or a sanction or penalty; or
- 790.21 (5) any form of discrimination.

790.22 Subd. 5. **Rebuttable presumption of retaliation.** (a) Except as provided in paragraphs

790.23 (b), (c), and (d), there is a rebuttable presumption that any action described in subdivision

790.24 3 or 4 and taken within 90 days of an initial action described in subdivision 2 is retaliatory.

790.25 (b) The presumption does not apply to actions described in subdivision 3, clause (4), if

790.26 a good faith report of maltreatment pursuant to section 626.557 is made by the facility or

790.27 agent of the facility against the visitor, family member, or other person with a personal,

790.28 legal, or professional relationship that is subject to the restriction or prohibition of access.

790.29 (c) The presumption does not apply to any oral or written communication described in

790.30 subdivision 3, clause (10), that is associated with a good faith report of maltreatment pursuant

791.1 to section 626.557 made by the facility or agent of the facility against the person advocating
791.2 on behalf of the resident.

791.3 (d) The presumption does not apply to a termination of a contract of admission, as that
791.4 term is defined under section 144.6501, subdivision 1, for a reason permitted under state
791.5 or federal law.

791.6 Subd. 6. **Remedy.** A resident who meets the criteria under section 325F.71, subdivision
791.7 1, has a cause of action under section 325F.71, subdivision 4, for the violation of this section,
791.8 unless the resident otherwise has a cause of action under section 626.557, subdivision 17.

791.9 **EFFECTIVE DATE.** This section is effective August 1, 2019, and expires July 31,
791.10 2021.

791.11 Sec. 3. **[144G.08] DECEPTIVE MARKETING AND BUSINESS PRACTICES**
791.12 **PROHIBITED.**

791.13 Subdivision 1. **Prohibitions.** (a) No employee or agent of any facility may make any
791.14 false, fraudulent, deceptive, or misleading statements or representations or material omissions
791.15 in marketing, advertising, or any other description or representation of care or services.

791.16 (b) No housing with services contract as required under section 144D.04, subdivision
791.17 1, may include any provision that the facility knows or should know to be deceptive,
791.18 unlawful, or unenforceable under state or federal law, nor include any provision that requires
791.19 or implies a lesser standard of care or responsibility than is required by law.

791.20 (c) No facility may advertise or represent that the facility has a dementia care unit without
791.21 complying with disclosure requirements under section 325F.72 and any training requirements
791.22 required by law or rule.

791.23 Subd. 2. **Remedies.** (a) A violation of this section constitutes a violation of section
791.24 325F.69, subdivision 1. The attorney general or a county attorney may enforce this section
791.25 using the remedies in section 325F.70.

791.26 (b) A resident who meets the criteria under section 325F.71, subdivision 1, has a cause
791.27 of action under section 325F.71, subdivision 4, for the violation of this section, unless the
791.28 resident otherwise has a cause of action under section 626.557, subdivision 17.

791.29 **EFFECTIVE DATE.** This section is effective August 1, 2019, and expires July 31,
791.30 2021.

792.1 Sec. 4. [144J.01] DEFINITIONS.

792.2 Subdivision 1. **Applicability.** For the purposes of this chapter, the following terms have
792.3 the meanings given them unless the context clearly indicates otherwise.

792.4 Subd. 2. **Assisted living contract.** "Assisted living contract" means the legal agreement
792.5 between a resident and an assisted living facility for housing and assisted living services.

792.6 Subd. 3. **Assisted living facility.** "Assisted living facility" has the meaning given in
792.7 section 144I.01, subdivision 6.

792.8 Subd. 4. **Assisted living facility with dementia care.** "Assisted living facility with
792.9 dementia care" has the meaning given in section 144I.01, subdivision 8.

792.10 Subd. 5. **Assisted living services.** "Assisted living services" has the meaning given in
792.11 section 144I.01, subdivision 7.

792.12 Subd. 6. **Attorney-in-fact.** "Attorney-in-fact" means a person designated by a principal
792.13 to exercise the powers granted by a written and valid power of attorney under chapter 523.

792.14 Subd. 7. **Conservator.** "Conservator" means a court-appointed conservator acting in
792.15 accordance with the powers granted to the conservator under chapter 524.

792.16 Subd. 8. **Designated representative.** "Designated representative" means a person
792.17 designated in writing by the resident in an assisted living contract and identified in the
792.18 resident's records on file with the assisted living facility.

792.19 Subd. 9. **Facility.** "Facility" means an assisted living facility.

792.20 Subd. 10. **Guardian.** "Guardian" means a court-appointed guardian acting in accordance
792.21 with the powers granted to the guardian under chapter 524.

792.22 Subd. 11. **Health care agent.** "Health care agent" has the meaning given in section
792.23 145C.01, subdivision 2.

792.24 Subd. 12. **Legal representative.** "Legal representative" means one of the following in
792.25 the order of priority listed, to the extent the person may reasonably be identified and located:

792.26 (1) a guardian;

792.27 (2) a conservator;

792.28 (3) a health care agent; or

792.29 (4) an attorney-in-fact.

792.30 Subd. 13. **Licensed health care professional.** "Licensed health care professional" means:

- 793.1 (1) a physician licensed under chapter 147;
- 793.2 (2) an advanced practice registered nurse, as that term is defined in section 148.171,
- 793.3 subdivision 3;
- 793.4 (3) a licensed practical nurse, as that term is defined in section 148.171, subdivision 8;
- 793.5 or
- 793.6 (4) a registered nurse, as that term is defined in section 148.171, subdivision 20.
- 793.7 Subd. 14. **Resident.** "Resident" means a person living in an assisted living facility.
- 793.8 Subd. 15. **Resident record.** "Resident record" has the meaning given in section 144I.01,
- 793.9 subdivision 53.
- 793.10 Subd. 16. **Service plan.** "Service plan" has the meaning given in section 144I.01,
- 793.11 subdivision 57.
- 793.12 **EFFECTIVE DATE.** This section is effective August 1, 2021.
- 793.13 Sec. 5. **[144J.02] RESIDENT RIGHTS.**
- 793.14 Subdivision 1. **Applicability.** This section applies to assisted living facility residents.
- 793.15 Subd. 2. **Legislative intent.** The rights established under this section for the benefit of
- 793.16 residents do not limit any other rights available under law. No facility may request or require
- 793.17 that any resident waive any of these rights at any time for any reason, including as a condition
- 793.18 of admission to the facility.
- 793.19 Subd. 3. **Information about rights and facility policies.** (a) Before receiving services,
- 793.20 residents have the right to be informed by the facility of the rights granted under this section.
- 793.21 The information must be in plain language and in terms residents can understand. The
- 793.22 facility must make reasonable accommodations for residents who have communication
- 793.23 disabilities and those who speak a language other than English.
- 793.24 (b) Every facility must:
- 793.25 (1) indicate what recourse residents have if their rights are violated; and
- 793.26 (2) provide the information required under section 144J.10.
- 793.27 (c) Upon request, residents and their legal representatives and designated representatives
- 793.28 have the right to copies of current facility policies and inspection findings of state and local
- 793.29 health authorities, and to receive further explanation of the rights provided under this section,
- 793.30 consistent with chapter 13 and section 626.557.

794.1 Subd. 4. **Courteous treatment.** Residents have the right to be treated with courtesy and
794.2 respect, and to have the resident's property treated with respect.

794.3 Subd. 5. **Appropriate care and services.** (a) Residents have the right to care and services
794.4 that are appropriate based on the resident's needs and according to an up-to-date service
794.5 plan. All service plans must be designed to enable residents to achieve their highest level
794.6 of emotional, psychological, physical, medical, and functional well-being and safety.

794.7 (b) Residents have the right to receive health care and other assisted living services with
794.8 continuity from people who are properly trained and competent to perform their duties and
794.9 in sufficient numbers to adequately provide the services agreed to in the assisted living
794.10 contract and the service plan.

794.11 Subd. 6. **Participation in care and service planning.** Residents have the right to actively
794.12 participate in the planning, modification, and evaluation of their care and services. This
794.13 right includes:

794.14 (1) the opportunity to discuss care, services, treatment, and alternatives with the
794.15 appropriate caregivers;

794.16 (2) the opportunity to request and participate in formal care conferences;

794.17 (3) the right to include a family member or the resident's health care agent and designated
794.18 representative, or both; and

794.19 (4) the right to be told in advance of, and take an active part in decisions regarding, any
794.20 recommended changes in the service plan.

794.21 Subd. 7. **Information about individuals providing services.** Before receiving services,
794.22 residents have the right to be told the type and disciplines of staff who will be providing
794.23 the services, the frequency of visits proposed to be furnished, and other choices that are
794.24 available for addressing the resident's needs.

794.25 Subd. 8. **Information about health care treatment.** Where applicable, residents have
794.26 the right to be given by their attending physician complete and current information concerning
794.27 their diagnosis, cognitive functioning level, treatment, alternatives, risks, and prognosis as
794.28 required by the physician's legal duty to disclose. This information must be in terms and
794.29 language the residents can reasonably be expected to understand. This information must
794.30 include the likely medical or major psychological results of the treatment and its alternatives.

794.31 Subd. 9. **Information about other providers and services.** (a) Residents have the right
794.32 to be informed by the assisted living facility, prior to executing an assisted living contract,
794.33 that other public and private services may be available and the resident has the right to

795.1 purchase, contract for, or obtain services from a provider other than the assisted living
795.2 facility or related assisted living services provider.

795.3 (b) Assisted living facilities must make every effort to assist residents in obtaining
795.4 information regarding whether Medicare, medical assistance, or another public program
795.5 will pay for any of the services.

795.6 Subd. 10. **Information about charges.** Before services are initiated, residents have the
795.7 right to be notified:

795.8 (1) of all charges for services;

795.9 (2) whether payment may be expected from health insurance, public programs, or other
795.10 sources, if known, and the amount of such payments; and

795.11 (3) what charges the resident may be responsible for paying.

795.12 Subd. 11. **Refusal of care or services.** (a) Residents have the right to refuse care or
795.13 services.

795.14 (b) A provider must document in the resident's record that the provider informed a
795.15 resident who refuses care, services, treatment, medication, or dietary restrictions of the
795.16 likely medical, health-related, or psychological consequences of the refusal.

795.17 (c) In cases where a resident lacks capacity but has not been adjudicated incompetent,
795.18 or when legal requirements limit the right to refuse medical treatment, the conditions and
795.19 circumstances must be fully documented by the attending physician in the resident's record.

795.20 Subd. 12. **Freedom from maltreatment.** Residents have the right to be free from
795.21 maltreatment. For the purposes of this subdivision, "maltreatment" means conduct described
795.22 in section 626.5572, subdivision 15, and includes the intentional and nontherapeutic infliction
795.23 of physical pain or injury, or any persistent course of conduct intended to produce mental
795.24 or emotional distress.

795.25 Subd. 13. **Personal and treatment privacy.** (a) Residents have the right to every
795.26 consideration of their privacy, individuality, and cultural identity as related to their social,
795.27 religious, and psychological well-being. Staff must respect the privacy of a resident's space
795.28 by knocking on the door and seeking consent before entering, except in an emergency or
795.29 where clearly inadvisable.

795.30 (b) Residents have the right to respect and privacy regarding the resident's health care
795.31 and personal care program. Case discussion, consultation, examination, and treatment are
795.32 confidential and must be conducted discreetly. Privacy must be respected during toileting,

796.1 bathing, and other activities of personal hygiene, except as needed for resident safety or
796.2 assistance.

796.3 Subd. 14. **Communication privacy.** (a) Residents have the right to communicate
796.4 privately with persons of their choice. Assisted living facilities that are unable to provide a
796.5 private area for communication must make reasonable arrangements to accommodate the
796.6 privacy of residents' communications.

796.7 (b) Personal mail must be sent by the assisted living facility without interference and
796.8 received unopened unless medically or programmatically contraindicated and documented
796.9 by a licensed health care professional listed in the resident's record.

796.10 (c) Residents must be provided access to a telephone to make and receive calls.

796.11 Subd. 15. **Confidentiality of records.** (a) Residents have the right to have personal,
796.12 financial, health, and medical information kept private, to approve or refuse release of
796.13 information to any outside party, and to be advised of the assisted living facility's policies
796.14 and procedures regarding disclosure of the information. Residents must be notified when
796.15 personal records are requested by any outside party.

796.16 (b) Residents have the right to access their own records and written information from
796.17 those records in accordance with sections 144.291 to 144.298.

796.18 Subd. 16. **Grievances and inquiries.** (a) Residents have the right to make and receive
796.19 a timely response to a complaint or inquiry, without limitation. Residents have the right to
796.20 know and every facility must provide the name and contact information of the person
796.21 representing the facility who is designated to handle and resolve complaints and inquiries.

796.22 (b) A facility must promptly investigate, make a good faith attempt to resolve, and
796.23 provide a timely response to the complaint or inquiry.

796.24 (c) Residents have the right to recommend changes in policies and services to staff and
796.25 managerial officials, as that term is defined in section 144I.01, subdivision 31.

796.26 Subd. 17. **Visitors and social participation.** (a) Residents have the right to meet with
796.27 or receive visits at any time by the resident's family, guardian, conservator, health care
796.28 agent, attorney, advocate, or religious or social work counselor, or any person of the resident's
796.29 choosing.

796.30 (b) Residents have the right to participate in commercial, religious, social, community,
796.31 and political activities without interference and at their discretion if the activities do not
796.32 infringe on the right to privacy of other residents.

797.1 Subd. 18. **Access to counsel and advocacy services.** Notwithstanding subdivision 15,
797.2 residents have the right to the immediate access by:

797.3 (1) the resident's legal counsel;

797.4 (2) any representative of the protection and advocacy system designated by the state
797.5 under Code of Federal Regulations, title 45, section 1326.21; or

797.6 (3) any representative of the Office of Ombudsman for Long-Term Care.

797.7 Subd. 19. **Right to come and go freely.** Residents have the right to enter and leave the
797.8 facility as they choose. This right may be restricted only as allowed by other law and
797.9 consistent with a resident's service plan.

797.10 Subd. 20. **Access to technology.** Residents have the right to access Internet service at
797.11 their expense, unless offered by the facility.

797.12 Subd. 21. **Resident councils.** Residents have the right to organize and participate in
797.13 resident councils. The facility must provide a resident council with space and privacy for
797.14 meetings, where doing so is reasonably achievable. Staff, visitors, or other guests may attend
797.15 resident council meetings only at the council's invitation. The facility must provide a
797.16 designated staff person who is approved by the resident council and the facility to be
797.17 responsible for providing assistance and responding to written requests that result from
797.18 meetings. The facility must consider the views of the resident council and must act promptly
797.19 upon the grievances and recommendations of the council, but a facility is not required to
797.20 implement as recommended every request of the council. The facility shall, with the approval
797.21 of the resident council, take reasonably achievable steps to make residents aware of upcoming
797.22 meetings in a timely manner.

797.23 Subd. 22. **Family councils.** Residents have the right to participate in family councils
797.24 formed by families or residents. The facility must provide a family council with space and
797.25 privacy for meetings, where doing so is reasonably achievable. The facility must provide a
797.26 designated staff person who is approved by the family council and the facility to be
797.27 responsible for providing assistance and responding to written requests that result from
797.28 meetings. The facility must consider the views of the family council and must act promptly
797.29 upon the grievances and recommendations of the council, but a facility is not required to
797.30 implement as recommended every request of the council. The facility shall, with the approval
797.31 of the family council, take reasonably achievable steps to make residents and family members
797.32 aware of upcoming meetings in a timely manner.

797.33 **EFFECTIVE DATE.** This section is effective August 1, 2019.

798.1 Sec. 6. [144J.03] RETALIATION PROHIBITED.

798.2 Subdivision 1. Retaliation prohibited. A facility or agent of a facility may not retaliate
798.3 against a resident or employee if the resident, employee, or any person acting on behalf of
798.4 the resident:

798.5 (1) files a complaint or grievance, makes an inquiry, or asserts any right;

798.6 (2) indicates an intention to file a complaint or grievance, make an inquiry, or assert any
798.7 right;

798.8 (3) files or indicates an intention to file a maltreatment report, whether mandatory or
798.9 voluntary, under section 626.557;

798.10 (4) seeks assistance from or reports a reasonable suspicion of a crime or systemic
798.11 problems or concerns to the administrator or manager of the facility, the Office of
798.12 Ombudsman for Long-Term Care, a regulatory or other government agency, or a legal or
798.13 advocacy organization;

798.14 (5) advocates or seeks advocacy assistance for necessary or improved care or services
798.15 or enforcement of rights under this section or other law;

798.16 (6) takes or indicates an intention to take civil action;

798.17 (7) participates or indicates an intention to participate in any investigation or
798.18 administrative or judicial proceeding;

798.19 (8) contracts or indicates an intention to contract to receive services from a service
798.20 provider of the resident's choice other than the facility; or

798.21 (9) places or indicates an intention to place a camera or electronic monitoring device in
798.22 the resident's private space as provided under section 144J.05.

798.23 Subd. 2. Retaliation against a resident. For purposes of this section, to retaliate against
798.24 a resident includes but is not limited to any of the following actions taken or threatened by
798.25 a facility or an agent of the facility against a resident, or any person with a familial, personal,
798.26 legal, or professional relationship with the resident:

798.27 (1) the discharge, eviction, transfer, or termination of services;

798.28 (2) the imposition of discipline, punishment, or a sanction or penalty;

798.29 (3) any form of discrimination;

798.30 (4) restriction or prohibition of access:

798.31 (i) of the resident to the facility or visitors; or

799.1 (ii) to the resident by a family member or a person with a personal, legal, or professional
 799.2 relationship with the resident;

799.3 (5) the imposition of involuntary seclusion or withholding food, care, or services;

799.4 (6) restriction of any of the rights granted to residents under state or federal law;

799.5 (7) restriction or reduction of access to or use of amenities, care, services, privileges, or
 799.6 living arrangements;

799.7 (8) an arbitrary increase in charges or fees;

799.8 (9) removing, tampering with, or deprivation of technology, communication, or electronic
 799.9 monitoring devices; or

799.10 (10) any oral or written communication of false information about a person advocating
 799.11 on behalf of the resident.

799.12 Subd. 3. **Retaliation against an employee.** For purposes of this section, to retaliate
 799.13 against an employee includes but is not limited to any of the following actions taken or
 799.14 threatened by the facility or an agent of the facility against an employee:

799.15 (1) discharge or transfer;

799.16 (2) demotion or refusal to promote;

799.17 (3) reduction in compensation, benefits, or privileges;

799.18 (4) the unwarranted imposition of discipline, punishment, or a sanction or penalty; or

799.19 (5) any form of discrimination.

799.20 Subd. 4. **Rebuttable presumption of retaliation.** (a) Except as provided in paragraphs
 799.21 (b), (c), and (d), there is a rebuttable presumption that any action described in subdivision
 799.22 2 or 3 and taken within 90 days of an initial action described in subdivision 1 is retaliatory.

799.23 (b) The presumption does not apply to actions described in subdivision 2, clause (4), if
 799.24 a good faith report of maltreatment pursuant to section 626.557 is made by the facility or
 799.25 agent of the facility against the visitor, family member, or other person with a personal,
 799.26 legal, or professional relationship that is subject to the restriction or prohibition of access.

799.27 (c) The presumption does not apply to any oral or written communication described in
 799.28 subdivision 2, clause (10), that is associated with a good faith report of maltreatment pursuant
 799.29 to section 626.557 made by the facility or agent of the facility against the person advocating
 799.30 on behalf of the resident.

800.1 (d) The presumption does not apply to a discharge, eviction, transfer, or termination of
800.2 services that occurs for a reason permitted under section 144J.08, subdivision 3 or 6, provided
800.3 the assisted living facility has complied with the applicable requirements in sections 144J.08
800.4 and 144.10.

800.5 Subd. 5. **Other laws.** Nothing in this section affects the rights available to a resident
800.6 under section 626.557.

800.7 **EFFECTIVE DATE.** This section is effective August 1, 2021.

800.8 Sec. 7. **[144J.04] DECEPTIVE MARKETING AND BUSINESS PRACTICES**
800.9 **PROHIBITED.**

800.10 (a) No employee or agent of any facility may make any false, fraudulent, deceptive, or
800.11 misleading statements or representations or material omissions in marketing, advertising,
800.12 or any other description or representation of care or services.

800.13 (b) No assisted living contract may include any provision that the facility knows or
800.14 should know to be deceptive, unlawful, or unenforceable under state or federal law, nor
800.15 include any provision that requires or implies a lesser standard of care or responsibility than
800.16 is required by law.

800.17 (c) No facility may advertise or represent that it is licensed as an assisted living facility
800.18 with dementia care without complying with disclosure requirements under section 325F.72
800.19 and any training requirements required under chapter 144I or in rule.

800.20 (d) A violation of this section constitutes a violation of section 325F.69, subdivision 1.
800.21 The attorney general or a county attorney may enforce this section using the remedies in
800.22 section 325F.70.

800.23 **EFFECTIVE DATE.** This section is effective August 1, 2021.

800.24 Sec. 8. **[144J.05] ELECTRONIC MONITORING IN CERTAIN FACILITIES.**

800.25 Subdivision 1. **Definitions.** (a) For the purposes of this section, the terms defined in this
800.26 subdivision have the meanings given.

800.27 (b) "Commissioner" means the commissioner of health.

800.28 (c) "Department" means the Department of Health.

800.29 (d) "Electronic monitoring" means the placement and use of an electronic monitoring
800.30 device by a resident in the resident's room or private living unit in accordance with this
800.31 section.

801.1 (e) "Electronic monitoring device" means a camera or other device that captures, records,
801.2 or broadcasts audio, video, or both, that is placed in a resident's room or private living unit
801.3 and is used to monitor the resident or activities in the room or private living unit.

801.4 (f) "Facility" means a facility that is:

801.5 (1) licensed as a nursing home under chapter 144A;

801.6 (2) licensed as a boarding care home under sections 144.50 to 144.56;

801.7 (3) until August 1, 2021, a housing with services establishment registered under chapter
801.8 144D that is either subject to chapter 144G or has a disclosed special unit under section
801.9 325F.72; or

801.10 (4) on or after August 1, 2021, an assisted living facility.

801.11 (g) "Resident" means a person 18 years of age or older residing in a facility.

801.12 (h) "Resident representative" means one of the following in the order of priority listed,
801.13 to the extent the person may reasonably be identified and located:

801.14 (1) a court-appointed guardian;

801.15 (2) a health care agent as defined in section 145C.01, subdivision 2; or

801.16 (3) a person who is not an agent of a facility or of a home care provider designated in
801.17 writing by the resident and maintained in the resident's records on file with the facility or
801.18 with the resident's executed housing with services contract or nursing home contract.

801.19 **Subd. 2. Electronic monitoring authorized.** (a) A resident or a resident representative
801.20 may conduct electronic monitoring of the resident's room or private living unit through the
801.21 use of electronic monitoring devices placed in the resident's room or private living unit as
801.22 provided in this section.

801.23 (b) Nothing in this section precludes the use of electronic monitoring of health care
801.24 allowed under other law.

801.25 (c) Electronic monitoring authorized under this section is not a covered service under
801.26 home and community-based waivers under sections 256B.0913, 256B.0915, 256B.092, and
801.27 256B.49.

801.28 (d) This section does not apply to monitoring technology authorized as a home and
801.29 community-based service under section 256B.0913, 256B.0915, 256B.092, or 256B.49.

801.30 **Subd. 3. Consent to electronic monitoring.** (a) Except as otherwise provided in this
801.31 subdivision, a resident must consent to electronic monitoring in the resident's room or private

802.1 living unit in writing on a notification and consent form. If the resident has not affirmatively
802.2 objected to electronic monitoring and the resident's medical professional determines that
802.3 the resident currently lacks the ability to understand and appreciate the nature and
802.4 consequences of electronic monitoring, the resident representative may consent on behalf
802.5 of the resident. For purposes of this subdivision, a resident affirmatively objects when the
802.6 resident orally, visually, or through the use of auxiliary aids or services declines electronic
802.7 monitoring. The resident's response must be documented on the notification and consent
802.8 form.

802.9 (b) Prior to a resident representative consenting on behalf of a resident, the resident must
802.10 be asked if the resident wants electronic monitoring to be conducted. The resident
802.11 representative must explain to the resident:

802.12 (1) the type of electronic monitoring device to be used;

802.13 (2) the standard conditions that may be placed on the electronic monitoring device's use,
802.14 including those listed in subdivision 6;

802.15 (3) with whom the recording may be shared under subdivision 10 or 11; and

802.16 (4) the resident's ability to decline all recording.

802.17 (c) A resident, or resident representative when consenting on behalf of the resident, may
802.18 consent to electronic monitoring with any conditions of the resident's or resident
802.19 representative's choosing, including the list of standard conditions provided in subdivision
802.20 6. A resident, or resident representative when consenting on behalf of the resident, may
802.21 request that the electronic monitoring device be turned off or the visual or audio recording
802.22 component of the electronic monitoring device be blocked at any time.

802.23 (d) Prior to implementing electronic monitoring, a resident, or resident representative
802.24 when acting on behalf of the resident, must obtain the written consent on the notification
802.25 and consent form of any other resident residing in the shared room or shared private living
802.26 unit. A roommate's or roommate's resident representative's written consent must comply
802.27 with the requirements of paragraphs (a) to (c). Consent by a roommate or a roommate's
802.28 resident representative under this paragraph authorizes the resident's use of any recording
802.29 obtained under this section, as provided under subdivision 10 or 11.

802.30 (e) Any resident conducting electronic monitoring must immediately remove or disable
802.31 an electronic monitoring device prior to a new roommate moving into a shared room or
802.32 shared private living unit, unless the resident obtains the roommate's or roommate's resident
802.33 representative's written consent as provided under paragraph (d) prior to the roommate

803.1 moving into the shared room or shared private living unit. Upon obtaining the new
803.2 roommate's signed notification and consent form and submitting the form to the facility as
803.3 required under subdivision 5, the resident may resume electronic monitoring.

803.4 (f) The resident or roommate, or the resident representative or roommate's resident
803.5 representative if the representative is consenting on behalf of the resident or roommate, may
803.6 withdraw consent at any time and the withdrawal of consent must be documented on the
803.7 original consent form as provided under subdivision 5, paragraph (d).

803.8 Subd. 4. **Refusal of roommate to consent.** If a resident of a facility who is residing in
803.9 a shared room or shared living unit, or the resident representative of such a resident when
803.10 acting on behalf of the resident, wants to conduct electronic monitoring and another resident
803.11 living in or moving into the same shared room or shared living unit refuses to consent to
803.12 the use of an electronic monitoring device, the facility shall make a reasonable attempt to
803.13 accommodate the resident who wants to conduct electronic monitoring. A facility has met
803.14 the requirement to make a reasonable attempt to accommodate a resident or resident
803.15 representative who wants to conduct electronic monitoring when, upon notification that a
803.16 roommate has not consented to the use of an electronic monitoring device in the resident's
803.17 room, the facility offers to move the resident to another shared room or shared living unit
803.18 that is available at the time of the request. If a resident chooses to reside in a private room
803.19 or private living unit in a facility in order to accommodate the use of an electronic monitoring
803.20 device, the resident must pay either the private room rate in a nursing home setting, or the
803.21 applicable rent in a housing with services establishment or assisted living facility. If a facility
803.22 is unable to accommodate a resident due to lack of space, the facility must reevaluate the
803.23 request every two weeks until the request is fulfilled. A facility is not required to provide
803.24 a private room, a single-bed room, or a private living unit to a resident who is unable to
803.25 pay.

803.26 Subd. 5. **Notice to facility; exceptions.** (a) Electronic monitoring may begin only after
803.27 the resident or resident representative who intends to place an electronic monitoring device
803.28 and any roommate or roommate's resident representative completes the notification and
803.29 consent form and submits the form to the facility.

803.30 (b) Notwithstanding paragraph (a), the resident or resident representative who intends
803.31 to place an electronic monitoring device may do so without submitting a notification and
803.32 consent form to the facility for up to 30 days:

803.33 (1) if the resident or the resident representative reasonably fears retaliation against the
803.34 resident by the facility, timely submits the completed notification and consent form to the

804.1 Office of Ombudsman for Long-Term Care, and timely submits a Minnesota Adult Abuse
804.2 Reporting Center report or police report, or both, upon evidence from the electronic
804.3 monitoring device that suspected maltreatment has occurred;

804.4 (2) if there has not been a timely written response from the facility to a written
804.5 communication from the resident or resident representative expressing a concern prompting
804.6 the desire for placement of an electronic monitoring device and if the resident or a resident
804.7 representative timely submits a completed notification and consent form to the Office of
804.8 Ombudsman for Long-Term Care; or

804.9 (3) if the resident or resident representative has already submitted a Minnesota Adult
804.10 Abuse Reporting Center report or police report regarding the resident's concerns prompting
804.11 the desire for placement and if the resident or a resident representative timely submits a
804.12 completed notification and consent form to the Office of Ombudsman for Long-Term Care.

804.13 (c) Upon receipt of any completed notification and consent form, the facility must place
804.14 the original form in the resident's file or file the original form with the resident's housing
804.15 with services contract. The facility must provide a copy to the resident and the resident's
804.16 roommate, if applicable.

804.17 (d) In the event that a resident or roommate, or the resident representative or roommate's
804.18 resident representative if the representative is consenting on behalf of the resident or
804.19 roommate, chooses to alter the conditions under which consent to electronic monitoring is
804.20 given or chooses to withdraw consent to electronic monitoring, the facility must make
804.21 available the original notification and consent form so that it may be updated. Upon receipt
804.22 of the updated form, the facility must place the updated form in the resident's file or file the
804.23 original form with the resident's signed housing with services contract. The facility must
804.24 provide a copy of the updated form to the resident and the resident's roommate, if applicable.

804.25 (e) If a new roommate, or the new roommate's resident representative when consenting
804.26 on behalf of the new roommate, does not submit to the facility a completed notification and
804.27 consent form and the resident conducting the electronic monitoring does not remove or
804.28 disable the electronic monitoring device, the facility must remove the electronic monitoring
804.29 device.

804.30 (f) If a roommate, or the roommate's resident representative when withdrawing consent
804.31 on behalf of the roommate, submits an updated notification and consent form withdrawing
804.32 consent and the resident conducting electronic monitoring does not remove or disable the
804.33 electronic monitoring device, the facility must remove the electronic monitoring device.

805.1 Subd. 6. Form requirements. (a) The notification and consent form completed by the
805.2 resident must include, at a minimum, the following information:

805.3 (1) the resident's signed consent to electronic monitoring or the signature of the resident
805.4 representative, if applicable. If a person other than the resident signs the consent form, the
805.5 form must document the following:

805.6 (i) the date the resident was asked if the resident wants electronic monitoring to be
805.7 conducted;

805.8 (ii) who was present when the resident was asked;

805.9 (iii) an acknowledgment that the resident did not affirmatively object; and

805.10 (iv) the source of authority allowing the resident representative to sign the notification
805.11 and consent form on the resident's behalf;

805.12 (2) the resident's roommate's signed consent or the signature of the roommate's resident
805.13 representative, if applicable. If a roommate's resident representative signs the consent form,
805.14 the form must document the following:

805.15 (i) the date the roommate was asked if the roommate wants electronic monitoring to be
805.16 conducted;

805.17 (ii) who was present when the roommate was asked;

805.18 (iii) an acknowledgment that the roommate did not affirmatively object; and

805.19 (iv) the source of authority allowing the resident representative to sign the notification
805.20 and consent form on the roommate's behalf;

805.21 (3) the type of electronic monitoring device to be used;

805.22 (4) a list of standard conditions or restrictions that the resident or a roommate may elect
805.23 to place on the use of the electronic monitoring device, including but not limited to:

805.24 (i) prohibiting audio recording;

805.25 (ii) prohibiting video recording;

805.26 (iii) prohibiting broadcasting of audio or video;

805.27 (iv) turning off the electronic monitoring device or blocking the visual recording
805.28 component of the electronic monitoring device for the duration of an exam or procedure by
805.29 a health care professional;

806.1 (v) turning off the electronic monitoring device or blocking the visual recording
806.2 component of the electronic monitoring device while dressing or bathing is performed; and

806.3 (vi) turning off the electronic monitoring device for the duration of a visit with a spiritual
806.4 adviser, ombudsman, attorney, financial planner, intimate partner, or other visitor;

806.5 (5) any other condition or restriction elected by the resident or roommate on the use of
806.6 an electronic monitoring device;

806.7 (6) a statement of the circumstances under which a recording may be disseminated under
806.8 subdivision 10;

806.9 (7) a signature box for documenting that the resident or roommate has withdrawn consent;
806.10 and

806.11 (8) an acknowledgment that the resident, in accordance with subdivision 3, consents to
806.12 the Office of Ombudsman for Long-Term Care and its representatives disclosing information
806.13 about the form. Disclosure under this clause shall be limited to:

806.14 (i) the fact that the form was received from the resident or resident representative;

806.15 (ii) if signed by a resident representative, the name of the resident representative and
806.16 the source of authority allowing the resident representative to sign the notification and
806.17 consent form on the resident's behalf; and

806.18 (iii) the type of electronic monitoring device placed.

806.19 (b) Facilities must make the notification and consent form available to the residents and
806.20 inform residents of their option to conduct electronic monitoring of their rooms or private
806.21 living unit.

806.22 (c) Notification and consent forms received by the Office of Ombudsman for Long-Term
806.23 Care are classified under section 256.9744.

806.24 Subd. 7. **Costs and installation.** (a) A resident or resident representative choosing to
806.25 conduct electronic monitoring must do so at the resident's own expense, including paying
806.26 purchase, installation, maintenance, and removal costs.

806.27 (b) If a resident chooses to place an electronic monitoring device that uses Internet
806.28 technology for visual or audio monitoring, the resident may be responsible for contracting
806.29 with an Internet service provider.

806.30 (c) The facility shall make a reasonable attempt to accommodate the resident's installation
806.31 needs, including allowing access to the facility's public-use Internet or Wi-Fi systems when

807.1 available for other public uses. A facility has the burden of proving that a requested
807.2 accommodation is not reasonable.

807.3 (d) All electronic monitoring device installations and supporting services must be
807.4 UL-listed.

807.5 Subd. 8. **Notice to visitors.** (a) A facility must post a sign at each facility entrance
807.6 accessible to visitors that states: "Electronic monitoring devices, including security cameras
807.7 and audio devices, may be present to record persons and activities."

807.8 (b) The facility is responsible for installing and maintaining the signage required in this
807.9 subdivision.

807.10 Subd. 9. **Obstruction of electronic monitoring devices.** (a) A person must not knowingly
807.11 hamper, obstruct, tamper with, or destroy an electronic monitoring device placed in a
807.12 resident's room or private living unit without the permission of the resident or resident
807.13 representative.

807.14 (b) It is not a violation of paragraph (a) if a person turns off the electronic monitoring
807.15 device or blocks the visual recording component of the electronic monitoring device at the
807.16 direction of the resident or resident representative, or if consent has been withdrawn.

807.17 Subd. 10. **Dissemination of meetings.** (a) No person may access any video or audio
807.18 recording created through authorized electronic monitoring without the written consent of
807.19 the resident or resident representative.

807.20 (b) Except as required under other law, a recording or copy of a recording made as
807.21 provided in this section may only be disseminated for the purpose of addressing health,
807.22 safety, or welfare concerns of one or more residents.

807.23 (c) A person disseminating a recording or copy of a recording made as provided in this
807.24 section in violation of paragraph (b) may be civilly or criminally liable.

807.25 Subd. 11. **Admissibility of evidence.** Subject to applicable rules of evidence and
807.26 procedure, any video or audio recording created through electronic monitoring under this
807.27 section may be admitted into evidence in a civil, criminal, or administrative proceeding.

807.28 Subd. 12. **Liability.** (a) For the purposes of state law, the mere presence of an electronic
807.29 monitoring device in a resident's room or private living unit is not a violation of the resident's
807.30 right to privacy under section 144.651 or 144A.44.

808.1 (b) For the purposes of state law, a facility or home care provider is not civilly or
808.2 criminally liable for the mere disclosure by a resident or a resident representative of a
808.3 recording.

808.4 Subd. 13. **Immunity from liability.** The Office of Ombudsman for Long-Term Care
808.5 and representatives of the office are immune from liability for conduct described in section
808.6 256.9742, subdivision 2.

808.7 Subd. 14. **Resident protections.** (a) A facility must not:

808.8 (1) refuse to admit a potential resident or remove a resident because the facility disagrees
808.9 with the decision of the potential resident, the resident, or a resident representative acting
808.10 on behalf of the resident regarding electronic monitoring;

808.11 (2) retaliate or discriminate against any resident for consenting or refusing to consent
808.12 to electronic monitoring, as provided in section 144.6512, 144G.07, or 144J.03; or

808.13 (3) prevent the placement or use of an electronic monitoring device by a resident who
808.14 has provided the facility or the Office of Ombudsman for Long-Term Care with notice and
808.15 consent as required under this section.

808.16 (b) Any contractual provision prohibiting, limiting, or otherwise modifying the rights
808.17 and obligations in this section is contrary to public policy and is void and unenforceable.

808.18 Subd. 15. **Employee discipline.** (a) An employee of the facility or an employee of a
808.19 contractor providing services at the facility who is the subject of proposed corrective or
808.20 disciplinary action based upon evidence obtained by electronic monitoring must be given
808.21 access to that evidence for purposes of defending against the proposed action.

808.22 (b) An employee who obtains a recording or a copy of the recording must treat the
808.23 recording or copy confidentially and must not further disseminate it to any other person
808.24 except as required under law. Any copy of the recording must be returned to the facility or
808.25 resident who provided the copy when it is no longer needed for purposes of defending
808.26 against a proposed action.

808.27 Subd. 16. **Penalties.** (a) The commissioner may issue a correction order as provided
808.28 under section 144A.10, 144A.45, or 144A.474, upon a finding that the facility has failed to
808.29 comply with:

808.30 (1) subdivision 5, paragraphs (c) to (f);

808.31 (2) subdivision 6, paragraph (b);

808.32 (3) subdivision 7, paragraph (c); and

809.1 (4) subdivisions 8 to 10 and 14.

809.2 (b) The commissioner may exercise the commissioner's authority under section 144D.05
809.3 to compel a housing with services establishment to meet the requirements of this section.

809.4 **EFFECTIVE DATE.** This section is effective August 1, 2019, and applies to all contracts
809.5 in effect, entered into, or renewed on or after that date.

809.6 **Sec. 9. [144J.06] NO DISCRIMINATION BASED ON SOURCE OF PAYMENT.**

809.7 All facilities must, regardless of the source of payment and for all persons seeking to
809.8 reside or residing in the facility:

809.9 (1) provide equal access to quality care; and

809.10 (2) establish, maintain, and implement identical policies and practices regarding residency,
809.11 transfer, and provision and termination of services.

809.12 **EFFECTIVE DATE.** This section is effective August 1, 2021.

809.13 **Sec. 10. [144J.07] CONSUMER ADVOCACY AND LEGAL SERVICES.**

809.14 Upon execution of an assisted living contract, every facility must provide the resident
809.15 and the resident's legal and designated representatives with the names and contact
809.16 information, including telephone numbers and e-mail addresses, of:

809.17 (1) nonprofit organizations that provide advocacy or legal services to residents including
809.18 but not limited to the designated protection and advocacy organization in Minnesota that
809.19 provides advice and representation to individuals with disabilities; and

809.20 (2) the Office of Ombudsman for Long-Term Care, including both the state and regional
809.21 contact information.

809.22 **EFFECTIVE DATE.** This section is effective August 1, 2021.

809.23 **Sec. 11. [144J.08] INVOLUNTARY DISCHARGES AND SERVICE**
809.24 **TERMINATIONS.**

809.25 Subdivision 1. **Definitions.** (a) For the purposes of this section and sections 144J.09 and
809.26 144J.10, the following terms have the meanings given them.

809.27 (b) "Facility" means:

809.28 (1) a housing with services establishment registered under section 144D.02 and operating
809.29 under title protection provided under chapter 144G; or

810.1 (2) on or after August 1, 2021, an assisted living facility.

810.2 (c) "Refusal to readmit" means a refusal by an assisted living facility, upon a request
 810.3 from a resident or an agent of the resident, to allow the resident to return to the facility,
 810.4 whether or not a notice of termination of housing or services has been issued.

810.5 (d) "Termination of housing or services" or "termination" means an involuntary
 810.6 facility-initiated discharge, eviction, transfer, or service termination not initiated at the oral
 810.7 or written request of the resident or to which the resident objects.

810.8 Subd. 2. Prerequisite to termination of housing or services. Before issuing a notice
 810.9 of termination, a facility must explain in person and in detail the reasons for the termination,
 810.10 and must convene a conference with the resident, the resident's legal representatives, the
 810.11 resident's designated representative, the resident's family, applicable state and social services
 810.12 agencies, and relevant health professionals to identify and offer reasonable accommodations
 810.13 and modifications, interventions, or alternatives to avoid the termination.

810.14 Subd. 3. Permissible reasons to terminate housing or services. (a) A facility is
 810.15 prohibited from terminating housing or services for grounds other than those specified in
 810.16 paragraphs (b) and (c). A facility initiating a termination under paragraph (b) or (c) must
 810.17 comply with subdivision 2.

810.18 (b) A facility may not initiate a termination unless the termination is necessary and the
 810.19 facility produces a written determination, supported by documentation, of the necessity of
 810.20 the termination. A termination is necessary only if:

810.21 (1) the resident has engaged in documented conduct that substantially interferes with
 810.22 the rights, health, or safety of other residents;

810.23 (2) the resident has committed any of the acts enumerated under section 504B.171 that
 810.24 substantially interfere with the rights, health, or safety of other residents; or

810.25 (3) the facility can demonstrate that the resident's needs exceed the scope of services for
 810.26 which the resident contracted or which are included in the resident's service plan.

810.27 (c) A facility may initiate a termination for nonpayment, provided the facility:

810.28 (1) makes reasonable efforts to accommodate temporary financial hardship;

810.29 (2) informs the resident of private subsidies and public benefits options that may be
 810.30 available, including but not limited to benefits available under sections 256B.0915 and
 810.31 256B.49; and

811.1 (3) if the resident applies for public benefits, timely responds to state or county agency
811.2 questions regarding the application.

811.3 (d) A facility may not initiate a termination of housing or services to a resident receiving
811.4 public benefits in the event of a temporary interruption in benefits. A temporary interruption
811.5 of benefits does not constitute nonpayment.

811.6 Subd. 4. **Notice of termination required.** (a) A facility initiating a termination of housing
811.7 or services must issue a written notice that complies with subdivision 5 at least 30 days
811.8 prior to the effective date of the termination to the resident, to the resident's legal
811.9 representative and designated representative, or if none, to a family member if known, and
811.10 to the Ombudsman for Long-Term Care.

811.11 (b) A facility may relocate a resident with less than 30 days' notice only in the event of
811.12 emergencies, as provided in subdivision 6.

811.13 (c) The notice requirements in paragraph (a) do not apply if the facility's license is
811.14 restricted by the commissioner or the facility ceases operations. In the event of a license
811.15 restriction or cessation of operations, the facility must follow the commissioner's directions
811.16 for resident relocations contained in section 144J.10.

811.17 Subd. 5. **Content of notice.** The notice required under subdivision 4 must contain, at a
811.18 minimum:

811.19 (1) the effective date of the termination;

811.20 (2) a detailed explanation of the basis for the termination, including, but not limited to,
811.21 clinical or other supporting rationale;

811.22 (3) contact information for, and a statement that the resident has the right to appeal the
811.23 termination to, the Office of Administrative Hearings;

811.24 (4) contact information for the Ombudsman for Long-Term Care;

811.25 (5) the name and contact information of a person employed by the facility with whom
811.26 the resident may discuss the notice of termination of housing or services;

811.27 (6) if the termination is for services, a statement that the notice of termination of services
811.28 does not constitute a termination of housing or an eviction from the resident's home, and
811.29 that the resident has the right to remain in the facility if the resident can secure necessary
811.30 services from another provider of the resident's choosing; and

811.31 (7) if the resident must relocate:

812.1 (i) a statement that the facility must actively participate in a coordinated transfer of the
812.2 resident's care to a safe and appropriate service provider; and

812.3 (ii) the name of and contact information for the new location or provider, or a statement
812.4 that the location or provider must be identified prior to the effective date of the termination.

812.5 Subd. 6. **Exception for emergencies.** (a) A facility may relocate a resident from a facility
812.6 with less than 30 days' notice if relocation is required:

812.7 (1) due to a resident's urgent medical needs and is ordered by a licensed health care
812.8 professional; or

812.9 (2) because of an imminent risk to the health or safety of another resident or a staff
812.10 member of the facility.

812.11 (b) A facility relocating a resident under this subdivision must:

812.12 (1) remove the resident to an appropriate location. A private home where the occupant
812.13 is unwilling or unable to care for the resident, a homeless shelter, a hotel, or a motel is not
812.14 an appropriate location; and

812.15 (2) provide notice of the contact information for and location to which the resident has
812.16 been relocated, contact information for any new service provider and for the Ombudsman
812.17 for Long-Term Care, the reason for the relocation, a statement that, if the resident is refused
812.18 readmission to the facility, the resident has the right to appeal any refusal to readmit to the
812.19 Office of Administrative Hearings, and, if ascertainable, the approximate date or range of
812.20 dates when the resident is expected to return to the facility or a statement that such date is
812.21 not currently ascertainable, to:

812.22 (i) the resident, the resident's legal representative and designated representative, or if
812.23 none, a family member if known immediately upon relocation of the resident; and

812.24 (ii) the Office of Ombudsman for Long-Term Care as soon as practicable if the resident
812.25 has been relocated from the facility for more than 48 hours.

812.26 (c) The resident has the right to return to the facility if the conditions under paragraph
812.27 (a) no longer exist.

812.28 (d) If the facility determines that the resident cannot return to the facility or the facility
812.29 cannot provide the necessary services to the resident upon return, the facility must as soon
812.30 as practicable but in no event later than 24 hours after the refusal or determination, comply
812.31 with subdivision 4, and section 144J.10.

813.1 **EFFECTIVE DATE.** (a) This section is effective August 1, 2019, and expires July 31,
813.2 2021, for housing with services establishments registered under section 144D.02 and
813.3 operating under title protection provided by and subject to chapter 144G.

813.4 (b) This section is effective for assisted living facilities August 1, 2021.

813.5 **Sec. 12. [144J.09] APPEAL OF TERMINATION OF HOUSING OR SERVICES.**

813.6 Subdivision 1. **Right to appeal termination of housing or services.** A resident, the
813.7 resident's legal representative or designated representative, or a family member, has the
813.8 right to appeal a termination of housing or services or a facility's refusal to readmit the
813.9 resident after an emergency relocation and to request a contested case hearing with the
813.10 Office of Administrative Hearings.

813.11 Subd. 2. **Appeals process.** (a) An appeal and request for a contested case hearing must
813.12 be filed in writing or electronically as authorized by the chief administrative law judge.

813.13 (b) The Office of Administrative Hearings must conduct an expedited hearing as soon
813.14 as practicable, and in any event no later than 14 calendar days after the office receives the
813.15 request and within three business days in the event of an appeal of a refusal to readmit. The
813.16 hearing must be held at the facility where the resident lives, unless it is impractical or the
813.17 parties agree to a different place. The hearing is not a formal evidentiary hearing. The hearing
813.18 may also be attended by telephone as allowed by the administrative law judge, after
813.19 considering how a telephonic hearing will affect the resident's ability to participate. The
813.20 hearing shall be limited to the amount of time necessary for the participants to expeditiously
813.21 present the facts about the proposed termination or refusal to readmit. The administrative
813.22 law judge shall issue a recommendation to the commissioner as soon as practicable, and in
813.23 any event no later than ten calendar days after the hearing or within two calendar days after
813.24 the hearing in the case of a refusal to readmit.

813.25 (c) The facility bears the burden of proof to establish by a preponderance of the evidence
813.26 that the termination of housing or services or the refusal to readmit is permissible under law
813.27 and does not constitute retaliation under section 144G.07 or 144J.03.

813.28 (d) Appeals from final determinations issued by the Office of Administrative Hearings
813.29 shall be as provided in sections 14.63 to 14.68.

813.30 (e) The Office of Administrative Hearings must grant the appeal and the commissioner
813.31 of health may order the assisted living facility to rescind the termination of housing and
813.32 services or readmit the resident if:

813.33 (1) the termination or refusal to readmit was in violation of state or federal law;

814.1 (2) the resident cures or demonstrates the ability to cure the reason for the termination
 814.2 or refusal to readmit, or has identified any reasonable accommodation or modification,
 814.3 intervention, or alternative to the termination;

814.4 (3) termination would result in great harm or potential great harm to the resident as
 814.5 determined by a totality of the circumstances; or

814.6 (4) the facility has failed to identify a safe and appropriate location to which the resident
 814.7 is to be relocated as required under section 144J.10.

814.8 (f) The Office of Administrative Hearings has the authority to make any other
 814.9 determinations or orders regarding any conditions that may be placed upon the resident's
 814.10 readmission or continued residency, including but not limited to changes to the service plan
 814.11 or required increases in services.

814.12 (g) Nothing in this section limits the right of a resident or the resident's designated
 814.13 representative to request or receive assistance from the Office of Ombudsman for Long-Term
 814.14 Care and the protection and advocacy agency protection and advocacy system designated
 814.15 by the state under Code of Federal Regulations, title 45, section 1326.21, concerning the
 814.16 termination of housing or services.

814.17 Subd. 3. **Representation at the hearing.** Parties may, but are not required to, be
 814.18 represented by counsel at a contested case hearing on an appeal. The appearance of a party
 814.19 without counsel does not constitute the unauthorized practice of law.

814.20 Subd. 4. **Service provision while appeal pending.** Housing or services may not be
 814.21 terminated during the pendency of an appeal and until a final determination is made by the
 814.22 Office of Administrative Hearings.

814.23 **EFFECTIVE DATE.** (a) This section is effective August 1, 2019, and expires July 31,
 814.24 2021, for housing with services establishments registered under section 144D.02 and
 814.25 operating under title protection provided by and subject to chapter 144G.

814.26 (b) This section is effective for assisted living facilities August 1, 2021.

814.27 Sec. 13. **[144J.10] HOUSING AND SERVICE TERMINATION; RELOCATION**
 814.28 **PLANNING.**

814.29 Subdivision 1. **Duties of the facility.** If a facility terminates housing or services, if a
 814.30 facility intends to cease operations, or if a facility's license is restricted by the commissioner
 814.31 requiring termination of housing or services to residents, the facility:

815.1 (1) in the event of a termination of housing, has an affirmative duty to ensure a
815.2 coordinated and orderly transfer of the resident to a safe location that is appropriate for the
815.3 resident. The facility must identify that location prior to any appeal hearing;

815.4 (2) in the event of a termination of services, has an affirmative duty to ensure a
815.5 coordinated and orderly transfer of the resident to an appropriate service provider, if services
815.6 are still needed and desired by the resident. The facility must identify the provider prior to
815.7 any appeal hearing; and

815.8 (3) must consult and cooperate with the resident; the resident's legal representatives,
815.9 designated representative, and family members; any interested professionals, including case
815.10 managers; and applicable agencies to consider the resident's goals and make arrangements
815.11 to relocate the resident.

815.12 Subd. 2. **Safe location.** A safe location is not a private home where the occupant is
815.13 unwilling or unable to care for the resident, a homeless shelter, a hotel, or a motel. A facility
815.14 may not terminate a resident's housing or services if the resident will, as a result of the
815.15 termination, become homeless, as that term is defined in section 116L.361, subdivision 5,
815.16 or if an adequate and safe discharge location or adequate and needed service provider has
815.17 not been identified.

815.18 Subd. 3. **Written relocation plan required.** The facility must prepare a written relocation
815.19 plan for a resident being relocated. The plan must:

815.20 (1) contain all the necessary steps to be taken to reduce transfer trauma; and

815.21 (2) specify the measures needed until relocation that protect the resident and meet the
815.22 resident's health and safety needs.

815.23 Subd. 4. **No relocation without receiving setting accepting.** A facility may not relocate
815.24 the resident unless the place to which the resident will be relocated indicates acceptance of
815.25 the resident.

815.26 Subd. 5. **No termination of services without another provider.** If a resident continues
815.27 to need and desire the services provided by the facility, the facility may not terminate services
815.28 unless another service provider has indicated that it will provide those services.

815.29 Subd. 6. **Information that must be conveyed.** If a resident is relocated to another facility
815.30 or to a nursing home, or if care is transferred to another provider, the facility must timely
815.31 convey to that facility, nursing home, or provider:

815.32 (1) the resident's full name, date of birth, and insurance information;

816.1 (2) the name, telephone number, and address of the resident's designated representatives
816.2 and legal representatives, if any;

816.3 (3) the resident's current documented diagnoses that are relevant to the services being
816.4 provided;

816.5 (4) the resident's known allergies that are relevant to the services being provided;

816.6 (5) the name and telephone number of the resident's physician, if known, and the current
816.7 physician orders that are relevant to the services being provided;

816.8 (6) all medication administration records that are relevant to the services being provided;

816.9 (7) the most recent resident assessment, if relevant to the services being provided; and

816.10 (8) copies of health care directives, "do not resuscitate" orders, and any guardianship
816.11 orders or powers of attorney.

816.12 Subd. 7. **Final accounting; return of money and property.** (a) Within 30 days of the
816.13 effective date of the termination of housing or services, the facility must:

816.14 (1) provide to the resident, resident's legal representatives, and the resident's designated
816.15 representative a final statement of account;

816.16 (2) provide any refunds due;

816.17 (3) return any money, property, or valuables held in trust or custody by the facility; and

816.18 (4) as required under section 504B.178, refund the resident's security deposit unless it
816.19 is applied to the first month's charges.

816.20 **EFFECTIVE DATE.** (a) This section is effective August 1, 2019, and expires July 31,
816.21 2021, for housing with services establishments registered under section 144D.02 and
816.22 operating under title protection provided by and subject to chapter 144G.

816.23 (b) This section is effective for assisted living facilities August 1, 2021.

816.24 Sec. 14. **[144J.11] FORCED ARBITRATION.**

816.25 (a) An assisted living facility must affirmatively disclose, orally and conspicuously in
816.26 writing in an assisted living contract, any arbitration provision in the contract that precludes,
816.27 limits, or delays the ability of a resident from taking a civil action.

816.28 (b) A forced arbitration requirement must not include a choice of law or choice of venue
816.29 provision. Assisted living contracts must adhere to Minnesota law and any other applicable

817.1 federal or local law. Any civil actions by any litigant must be taken in Minnesota judicial
 817.2 or administrative courts.

817.3 (c) A forced arbitration provision must not be unconscionable. All or the portion of a
 817.4 forced arbitration provision found by a court to be unconscionable shall have no effect on
 817.5 the remaining provisions, terms, or conditions of the contract.

817.6 **EFFECTIVE DATE.** This section is effective August 1, 2019, for contracts entered
 817.7 into on or after that date.

817.8 Sec. 15. **[144J.12] VIOLATION OF RIGHTS.**

817.9 (a) A resident who meets the criteria under section 325F.71, subdivision 1, has a cause
 817.10 of action under section 325F.71, subdivision 4, for the violation of section 144J.02,
 817.11 subdivisions 12, 15, and 18, or section 144J.04.

817.12 (b) A resident who meets the criteria under section 325F.71, subdivision 1, has a cause
 817.13 of action under section 325F.71, subdivision 4, for the violation of section 144J.03, unless
 817.14 the resident otherwise has a cause of action under section 626.557, subdivision 17.

817.15 **EFFECTIVE DATE.** This section is effective August 1, 2021.

817.16 Sec. 16. **[144J.13] APPLICABILITY OF OTHER LAWS.**

817.17 Assisted living facilities:

817.18 (1) are subject to and must comply with chapter 504B;

817.19 (2) must comply with section 325F.72; and

817.20 (3) are not required to obtain a lodging license under chapter 157 and related rules.

817.21 **EFFECTIVE DATE.** This section is effective August 1, 2021.

817.22 Sec. 17. Minnesota Statutes 2018, section 325F.72, subdivision 4, is amended to read:

817.23 Subd. 4. **Remedy.** The attorney general may seek the remedies set forth in section 8.31
 817.24 for repeated and intentional violations of this section. ~~However, no private right of action~~
 817.25 ~~may be maintained as provided under section 8.31, subdivision 3a.~~

ARTICLE 15

INDEPENDENT SENIOR LIVING FACILITIES

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Section 1. [144K.01] DEFINITIONS.

Subdivision 1. **Applicability.** For the purposes of this chapter, the definitions in this section have the meanings given.

Subd. 2. **Commissioner.** "Commissioner" means the commissioner of health.

Subd. 3. **Dementia.** "Dementia" means the loss of intellectual function of sufficient severity that interferes with an individual's daily functioning. Dementia affects an individual's memory and ability to think, reason, speak, and move. Symptoms may also include changes in personality, mood, and behavior. Irreversible dementias include but are not limited to:

(1) Alzheimer's disease;

(2) vascular dementia;

(3) Lewy body dementia;

(4) frontal-temporal lobe dementia;

(5) alcohol dementia;

(6) Huntington's disease; and

(7) Creutzfeldt-Jakob disease.

Subd. 4. **Designated representative.** "Designated representative" means a person designated in writing by the resident in a residency and service contract and identified in the resident's records on file with the independent senior living facility.

Subd. 5. **Facility.** "Facility" means an independent senior living facility.

Subd. 6. **Independent senior living facility.** "Independent senior living facility" means a facility that:

(1) provides sleeping accommodations to one or more adults, at least 80 percent of which are 55 years of age or older; and

(2) offers supportive services.

Subd. 7. **Manager.** "Manager" means a manager of an independent senior living facility.

Subd. 8. **Residency and services contract or contract.** "Residency and services contract" or "contract" means the legal agreement between an independent senior living facility and a resident for the provision of housing and supportive services.

819.1 Subd. 9. **Related supportive services provider.** "Related supportive services provider"
819.2 means a service provider that provides supportive services to a resident under a business
819.3 relationship or other affiliation with the independent senior living facility.

819.4 Subd. 10. **Resident.** "Resident" means a person residing in an independent senior living
819.5 facility.

819.6 Subd. 11. **Supportive services.** "Supportive services" means:

819.7 (1) assistance with laundry, shopping, and household chores;

819.8 (2) housekeeping services;

819.9 (3) provision of meals or assistance with meals or food preparation;

819.10 (4) help with arranging, or arranging transportation to, medical, social, recreational,
819.11 personal, or social services appointments;

819.12 (5) provision of social or recreational services; or

819.13 (6) wellness check services.

819.14 Arranging for services does not include making referrals or contacting a service provider
819.15 in an emergency.

819.16 Subd. 12. **Wellness check services.** "Wellness check services" means having,
819.17 maintaining, and documenting a system to visually check on each resident a minimum of
819.18 once daily or more than once daily according to the residency and service contract.

819.19 Sec. 2. **[144K.02] AUTHORITY OF THE COMMISSIONER.**

819.20 Subdivision 1. **Investigations, correction orders, fines.** The commissioner of health
819.21 has the authority, upon receipt of a complaint by a resident, to:

819.22 (1) investigate violations of the residency and services contract; and

819.23 (2) issue correction orders and impose fines consistent with the commissioner's authority
819.24 under chapter 144A.

819.25 Subd. 2. **Compelling compliance.** The commissioner shall have standing to bring an
819.26 action for injunctive relief in the district court in the district in which a facility is located to
819.27 compel the independent senior living facility to comply with a correction order. Proceedings
819.28 for securing an injunction may be brought by the commissioner through the attorney general
819.29 or through the appropriate county attorney.

820.1 Subd. 3. **Other sanctions.** The sanctions in this section do not restrict the availability
820.2 of other sanctions.

820.3 Sec. 3. **[144K.03] RESIDENCY AND SERVICES CONTRACT.**

820.4 Subdivision 1. **Contract required.** (a) No independent senior living facility may operate
820.5 in this state unless a written contract that meets the requirements of subdivision 2 is executed
820.6 between the facility and each resident and unless the establishment operates in accordance
820.7 with the terms of the contract.

820.8 (b) The facility must give a complete copy of any signed contract and any addendums,
820.9 and all supporting documents and attachments, to the resident promptly after a contract and
820.10 any addendums have been signed by the resident.

820.11 (c) The contract must contain all the terms concerning the provision of housing and
820.12 supportive services, whether the services are provided directly or through a related supportive
820.13 services provider.

820.14 Subd. 2. **Contents of contract.** A residency and services contract must include at least
820.15 the following elements in itself or through supporting documents or attachments:

820.16 (1) the name, telephone number, and physical mailing address, which may not be a
820.17 public or private post office box, of:

820.18 (i) the facility and, where applicable, the related supportive services provider;

820.19 (ii) the managing agent of the facility, if applicable; and

820.20 (iii) at least one natural person who is authorized to accept service of process on behalf
820.21 of the facility;

820.22 (2) the term of the contract;

820.23 (3) a description of all the terms and conditions of the contract, including a description
820.24 of the services to be provided and any limitations to the services provided to the resident
820.25 for the contracted amount;

820.26 (4) a delineation of the cost and a description of any other services to be provided for
820.27 an additional fee;

820.28 (5) a delineation of the grounds under which the resident may be evicted or have services
820.29 terminated;

820.30 (6) billing and payment procedures and requirements;

821.1 (7) a statement regarding the ability of a resident to receive services from service
 821.2 providers with whom the facility does not have a business relationship;

821.3 (8) a description of the facility's complaint resolution process available to residents,
 821.4 including the name and contact information of the person representing the facility who is
 821.5 designated to handle and resolve complaints;

821.6 (9) the toll-free complaint line for the Office of Ombudsman for Long-Term Care; and

821.7 (10) a statement regarding the availability of and contact information for long-term care
 821.8 consultation services under section 256B.0911 in the county in which the facility is located.

821.9 Subd. 3. **Designation of representative.** (a) Before or at the time of execution of a
 821.10 residency and services contract, every facility must offer the resident the opportunity to
 821.11 identify a designated representative in writing in the contract and provide the following
 821.12 verbatim notice on a document separate from the contract:

821.13 **RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES.**

821.14 You have the right to name anyone as your "Designated Representative" to assist you
 821.15 or, if you are unable, advocate on your behalf. A "Designated Representative" does not take
 821.16 the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health
 821.17 care power of attorney ("health care agent").

821.18 (b) The contract must contain a page or space for the name and contact information of
 821.19 the designated representative and a box the resident must initial if the resident declines to
 821.20 name a designated representative. Notwithstanding subdivision 5, the resident has the right
 821.21 at any time to add or change the name and contact information of the designated
 821.22 representative.

821.23 Subd. 4. **Contracts are consumer contracts.** A contract under this section is a consumer
 821.24 contract under sections 325G.29 to 325G.37.

821.25 Subd. 5. **Additions and amendments to contract.** The resident must agree in writing
 821.26 to any additions or amendments to the contract. Upon agreement between the resident or
 821.27 resident's designated representative and the facility, a new contract or an addendum to the
 821.28 existing contract must be executed and signed and provided to the resident and the resident's
 821.29 legal representative.

821.30 Subd. 6. **Contracts in permanent files.** Residency and services contracts and related
 821.31 documents executed by each resident must be maintained by the facility in files from the
 821.32 date of execution until three years after the contract is terminated. The contracts must be
 821.33 made available for on-site inspection by the commissioner upon request at any time.

822.1 Subd. 7. **Waivers of liability prohibited.** The contract must not include a waiver of
822.2 facility liability for the health and safety or personal property of a resident. The contract
822.3 must not include any provision that the facility knows or should know to be deceptive,
822.4 unlawful, or unenforceable under state or federal law, and must not include any provision
822.5 that requires or implies a lesser standard of responsibility than is required by law.

822.6 Sec. 4. **[144K.04] TERMINATION OF RESIDENCY AND SERVICES CONTRACT.**

822.7 Subdivision 1. **Notice required.** An independent senior living facility must provide at
822.8 least 30 days prior notice of a termination of the residency and services contract.

822.9 Subd. 2. **Content of notice.** The notice required under subdivision 1 must contain, at a
822.10 minimum:

822.11 (1) the effective date of termination of the contract;

822.12 (2) a detailed explanation of the basis for the termination;

822.13 (3) a list of known facilities in the immediate geographic area;

822.14 (4) information on how to contact the Office of Ombudsman for Long-Term Care and
822.15 the Ombudsman for Mental Health and Developmental Disabilities;

822.16 (6) a statement of any steps the resident can take to avoid termination;

822.17 (7) the name and contact information of a person employed by the facility with whom
822.18 the resident may discuss the notice of termination and, without extending the termination
822.19 notice period, an affirmative offer to meet with the resident and any person or persons of
822.20 the resident's choosing to discuss the termination;

822.21 (8) a statement that, with respect to the notice of termination, reasonable accommodation
822.22 is available for a resident with a disability; and

822.23 (9) an explanation that:

822.24 (i) the resident must vacate the apartment, along with all personal possessions, on or
822.25 before the effective date of termination;

822.26 (ii) failure to vacate the apartment by the date of termination may result in the filing of
822.27 an eviction action in court by the facility, and that the resident may present a defense, if
822.28 any, to the court at that time; and

822.29 (iii) the resident may seek legal counsel in connection with the notice of termination.

823.1 **Sec. 5. [144K.05] MANAGER REQUIREMENTS.**

823.2 (a) The manager of an independent senior living facility must obtain at least 30 hours
 823.3 of continuing education every two years of employment as the manager in topics relevant
 823.4 to the operations of the facility and the needs of its residents. Continuing education earned
 823.5 to maintain a professional license, such as a nursing home administrator license, nursing
 823.6 license, social worker license, or real estate license, may be used to satisfy this requirement.
 823.7 The continuing education must include at least four hours of documented training on dementia
 823.8 and related disorders, activities of daily living, problem solving with challenging behaviors,
 823.9 and communication skills within 160 working hours of hire and two hours of training on
 823.10 these topics for each 12 months of employment thereafter.

823.11 (b) The facility must maintain records for at least three years demonstrating that the
 823.12 manager has attended educational programs as required by this section. New managers may
 823.13 satisfy the initial dementia training requirements by producing written proof of having
 823.14 previously completed required training within the past 18 months.

823.15 **Sec. 6. [144K.06] FIRE PROTECTION AND PHYSICAL ENVIRONMENT.**

823.16 Subdivision 1. **Comprehensive fire protection system required.** Every independent
 823.17 senior living facility must have a comprehensive fire protection system that includes:

823.18 (1) protection throughout the facility by an approved supervised automatic sprinkler
 823.19 system according to building code requirements established in Minnesota Rules, part
 823.20 1305.0903, or smoke detectors in each occupied room installed and maintained in accordance
 823.21 with the National Fire Protection Association (NFPA) Standard 72;

823.22 (2) portable fire extinguishers installed and tested in accordance with the NFPA Standard
 823.23 10; and

823.24 (3) the physical environment, including walls, floors, ceiling, all furnishings, grounds,
 823.25 systems, and equipment kept in a continuous state of good repair and operation with regard
 823.26 to the health, safety, comfort, and well-being of the residents in accordance with a
 823.27 maintenance and repair program.

823.28 Subd. 2. **Fire drills.** Fire drills shall be conducted in accordance with the residential
 823.29 board and care requirements in the Life Safety Code.

823.30 **Sec. 7. [144K.07] EMERGENCY PLANNING.**

823.31 Subdivision 1. **Requirements.** Each independent senior living facility must meet the
 823.32 following requirements:

824.1 (1) have a written emergency disaster plan that contains a plan for evacuation, addresses
 824.2 elements of sheltering in-place, identifies temporary relocation sites, and details staff
 824.3 assignments in the event of a disaster or an emergency;

824.4 (2) post an emergency disaster plan prominently;

824.5 (3) provide building emergency exit diagrams to all residents upon signing a residency
 824.6 and services contract;

824.7 (4) post emergency exit diagrams on each floor; and

824.8 (5) have a written policy and procedure regarding missing residents.

824.9 Subd. 2. **Emergency and disaster training.** Each independent senior living facility
 824.10 must provide emergency and disaster training to all staff during the initial staff orientation
 824.11 and annually thereafter and must make emergency and disaster training available to all
 824.12 residents annually. Staff who have not received emergency and disaster training are allowed
 824.13 to work only when trained staff are also working on site.

824.14 **Sec. 8. [144K.08] OTHER LAWS.**

824.15 An independent senior living facility must comply with chapter 504B and must obtain
 824.16 and maintain all other licenses, permits, registrations, or other governmental approvals
 824.17 required of it. No independent senior living facility shall be required to be licensed as a
 824.18 boarding establishment, food and beverage service establishment, hotel or motel, lodging
 824.19 establishment, or resort or restaurant as defined in section 157.15.

824.20 **EFFECTIVE DATE.** This section is effective August 1, 2021.

824.21 **ARTICLE 16**

824.22 **ASSISTED LIVING LICENSURE**

824.23 Section 1. Minnesota Statutes 2018, section 144.122, is amended to read:

824.24 **144.122 LICENSE, PERMIT, AND SURVEY FEES.**

824.25 (a) The state commissioner of health, by rule, may prescribe procedures and fees for
 824.26 filing with the commissioner as prescribed by statute and for the issuance of original and
 824.27 renewal permits, licenses, registrations, and certifications issued under authority of the
 824.28 commissioner. The expiration dates of the various licenses, permits, registrations, and
 824.29 certifications as prescribed by the rules shall be plainly marked thereon. Fees may include
 824.30 application and examination fees and a penalty fee for renewal applications submitted after
 824.31 the expiration date of the previously issued permit, license, registration, and certification.

825.1 The commissioner may also prescribe, by rule, reduced fees for permits, licenses,
 825.2 registrations, and certifications when the application therefor is submitted during the last
 825.3 three months of the permit, license, registration, or certification period. Fees proposed to
 825.4 be prescribed in the rules shall be first approved by the Department of Management and
 825.5 Budget. All fees proposed to be prescribed in rules shall be reasonable. The fees shall be
 825.6 in an amount so that the total fees collected by the commissioner will, where practical,
 825.7 approximate the cost to the commissioner in administering the program. All fees collected
 825.8 shall be deposited in the state treasury and credited to the state government special revenue
 825.9 fund unless otherwise specifically appropriated by law for specific purposes.

825.10 (b) The commissioner may charge a fee for voluntary certification of medical laboratories
 825.11 and environmental laboratories, and for environmental and medical laboratory services
 825.12 provided by the department, without complying with paragraph (a) or chapter 14. Fees
 825.13 charged for environment and medical laboratory services provided by the department must
 825.14 be approximately equal to the costs of providing the services.

825.15 (c) The commissioner may develop a schedule of fees for diagnostic evaluations
 825.16 conducted at clinics held by the services for children with disabilities program. All receipts
 825.17 generated by the program are annually appropriated to the commissioner for use in the
 825.18 maternal and child health program.

825.19 (d) The commissioner shall set license fees for hospitals and nursing homes that are not
 825.20 boarding care homes at the following levels:

825.21	Joint Commission on Accreditation of	\$7,655 plus \$16 per bed
825.22	Healthcare Organizations (JCAHO) and	
825.23	American Osteopathic Association (AOA)	
825.24	hospitals	
825.25	Non-JCAHO and non-AOA hospitals	\$5,280 plus \$250 per bed
825.26	Nursing home	\$183 plus \$91 per bed until June 30, 2018.
825.27		\$183 plus \$100 per bed between July 1, 2018,
825.28		and June 30, 2020. \$183 plus \$105 per bed
825.29		beginning July 1, 2020.

825.30 The commissioner shall set license fees for outpatient surgical centers, boarding care
 825.31 homes, ~~and supervised living facilities,~~ assisted living facilities, and assisted living facilities
 825.32 with dementia care at the following levels:

825.33	Outpatient surgical centers	\$3,712
825.34	Boarding care homes	\$183 plus \$91 per bed
825.35	Supervised living facilities	\$183 plus \$91 per bed.
825.36	<u>Assisted living facilities with dementia care</u>	<u>\$..... plus \$..... per bed.</u>
825.37	<u>Assisted living facilities</u>	<u>\$..... plus \$..... per bed.</u>

826.1 Fees collected under this paragraph are nonrefundable. The fees are nonrefundable even if
 826.2 received before July 1, 2017, for licenses or registrations being issued effective July 1, 2017,
 826.3 or later.

826.4 (e) Unless prohibited by federal law, the commissioner of health shall charge applicants
 826.5 the following fees to cover the cost of any initial certification surveys required to determine
 826.6 a provider's eligibility to participate in the Medicare or Medicaid program:

826.7	Prospective payment surveys for hospitals	\$	900
826.8	Swing bed surveys for nursing homes	\$	1,200
826.9	Psychiatric hospitals	\$	1,400
826.10	Rural health facilities	\$	1,100
826.11	Portable x-ray providers	\$	500
826.12	Home health agencies	\$	1,800
826.13	Outpatient therapy agencies	\$	800
826.14	End stage renal dialysis providers	\$	2,100
826.15	Independent therapists	\$	800
826.16	Comprehensive rehabilitation outpatient facilities	\$	1,200
826.17	Hospice providers	\$	1,700
826.18	Ambulatory surgical providers	\$	1,800
826.19	Hospitals	\$	4,200
826.20	Other provider categories or additional		Actual surveyor costs: average
826.21	resurveys required to complete initial		surveyor cost x number of hours for
826.22	certification		the survey process.

826.23 These fees shall be submitted at the time of the application for federal certification and
 826.24 shall not be refunded. All fees collected after the date that the imposition of fees is not
 826.25 prohibited by federal law shall be deposited in the state treasury and credited to the state
 826.26 government special revenue fund.

826.27 **Sec. 2. [144I.01] DEFINITIONS.**

826.28 **Subdivision 1. Applicability.** For the purposes of this chapter, the definitions in this
 826.29 section have the meanings given.

826.30 **Subd. 2. Adult.** "Adult" means a natural person who has attained the age of 18 years.

826.31 **Subd. 3. Agent.** "Agent" means the person upon whom all notices and orders shall be
 826.32 served and who is authorized to accept service of notices and orders on behalf of the facility.

826.33 **Subd. 4. Applicant.** "Applicant" means an individual, legal entity, controlling individual,
 826.34 or other organization that has applied for licensure under this chapter.

827.1 Subd. 5. **Assisted living administrator.** "Assisted living administrator" means a person
827.2 who administers, manages, supervises, or is in general administrative charge of an assisted
827.3 living facility, whether or not the individual has an ownership interest in the facility, and
827.4 whether or not the person's functions or duties are shared with one or more individuals and
827.5 who is licensed by the Board of Executives for Long Term Services and Supports pursuant
827.6 to section 144I.31.

827.7 Subd. 6. **Assisted living facility.** "Assisted living facility" means a licensed facility that:
827.8 (1) provides sleeping accommodations to one or more adults; and (2) provides basic care
827.9 services and comprehensive assisted living services. For purposes of this chapter, assisted
827.10 living facility does not include:

827.11 (i) emergency shelter, transitional housing, or any other residential units serving
827.12 exclusively or primarily homeless individuals, as defined under section 116L.361;

827.13 (ii) a nursing home licensed under chapter 144A;

827.14 (iii) a hospital, certified boarding care, or supervised living facility licensed under sections
827.15 144.50 to 144.56;

827.16 (iv) a lodging establishment licensed under chapter 157 and Minnesota Rules, parts
827.17 9520.0500 to 9520.0670, or under chapter 245D or 245G, except lodging establishments
827.18 that provide dementia care services;

827.19 (v) a lodging establishment serving as a shelter for individuals fleeing domestic violence;

827.20 (vi) services and residential settings licensed under chapter 245A, including adult foster
827.21 care and services and settings governed under the standards in chapter 245D;

827.22 (vii) private homes where the residents own or rent the home and control all aspects of
827.23 the property and building;

827.24 (viii) a duly organized condominium, cooperative, and common interest community, or
827.25 owners' association of the condominium, cooperative, and common interest community
827.26 where at least 80 percent of the units that comprise the condominium, cooperative, or
827.27 common interest community are occupied by individuals who are the owners, members, or
827.28 shareholders of the units;

827.29 (ix) temporary family health care dwellings as defined in sections 394.307 and 462.3593;

827.30 (x) settings offering services conducted by and for the adherents of any recognized
827.31 church or religious denomination for its members through spiritual means or by prayer for
827.32 healing;

828.1 (xi) housing financed pursuant to sections 462A.37 and 462A.375, units financed with
 828.2 low-income housing tax credits pursuant to United States Code, title 26, section 42, and
 828.3 units financed by the Minnesota Housing Finance Agency that are intended to serve
 828.4 individuals with disabilities or individuals who are homeless;

828.5 (xii) rental housing developed under United States Code, title 42, section 1437, or United
 828.6 States Code, title 12, section 1701q;

828.7 (xiii) rental housing designated for occupancy by only elderly or elderly and disabled
 828.8 residents under United States Code, title 42, section 1437e, or rental housing for qualifying
 828.9 families under Code of Federal Regulations, title 24, section 983.56; or

828.10 (xiv) rental housing funded under United States Code, title 42, chapter 89, or United
 828.11 States Code, title 42, section 8011.

828.12 Subd. 7. **Assisted living services.** "Assisted living services" include any of the basic
 828.13 care services and one or more of the following:

828.14 (1) services of an advanced practice nurse, registered nurse, licensed practical nurse,
 828.15 physical therapist, respiratory therapist, occupational therapist, speech-language pathologist,
 828.16 dietitian or nutritionist, or social worker;

828.17 (2) tasks delegated to unlicensed personnel by a registered nurse or assigned by a licensed
 828.18 health professional within the person's scope of practice;

828.19 (3) medication management services;

828.20 (4) hands-on assistance with transfers and mobility;

828.21 (5) treatment and therapies;

828.22 (6) assisting residents with eating when the clients have complicated eating problems
 828.23 as identified in the resident record or through an assessment such as difficulty swallowing,
 828.24 recurrent lung aspirations, or requiring the use of a tube or parenteral or intravenous
 828.25 instruments to be fed; or

828.26 (7) providing other complex or specialty health care services.

828.27 Subd. 8. **Assisted living facility with dementia care.** "Assisted living facility with
 828.28 dementia care" means a licensed assisted living facility that also provides dementia care
 828.29 services. An assisted living facility with dementia care may also have a secured dementia
 828.30 care unit.

829.1 Subd. 9. **Assisted living facility contract.** "Assisted living facility contract" means the
829.2 legal agreement between an assisted living facility and a resident for the provision of housing
829.3 and services.

829.4 Subd. 10. **Basic care services.** "Basic care services" means assistive tasks provided by
829.5 licensed or unlicensed personnel that include:

829.6 (1) assisting with dressing, self-feeding, oral hygiene, hair care, grooming, toileting, and
829.7 bathing;

829.8 (2) providing standby assistance;

829.9 (3) providing verbal or visual reminders to the resident to take regularly scheduled
829.10 medication, which includes bringing the client previously set-up medication, medication in
829.11 original containers, or liquid or food to accompany the medication;

829.12 (4) providing verbal or visual reminders to the client to perform regularly scheduled
829.13 treatments and exercises;

829.14 (5) preparing modified diets ordered by a licensed health professional;

829.15 (6) having, maintaining, and documenting a system to visually check on each resident
829.16 a minimum of once daily or more than once daily depending on the person-centered care
829.17 plan; and

829.18 (7) supportive services in addition to the provision of at least one of the activities in
829.19 clauses (1) to (5).

829.20 Subd. 11. **Change of ownership.** "Change of ownership" means a change in the individual
829.21 or legal entity that is responsible for the operation of a facility.

829.22 Subd. 12. **Commissioner.** "Commissioner" means the commissioner of health.

829.23 Subd. 13. **Compliance officer.** "Compliance officer" means a designated individual
829.24 who is qualified by knowledge, training, and experience in health care or risk management
829.25 to promote, implement, and oversee the facility's compliance program. The compliance
829.26 officer shall also exhibit knowledge of relevant regulations; provide expertise in compliance
829.27 processes; and address fraud, abuse, and waste under this chapter and state and federal law.

829.28 Subd. 14. **Controlled substance.** "Controlled substance" has the meaning given in
829.29 section 152.01, subdivision 4.

829.30 Subd. 15. **Controlling individual.** (a) "Controlling individual" means an owner of a
829.31 facility licensed under this chapter and the following individuals, if applicable:

830.1 (1) each officer of the organization, including the chief executive officer and chief
830.2 financial officer;

830.3 (2) the individual designated as the authorized agent under section 245A.04, subdivision
830.4 1, paragraph (b);

830.5 (3) the individual designated as the compliance officer under section 256B.04, subdivision
830.6 21, paragraph (b); and

830.7 (4) each managerial official whose responsibilities include the direction of the
830.8 management or policies of the facility.

830.9 (b) Controlling individual also means any owner who directly or indirectly owns five
830.10 percent or more interest in:

830.11 (1) the land on which the facility is located, including a real estate investment trust
830.12 (REIT);

830.13 (2) the structure in which a facility is located;

830.14 (3) any mortgage, contract for deed, or other obligation secured in whole or part by the
830.15 land or structure comprising the facility; or

830.16 (4) any lease or sublease of the land, structure, or facilities comprising the facility.

830.17 (c) Controlling individual does not include:

830.18 (1) a bank, savings bank, trust company, savings association, credit union, industrial
830.19 loan and thrift company, investment banking firm, or insurance company unless the entity
830.20 operates a program directly or through a subsidiary;

830.21 (2) government and government-sponsored entities such as the U.S. Department of
830.22 Housing and Urban Development, Ginnie Mae, Fannie Mae, Freddie Mac, and the Minnesota
830.23 Housing Finance Agency which provide loans, financing, and insurance products for housing
830.24 sites;

830.25 (3) an individual who is a state or federal official, or a state or federal employee, or a
830.26 member or employee of the governing body of a political subdivision of the state or federal
830.27 government that operates one or more facilities, unless the individual is also an officer,
830.28 owner, or managerial official of the facility, receives remuneration from the facility, or
830.29 owns any of the beneficial interests not excluded in this subdivision;

830.30 (4) an individual who owns less than five percent of the outstanding common shares of
830.31 a corporation;

831.1 (i) whose securities are exempt under section 80A.45, clause (6); or

831.2 (ii) whose transactions are exempt under section 80A.46, clause (2);

831.3 (5) an individual who is a member of an organization exempt from taxation under section
 831.4 290.05, unless the individual is also an officer, owner, or managerial official of the license
 831.5 or owns any of the beneficial interests not excluded in this subdivision. This clause does
 831.6 not exclude from the definition of controlling individual an organization that is exempt from
 831.7 taxation; or

831.8 (6) an employee stock ownership plan trust, or a participant or board member of an
 831.9 employee stock ownership plan, unless the participant or board member is a controlling
 831.10 individual.

831.11 Subd. 16. **Dementia.** "Dementia" means the loss of intellectual function of sufficient
 831.12 severity that interferes with an individual's daily functioning. Dementia affects an individual's
 831.13 memory and ability to think, reason, speak, and move. Symptoms may also include changes
 831.14 in personality, mood, and behavior. Irreversible dementias include but are not limited to:

831.15 (1) Alzheimer's disease;

831.16 (2) vascular dementia;

831.17 (3) Lewy body dementia;

831.18 (4) frontal-temporal lobe dementia;

831.19 (5) alcohol dementia;

831.20 (6) Huntington's disease; and

831.21 (7) Creutzfeldt-Jakob disease.

831.22 Subd. 17. **Dementia care services.** "Dementia care services" means a distinct form of
 831.23 long-term care designed to meet the specific needs of an individual with dementia.

831.24 Subd. 18. **Dementia-trained staff.** "Dementia-trained staff" means any employee that
 831.25 has completed the minimum training requirements and has demonstrated knowledge and
 831.26 understanding in supporting individuals with dementia.

831.27 Subd. 19. **Designated representative.** "Designated representative" means one of the
 831.28 following in the order of priority listed, to the extent the person may reasonably be identified
 831.29 and located:

831.30 (1) a court-appointed guardian acting in accordance with the powers granted to the
 831.31 guardian under chapter 524;

832.1 (2) a conservator acting in accordance with the powers granted to the conservator under
832.2 chapter 524;

832.3 (3) a health care agent acting in accordance with the powers granted to the health care
832.4 agent under chapter 145C;

832.5 (4) a power of attorney acting in accordance with the powers granted to the
832.6 attorney-in-fact under chapter 523; or

832.7 (5) the resident representative.

832.8 Subd. 20. **Dietary supplement.** "Dietary supplement" means a product taken by mouth
832.9 that contains a dietary ingredient intended to supplement the diet. Dietary ingredients may
832.10 include vitamins, minerals, herbs or other botanicals, amino acids, and substances such as
832.11 enzymes, organ tissue, glandulars, or metabolites.

832.12 Subd. 21. **Direct contact.** "Direct contact" means providing face-to-face care, training,
832.13 supervision, counseling, consultation, or medication assistance to residents of a facility.

832.14 Subd. 22. **Direct ownership interest.** "Direct ownership interest" means an individual
832.15 or organization with the possession of at least five percent equity in capital, stock, or profits
832.16 of an organization, or who is a member of a limited liability company. An individual with
832.17 a five percent or more direct ownership is presumed to have an effect on the operation of
832.18 the facility with respect to factors affecting the care or training provided.

832.19 Subd. 23. **Facility.** "Facility" means an assisted living facility and an assisted living
832.20 facility with dementia care.

832.21 Subd. 24. **Hands-on assistance.** "Hands-on assistance" means physical help by another
832.22 person without which the resident is not able to perform the activity.

832.23 Subd. 25. **Indirect ownership interest.** "Indirect ownership interest" means an individual
832.24 or organization with a direct ownership interest in an entity that has a direct or indirect
832.25 ownership interest in a facility of at least five percent or more. An individual with a five
832.26 percent or more indirect ownership is presumed to have an effect on the operation of the
832.27 facility with respect to factors affecting the care or training provided.

832.28 Subd. 26. **Licensed health professional.** "Licensed health professional" means a person
832.29 licensed in Minnesota to practice the professions described in section 214.01, subdivision
832.30 2.

832.31 Subd. 27. **Licensed resident bed capacity.** "Licensed resident bed capacity" means the
832.32 resident occupancy level requested by a licensee and approved by the commissioner.

833.1 Subd. 28. **Licensee.** "Licensee" means a person or legal entity to whom the commissioner
833.2 issues a license for a facility and who is responsible for the management, control, and
833.3 operation of a facility. A facility must be managed, controlled, and operated in a manner
833.4 that enables it to use its resources effectively and efficiently to attain or maintain the highest
833.5 practicable physical, mental, and psychosocial well-being of each resident.

833.6 Subd. 29. **Maltreatment.** "Maltreatment" means conduct described in section 626.5572,
833.7 subdivision 15, or the intentional and nontherapeutic infliction of physical pain or injury or
833.8 any persistent course of conduct intended to produce mental or emotional distress.

833.9 Subd. 30. **Management agreement.** "Management agreement" means a written, executed
833.10 agreement between a licensee and manager regarding the provision of certain services on
833.11 behalf of the licensee.

833.12 Subd. 31. **Managerial official.** "Managerial official" means an individual who has the
833.13 decision-making authority related to the operation of the facility and the responsibility for
833.14 the ongoing management or direction of the policies, services, or employees of the facility.

833.15 Subd. 32. **Medication.** "Medication" means a prescription or over-the-counter drug. For
833.16 purposes of this chapter only, medication includes dietary supplements.

833.17 Subd. 33. **Medication administration.** "Medication administration" means performing
833.18 a set of tasks that includes the following:

833.19 (1) checking the client's medication record;

833.20 (2) preparing the medication as necessary;

833.21 (3) administering the medication to the client;

833.22 (4) documenting the administration or reason for not administering the medication; and

833.23 (5) reporting to a registered nurse or appropriate licensed health professional any concerns
833.24 about the medication, the resident, or the resident's refusal to take the medication.

833.25 Subd. 34. **Medication management.** "Medication management" means the provision
833.26 of any of the following medication-related services to a resident:

833.27 (1) performing medication setup;

833.28 (2) administering medications;

833.29 (3) storing and securing medications;

833.30 (4) documenting medication activities;

834.1 (5) verifying and monitoring the effectiveness of systems to ensure safe handling and
834.2 administration;

834.3 (6) coordinating refills;

834.4 (7) handling and implementing changes to prescriptions;

834.5 (8) communicating with the pharmacy about the resident's medications; and

834.6 (9) coordinating and communicating with the prescriber.

834.7 Subd. 35. **Medication reconciliation.** "Medication reconciliation" means the process
834.8 of identifying the most accurate list of all medications the resident is taking, including the
834.9 name, dosage, frequency, and route by comparing the resident record to an external list of
834.10 medications obtained from the resident, hospital, prescriber or other provider.

834.11 Subd. 36. **Medication setup.** "Medication setup" means arranging medications by a
834.12 nurse, pharmacy, or authorized prescriber for later administration by the resident or by
834.13 facility staff.

834.14 Subd. 37. **New construction.** "New construction" means a new building, renovation,
834.15 modification, reconstruction, physical changes altering the use of occupancy, or an addition
834.16 to a building.

834.17 Subd. 38. **Nurse.** "Nurse" means a person who is licensed under sections 148.171 to
834.18 148.285.

834.19 Subd. 39. **Occupational therapist.** "Occupational therapist" means a person who is
834.20 licensed under sections 148.6401 to 148.6449.

834.21 Subd. 40. **Ombudsman.** "Ombudsman" means the ombudsman for long-term care.

834.22 Subd. 41. **Owner.** "Owner" means an individual or organization that has a direct or
834.23 indirect ownership interest of five percent or more in a facility. For purposes of this chapter,
834.24 "owner of a nonprofit corporation" means the president and treasurer of the board of directors
834.25 or, for an entity owned by an employee stock ownership plan, means the president and
834.26 treasurer of the entity. A government entity that is issued a license under this chapter shall
834.27 be designated the owner. An individual with a five percent or more direct or indirect
834.28 ownership is presumed to have an effect on the operation of the facility with respect to
834.29 factors affecting the care or training provided.

834.30 Subd. 42. **Over-the-counter drug.** "Over-the-counter drug" means a drug that is not
834.31 required by federal law to bear the symbol "Rx only."

835.1 Subd. 43. **Person-centered planning and service delivery.** "Person-centered planning
835.2 and service delivery" means services as defined in section 245D.07, subdivision 1a, paragraph
835.3 (b).

835.4 Subd. 44. **Pharmacist.** "Pharmacist" has the meaning given in section 151.01, subdivision
835.5 3.

835.6 Subd. 45. **Physical therapist.** "Physical therapist" means a person who is licensed under
835.7 sections 148.65 to 148.78.

835.8 Subd. 46. **Physician.** "Physician" means a person who is licensed under chapter 147.

835.9 Subd. 47. **Prescriber.** "Prescriber" means a person who is authorized by sections 148.235;
835.10 151.01, subdivision 23; and 151.37 to prescribe prescription drugs.

835.11 Subd. 48. **Prescription.** "Prescription" has the meaning given in section 151.01,
835.12 subdivision 16a.

835.13 Subd. 49. **Provisional license.** "Provisional license" means the initial license the
835.14 department issues after approval of a complete written application and before the department
835.15 completes the provisional license survey and determines that the provisional licensee is in
835.16 substantial compliance.

835.17 Subd. 50. **Regularly scheduled.** "Regularly scheduled" means ordered or planned to be
835.18 completed at predetermined times or according to a predetermined routine.

835.19 Subd. 51. **Reminder.** "Reminder" means providing a verbal or visual reminder to a
835.20 resident.

835.21 Subd. 52. **Resident.** "Resident" means a person living in an assisted living facility.

835.22 Subd. 53. **Resident record.** "Resident record" means all records that document
835.23 information about the services provided to the resident.

835.24 Subd. 54. **Resident representative.** "Resident representative" means a person designated
835.25 in writing by the resident and identified in the resident's records on file with the facility.

835.26 Subd. 55. **Respiratory therapist.** "Respiratory therapist" means a person who is licensed
835.27 under chapter 147C.

835.28 Subd. 56. **Revenues.** "Revenues" means all money received by a licensee derived from
835.29 the provision of home care services, including fees for services and appropriations of public
835.30 money for home care services.

836.1 Subd. 57. **Service plan.** "Service plan" means the written plan between the resident or
836.2 the resident's representative and the provisional licensee or licensee about the services that
836.3 will be provided to the resident.

836.4 Subd. 58. **Social worker.** "Social worker" means a person who is licensed under chapter
836.5 148D or 148E.

836.6 Subd. 59. **Speech-language pathologist.** "Speech-language pathologist" has the meaning
836.7 given in section 148.512.

836.8 Subd. 60. **Standby assistance.** "Standby assistance" means the presence of another
836.9 person within arm's reach to minimize the risk of injury while performing daily activities
836.10 through physical intervention or cueing to assist a resident with an assistive task by providing
836.11 cues, oversight, and minimal physical assistance.

836.12 Subd. 61. **Substantial compliance.** "Substantial compliance" means complying with
836.13 the requirements in this chapter sufficiently to prevent unacceptable health or safety risks
836.14 to residents.

836.15 Subd. 62. **Supportive services.** "Supportive services" means:

836.16 (1) assistance with laundry, shopping, and household chores;

836.17 (2) housekeeping services;

836.18 (3) provision or assistance with meals or food preparation;

836.19 (4) help with arranging for, or arranging transportation to medical, social, recreational,
836.20 personal, or social services appointments; or

836.21 (5) provision of social or recreational services.

836.22 Arranging for services does not include making referrals, or contacting a service provider
836.23 in an emergency.

836.24 Subd. 63. **Survey.** "Survey" means an inspection of a licensee or applicant for licensure
836.25 for compliance with this chapter.

836.26 Subd. 64. **Surveyor.** "Surveyor" means a staff person of the department who is authorized
836.27 to conduct surveys of assisted living facilities and applicants.

836.28 Subd. 65. **Termination of housing or services.** "Termination of housing or services"
836.29 means a discharge, eviction, transfer, or service termination initiated by the facility. A
836.30 facility-initiated termination is one which the resident objects to and did not originate through
836.31 a resident's verbal or written request. A resident-initiated termination is one where a resident

837.1 or, if appropriate, a designated representative provided a verbal or written notice of intent
837.2 to leave the facility. A resident-initiated termination does not include the general expression
837.3 of a desire to return home or the elopement of residents with cognitive impairment.

837.4 Subd. 66. **Treatment or therapy.** "Treatment" or "therapy" means the provision of care,
837.5 other than medications, ordered or prescribed by a licensed health professional and provided
837.6 to a resident to cure, rehabilitate, or ease symptoms.

837.7 Subd. 67. **Unit of government.** "Unit of government" means a city, county, town, school
837.8 district, other political subdivision of the state, or an agency of the state or federal
837.9 government, that includes any instrumentality of a unit of government.

837.10 Subd. 68. **Unlicensed personnel.** "Unlicensed personnel" means individuals not otherwise
837.11 licensed or certified by a governmental health board or agency who provide services to a
837.12 resident.

837.13 Subd. 69. **Verbal.** "Verbal" means oral and not in writing.

837.14 Sec. 3. **[144I.02] ASSISTED LIVING FACILITY LICENSE.**

837.15 Subdivision 1. **License required.** Beginning August 1, 2021, an entity may not operate
837.16 an assisted living facility in Minnesota unless it is licensed under this chapter.

837.17 Subd. 2. **Licensure categories.** (a) The categories in this subdivision are established for
837.18 assisted living facility licensure.

837.19 (b) An assisted living category is an assisted living facility that provides basic care
837.20 services and comprehensive assisted living services.

837.21 (c) An assisted living facility with dementia care category is an assisted living facility
837.22 that provides basic care services, comprehensive assisted living services, and dementia care
837.23 services. An assisted living facility with dementia care may also provide dementia care
837.24 services in a secure dementia care unit.

837.25 Subd. 3. **Violations; penalty.** (a) Operating a facility without a license is a misdemeanor
837.26 punishable by a fine imposed by the commissioner.

837.27 (b) A controlling individual of the facility in violation of this section is guilty of a
837.28 misdemeanor. This paragraph shall not apply to any controlling individual who had no legal
837.29 authority to affect or change decisions related to the operation of the facility.

837.30 (c) The sanctions in this section do not restrict other available sanctions in law.

838.1 Sec. 4. [144I.03] PROVISIONAL LICENSE.

838.2 Subdivision 1. Provisional license. (a) Beginning August 1, 2021, for new applicants,
838.3 the commissioner shall issue a provisional license to each of the licensure categories specified
838.4 in section 144I.02, subdivision 2, which is effective for up to one year from the license
838.5 effective date, except that a provisional license may be extended according to subdivision
838.6 2, paragraph (c).

838.7 (b) Assisted living facilities are subject to evaluation and approval by the commissioner
838.8 of the facility's physical environment and its operational aspects before a change in ownership
838.9 or capacity, or an addition of services which necessitates a change in the facility's physical
838.10 environment.

838.11 Subd. 2. Initial survey; licensure. (a) During the provisional license period, the
838.12 commissioner shall survey the provisional licensee after the commissioner is notified or
838.13 has evidence that the provisional licensee has residents and is providing services.

838.14 (b) Within two days of beginning to provide services, the provisional licensee must
838.15 provide notice to the commissioner that it is serving residents by sending an e-mail to the
838.16 e-mail address provided by the commissioner. If the provisional licensee does not provide
838.17 services during the provisional license year period, then the provisional license expires at
838.18 the end of the period and the applicant must reapply for the provisional facility license.

838.19 (c) If the provisional licensee notifies the commissioner that the licensee has residents
838.20 within 45 days prior to the provisional license expiration, the commissioner may extend the
838.21 provisional license for up to 60 days in order to allow the commissioner to complete the
838.22 on-site survey required under this section and follow-up survey visits.

838.23 (d) If the provisional licensee is in substantial compliance with the survey, the
838.24 commissioner shall issue a facility license. If the provisional licensee is not in substantial
838.25 compliance with the initial survey, the commissioner shall either: (1) not issue the facility
838.26 license and terminate the provisional license; or (2) extend the provisional license for a
838.27 period not to exceed 90 days and apply conditions necessary to bring the facility into
838.28 substantial compliance. If the provisional licensee is not in substantial compliance with the
838.29 survey within the time period of the extension or if the provisional licensee does not satisfy
838.30 the license conditions, the commissioner may deny the license.

838.31 Subd. 3. Reconsideration. (a) If a provisional licensee whose facility license has been
838.32 denied or extended with conditions disagrees with the conclusions of the commissioner,
838.33 then the provisional licensee may request a reconsideration by the commissioner or

839.1 commissioner's designee. The reconsideration request process must be conducted internally
839.2 by the commissioner or designee and chapter 14 does not apply.

839.3 (b) The provisional licensee requesting the reconsideration must make the request in
839.4 writing and must list and describe the reasons why the provisional licensee disagrees with
839.5 the decision to deny the facility license or the decision to extend the provisional license
839.6 with conditions.

839.7 (c) The reconsideration request and supporting documentation must be received by the
839.8 commissioner within 15 calendar days after the date the provisional licensee receives the
839.9 denial or provisional license with conditions.

839.10 Subd. 4. **Continued operation.** A provisional licensee whose license is denied is
839.11 permitted to continue operating during the period of time when:

839.12 (1) a reconsideration is in process;

839.13 (2) an extension of the provisional license and terms associated with it is in active
839.14 negotiation between the commissioner and the licensee and the commissioner confirms the
839.15 negotiation is active; or

839.16 (3) a transfer of residents to a new facility is underway and not all of the residents have
839.17 relocated.

839.18 Subd. 5. **Requirements for notice and transfer.** A provisional licensee whose license
839.19 is denied must comply with the requirements for notification and transfer of residents in
839.20 section 144J.08.

839.21 Subd. 6. **Fines.** The fee for failure to comply with the notification requirements in section
839.22 144J.08, subdivision 6, paragraph (b), is \$1,000.

839.23 Sec. 5. **[144I.04] APPLICATION FOR LICENSURE.**

839.24 Subdivision 1. **License applications.** (a) Each application for a facility license, including
839.25 a provisional license, must include information sufficient to show that the applicant meets
839.26 the requirements of licensure, including:

839.27 (1) the business name and legal entity name of the operating entity; street address and
839.28 mailing address of the facility; and the names, e-mail addresses, telephone numbers, and
839.29 mailing addresses of all owners, controlling individuals, managerial officials, and the assisted
839.30 living administrator;

839.31 (2) the name and e-mail address of the managing agent, if applicable;

- 840.1 (3) the licensed bed capacity and the license category;
- 840.2 (4) the license fee in the amount specified in section 144.122;
- 840.3 (5) any judgments, private or public litigation, tax liens, written complaints, administrative
840.4 actions, or investigations by any government agency against the applicant, owner, controlling
840.5 individual, managerial official, or assisted living administrator that are unresolved or
840.6 otherwise filed or commenced within the preceding ten years;
- 840.7 (6) documentation of compliance with the background study requirements in section
840.8 144I.06 for the owner, controlling individuals, and managerial officials. Each application
840.9 for a new license must include documentation for the applicant and for each individual with
840.10 five percent or more direct or indirect ownership in the applicant;
- 840.11 (7) evidence of workers' compensation coverage as required by sections 176.181 and
840.12 176.182;
- 840.13 (8) disclosure that the provider has no liability coverage or, if the provider has coverage,
840.14 documentation of coverage;
- 840.15 (9) a copy of the executed lease agreement if applicable;
- 840.16 (10) a copy of the management agreement if applicable;
- 840.17 (11) a copy of the operations transfer agreement or similar agreement if applicable;
- 840.18 (12) a copy of the executed agreement if the facility has contracted services with another
840.19 organization or individual for services such as managerial, billing, consultative, or medical
840.20 personnel staffing;
- 840.21 (13) a copy of the organizational chart that identifies all organizations and individuals
840.22 with any ownership interests in the facility;
- 840.23 (14) whether any applicant, owner, controlling individual, managerial official, or assisted
840.24 living administrator of the facility has ever been convicted of a crime or found civilly liable
840.25 for an offense involving moral turpitude, including forgery, embezzlement, obtaining money
840.26 under false pretenses, larceny, extortion, conspiracy to defraud, or any other similar offense
840.27 or violation; any violation of section 626.557 or any other similar law in any other state; or
840.28 any violation of a federal or state law or regulation in connection with activities involving
840.29 any consumer fraud, false advertising, deceptive trade practices, or similar consumer
840.30 protection law;

841.1 (15) whether the applicant or any owner, controlling individual, managerial official, or
841.2 assisted living administrator of the facility has a record of defaulting in the payment of
841.3 money collected for others, including the discharge of debts through bankruptcy proceedings;

841.4 (16) documentation that the applicant has designated one or more owners, controlling
841.5 individuals, or employees as an agent or agents, which shall not affect the legal responsibility
841.6 of any other owner or controlling individual under this chapter;

841.7 (17) the signature of the owner or owners, or an authorized agent of the owner or owners
841.8 of the facility applicant. An application submitted on behalf of a business entity must be
841.9 signed by at least two owners or controlling individuals;

841.10 (18) identification of all states where the applicant or individual having a five percent
841.11 or more ownership, currently or previously has been licensed as owner or operator of a
841.12 long-term care, community-based, or health care facility or agency where its license or
841.13 federal certification has been denied, suspended, restricted, conditioned, or revoked under
841.14 a private or state-controlled receivership, or where these same actions are pending under
841.15 the laws of any state or federal authority; and

841.16 (19) any other information required by the commissioner.

841.17 Subd. 2. **Agents.** (a) An application for a facility license or for renewal of a facility
841.18 license must specify one or more owners, controlling individuals, or employees as agents:

841.19 (1) who shall be responsible for dealing with the commissioner on all requirements of
841.20 this chapter; and

841.21 (2) on whom personal service of all notices and orders shall be made and who shall be
841.22 authorized to accept service on behalf of all of the controlling individuals of the facility in
841.23 proceedings under this chapter.

841.24 (b) Notwithstanding any law to the contrary, personal service on the designated person
841.25 or persons named in the application is deemed to be service on all of the controlling
841.26 individuals or managerial employees of the facility and it is not a defense to any action
841.27 arising under this chapter that personal service was not made on each controlling individual
841.28 or managerial official of the facility. The designation of one or more controlling individuals
841.29 or managerial officials under this subdivision shall not affect the legal responsibility of any
841.30 other controlling individual or managerial official under this chapter.

841.31 Subd. 3. **Fees.** (a) An initial applicant, renewal applicant, or applicant filing a change
841.32 of ownership for assisted living facility licensure must submit the application fee required
841.33 in section 144I.122 to the commissioner along with a completed application.

842.1 (b) The penalty for late submission of the renewal application after expiration of the
 842.2 license is \$200. The penalty for operating a facility after expiration of the license and before
 842.3 a renewal license is issued, is \$250 each day after expiration of the license until the renewal
 842.4 license issuance date. The facility is still subject to the criminal gross misdemeanor penalties
 842.5 for operating after license expiration.

842.6 (c) Fees collected under this section shall be deposited in the state treasury and credited
 842.7 to the state government special revenue fund. All fees are nonrefundable.

842.8 (d) Fines collected under this subdivision shall be deposited in a dedicated special revenue
 842.9 account. On an annual basis, the balance in the special revenue account shall be appropriated
 842.10 to the commissioner to implement the recommendations of the advisory council established
 842.11 in section 144A.4799.

842.12 **Sec. 6. [144I.05] TRANSFER OF LICENSE PROHIBITED.**

842.13 Subdivision 1. **Transfers prohibited.** Any facility license issued by the commissioner
 842.14 may not be transferred to another party.

842.15 Subd. 2. **New license required.** (a) Before acquiring ownership of a facility, a prospective
 842.16 applicant must apply for a new license. The licensee of an assisted living facility must
 842.17 change whenever the following events occur, including but not limited to:

842.18 (1) the licensee's form of legal organization is changed;

842.19 (2) the licensee transfers ownership of the facility business enterprise to another party
 842.20 regardless of whether ownership of some or all of the real property or personal property
 842.21 assets of the assisted living facility is also transferred;

842.22 (3) the licensee dissolves, consolidates, or merges with another legal organization and
 842.23 the licensee's legal organization does not survive;

842.24 (4) during any continuous 24-month period, 50 percent or more of the licensed entity is
 842.25 transferred, whether by a single transaction or multiple transactions, to:

842.26 (i) a different person; or

842.27 (ii) a person who had less than a five percent ownership interest in the facility at the
 842.28 time of the first transaction; or

842.29 (5) any other event or combination of events that results in a substitution, elimination,
 842.30 or withdrawal of the licensee's control of the facility.

843.1 (b) As used in this section, "control" means the possession, directly or indirectly, of the
843.2 power to direct the management, operation, and policies of the licensee or facility, whether
843.3 through ownership, voting control, by agreement, by contract, or otherwise.

843.4 (c) The current facility licensee must provide written notice to the department and
843.5 residents, or designated representatives, at least 60 calendar days prior to the anticipated
843.6 date of the change of licensee.

843.7 Subd. 3. **Survey required.** For all new licensees after a change in ownership, the
843.8 commissioner shall complete a survey within six months after the new license is issued.

843.9 Sec. 7. **[144I.06] BACKGROUND STUDIES.**

843.10 Subdivision 1. **Background studies required.** (a) Before the commissioner issues a
843.11 provisional license, issues a license as a result of an approved change of ownership, or
843.12 renews a license, a controlling individual or managerial official is required to complete a
843.13 background study under section 144.057. No person may be involved in the management,
843.14 operation, or control of a facility if the person has been disqualified under chapter 245C.
843.15 For the purposes of this section, managerial officials subject to the background check
843.16 requirement are individuals who provide direct contact.

843.17 (b) The commissioner shall not issue a license if the controlling individual or managerial
843.18 official has been unsuccessful in having a background study disqualification set aside under
843.19 section 144.057 and chapter 245C.

843.20 (c) Employees, contractors, and volunteers of the facility are subject to the background
843.21 study required by section 144.057 and may be disqualified under chapter 245C. Nothing in
843.22 this section shall be construed to prohibit the facility from requiring self-disclosure of
843.23 criminal conviction information.

843.24 Subd. 2. **Reconsideration.** If an individual is disqualified under section 144.057 or
843.25 chapter 245C, the individual may request reconsideration of the disqualification. If the
843.26 individual requests reconsideration and the commissioner sets aside or rescinds the
843.27 disqualification, the individual is eligible to be involved in the management, operation, or
843.28 control of the facility. If an individual has a disqualification under section 245C.15,
843.29 subdivision 1, and the disqualification is affirmed, the individual's disqualification is barred
843.30 from a set aside, and the individual must not be involved in the management, operation, or
843.31 control of the facility.

843.32 Subd. 3. **Data classification.** Data collected under this subdivision shall be classified
843.33 as private data on individuals under section 13.02, subdivision 12.

844.1 Subd. 4. **Termination in good faith.** Termination of an employee in good faith reliance
844.2 on information or records obtained under this section regarding a confirmed conviction does
844.3 not subject the assisted living facility to civil liability or liability for unemployment benefits.

844.4 **Sec. 8. [144I.07] LICENSE RENEWAL.**

844.5 Except as provided in section, a license that is not a provisional license may be
844.6 renewed for a period of up to one year if the licensee satisfies the following:

844.7 (1) submits an application for renewal in the format provided by the commissioner at
844.8 least 60 days before expiration of the license;

844.9 (2) submits the renewal fee under section 144I.04, subdivision 3;

844.10 (3) submits the late fee under section 144I.04, subdivision 3, if the renewal application
844.11 is received less than 30 days before the expiration date of the license;

844.12 (4) provides information sufficient to show that the applicant meets the requirements of
844.13 licensure, including items required under section 144I.04, subdivision 1; and

844.14 (5) provides any other information deemed necessary by the commissioner.

844.15 **Sec. 9. [144I.08] NOTIFICATION OF CHANGES IN INFORMATION.**

844.16 A provisional licensee or licensee shall notify the commissioner in writing prior to any
844.17 financial or contractual change and within 60 calendar days after any change in the
844.18 information required in section 144I.04, subdivision 1.

844.19 **Sec. 10. [144I.09] CONSIDERATION OF APPLICATIONS.**

844.20 (a) The commissioner shall consider an applicant's performance history in Minnesota
844.21 and in other states, including repeat violations or rule violations, before issuing a provisional
844.22 license, license, or renewal license.

844.23 (b) An applicant must not have a history within the last five years in Minnesota or in
844.24 any other state of a license or certification involuntarily suspended or voluntarily terminated
844.25 during any enforcement process in a facility that provides care to children, the elderly or ill
844.26 individuals, or individuals with disabilities.

844.27 (c) Failure to provide accurate information or demonstrate required performance history
844.28 may result in the denial of a license.

844.29 (d) The commissioner may deny, revoke, suspend, restrict, or refuse to renew the license
844.30 or impose conditions if:

845.1 (1) the applicant fails to provide complete and accurate information on the application
845.2 and the commissioner concludes that the missing or corrected information is needed to
845.3 determine if a license shall be granted;

845.4 (2) the applicant, knowingly or with reason to know, made a false statement of a material
845.5 fact in an application for the license or any data attached to the application or in any matter
845.6 under investigation by the department;

845.7 (3) the applicant refused to allow representatives or agents of the department to inspect
845.8 its books, records, and files, or any portion of the premises;

845.9 (4) willfully prevented, interfered with, or attempted to impede in any way: (i) the work
845.10 of any authorized representative of the department, the ombudsman for long-term care, or
845.11 the ombudsman for mental health and developmental disabilities; or (ii) the duties of the
845.12 commissioner, local law enforcement, city or county attorneys, adult protection, county
845.13 case managers, or other local government personnel;

845.14 (5) the applicant has a history of noncompliance with federal or state regulations that
845.15 were detrimental to the health, welfare, or safety of a resident or a client; and

845.16 (6) the applicant violates any requirement in this chapter.

845.17 (e) For all new licensees after a change in ownership, the commissioner shall complete
845.18 a survey within six months after the new license is issued.

845.19 **Sec. 11. [144I.10] MINIMUM ASSISTED LIVING FACILITY REQUIREMENTS.**

845.20 Subdivision 1. **Minimum requirements.** All licensed facilities shall:

845.21 (1) distribute to residents, families, and resident representatives the assisted living bill
845.22 of rights in section 144J.02;

845.23 (2) provide health-related services in a manner that complies with the Nurse Practice
845.24 Act in sections 148.171 to 148.285;

845.25 (3) utilize person-centered planning and service delivery process as defined in section
845.26 245D.07;

845.27 (4) have and maintain a system for delegation of health care activities to unlicensed
845.28 personnel by a registered nurse, including supervision and evaluation of the delegated
845.29 activities as required by the Nurse Practice Act in sections 148.171 to 148.285;

845.30 (5) provide a means for residents to request assistance for health and safety needs 24
845.31 hours per day, seven days per week;

- 846.1 (6) allow residents the ability to furnish and decorate the resident's unit within the terms
846.2 of the lease;
- 846.3 (7) permit residents access to food at any time;
- 846.4 (8) allow residents to choose the resident's visitors and times of visits;
- 846.5 (9) allow the resident the right to choose a roommate if sharing a unit;
- 846.6 (10) notify the resident of the resident's right to have and use a lockable door to the
846.7 resident's unit. The licensee shall provide the locks on the unit. Only a staff member with
846.8 a specific need to enter the unit shall have keys, and advance notice must be given to the
846.9 resident before entrance, when possible;
- 846.10 (11) develop and implement a staffing plan for determining its staffing level that:
- 846.11 (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness
846.12 of staffing levels in the facility;
- 846.13 (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably
846.14 foreseeable unscheduled needs of each resident as required by the residents' assessments
846.15 and service plans on a 24-hour per day basis; and
- 846.16 (iii) ensures that the facility can respond promptly and effectively to individual resident
846.17 emergencies and to emergency, life safety, and disaster situations affecting staff or residents
846.18 in the facility;
- 846.19 (12) ensures that a person or persons are available 24 hours per day, seven days per
846.20 week, who are responsible for responding to the requests of residents for assistance with
846.21 health or safety needs, who shall be:
- 846.22 (i) awake;
- 846.23 (ii) located in the same building, in an attached building, or on a contiguous campus
846.24 with the facility in order to respond within a reasonable amount of time;
- 846.25 (iii) capable of communicating with residents;
- 846.26 (iv) capable of providing or summoning the appropriate assistance; and
- 846.27 (v) capable of following directions. For an assisted living facility providing dementia
846.28 care, the awake person must be physically present in the locked or secure unit; and
- 846.29 (13) offer to provide or make available at least the following services to residents:
- 846.30 (i) at least three daily nutritious meals with snacks available seven days per week,
846.31 according to the recommended dietary allowances in the United States Department of

847.1 Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The
847.2 following apply:

847.3 (A) modified special diets that are appropriate to residents' needs and choices;

847.4 (B) menus prepared at least one week in advance, and made available to all residents.

847.5 The facility must encourage residents' involvement in menu planning. Meal substitutions
847.6 must be of similar nutritional value if a resident refuses a food that is served. Residents
847.7 must be informed in advance of menu changes;

847.8 (C) food must be prepared and served according to the Minnesota Food Code, Minnesota
847.9 Rules, chapter 4626; and

847.10 (D) the facility cannot require a resident to include and pay for meals in their contract;

847.11 (ii) weekly housekeeping;

847.12 (iii) weekly laundry service;

847.13 (iv) upon the request of the resident, provide direct or reasonable assistance with arranging
847.14 for transportation to medical and social services appointments, shopping, and other recreation,
847.15 and provide the name of or other identifying information about the person or persons
847.16 responsible for providing this assistance;

847.17 (v) upon the request of the resident, provide reasonable assistance with accessing
847.18 community resources and social services available in the community, and provide the name
847.19 of or other identifying information about the person or persons responsible for providing
847.20 this assistance; and

847.21 (vi) have a daily program of social and recreational activities that are based upon
847.22 individual and group interests, physical, mental, and psychosocial needs, and that creates
847.23 opportunities for active participation in the community at large.

847.24 Subd. 2. **Policies and procedures.** (a) Each facility must have policies and procedures
847.25 in place to address the following and keep them current:

847.26 (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults;

847.27 (2) conducting and handling background studies on employees;

847.28 (3) orientation, training, and competency evaluations of staff, and a process for evaluating
847.29 staff performance;

847.30 (4) handling complaints from residents, family members, or designated representatives
847.31 regarding staff or services provided by staff;

848.1 (5) conducting initial evaluation of residents' needs and the providers' ability to provide
848.2 those services;

848.3 (6) conducting initial and ongoing resident evaluations and assessments and how changes
848.4 in a resident's condition are identified, managed, and communicated to staff and other health
848.5 care providers as appropriate;

848.6 (7) orientation to and implementation of the assisted living bill of rights;

848.7 (8) infection control practices;

848.8 (9) reminders for medications, treatments, or exercises, if provided; and

848.9 (10) conducting appropriate screenings, or documentation of prior screenings, to show
848.10 that staff are free of tuberculosis, consistent with current United States Centers for Disease
848.11 Control and Prevention standards.

848.12 (b) For assisted living facilities and assisted living facilities with dementia care, the
848.13 following are also required:

848.14 (1) conducting initial and ongoing assessments of the resident's needs by a registered
848.15 nurse or appropriate licensed health professional, including how changes in the resident's
848.16 conditions are identified, managed, and communicated to staff and other health care
848.17 providers, as appropriate;

848.18 (2) ensuring that nurses and licensed health professionals have current and valid licenses
848.19 to practice;

848.20 (3) medication and treatment management;

848.21 (4) delegation of tasks by registered nurses or licensed health professionals;

848.22 (5) supervision of registered nurses and licensed health professionals; and

848.23 (6) supervision of unlicensed personnel performing delegated tasks.

848.24 Subd. 3. **Infection control program.** The facility shall establish and maintain an infection
848.25 control program.

848.26 Subd. 4. **Clinical nurse supervision.** All assisted living facilities must have a clinical
848.27 nurse supervisor who is a registered nurse licensed in Minnesota.

848.28 Subd. 5. **Resident and family or resident representative councils.** (a) If a resident,
848.29 family, or designated representative chooses to establish a council, the licensee shall support
848.30 the council's establishment. The facility must provide assistance and space for meetings and
848.31 afford privacy. Staff or visitors may attend meetings only upon the council's invitation. A

849.1 staff person must be designated the responsibility of providing this assistance and responding
849.2 to written requests that result from council meetings. Resident council minutes are public
849.3 data and shall be available to all residents in the facility. Family or resident representatives
849.4 may attend resident councils upon invitation by a resident on the council.

849.5 (b) All assisted living facilities shall engage their residents and families or designated
849.6 representatives in the operation of their community and document the methods and results
849.7 of this engagement.

849.8 Subd. 6. **Resident grievances.** All facilities must post in a conspicuous place information
849.9 about the facilities' grievance procedure, and the name, telephone number, and e-mail contact
849.10 information for the individuals who are responsible for handling resident grievances. The
849.11 notice must also have the contact information for the state and applicable regional Office
849.12 of Ombudsman for Long-Term Care.

849.13 Subd. 7. **Protecting resident rights.** A facility shall ensure that every resident has access
849.14 to consumer advocacy or legal services by:

849.15 (1) providing names and contact information, including telephone numbers and e-mail
849.16 addresses of at least three organizations that provide advocacy or legal services to residents;

849.17 (2) providing the name and contact information for the Minnesota Office of Ombudsman
849.18 for Long-Term Care and the Office of the Ombudsman for Mental Health and Developmental
849.19 Disabilities, including both the state and regional contact information;

849.20 (3) assisting residents in obtaining information on whether Medicare or medical assistance
849.21 under chapter 256B will pay for services;

849.22 (4) making reasonable accommodations for people who have communication disabilities
849.23 and those who speak a language other than English; and

849.24 (5) providing all information and notices in plain language and in terms the residents
849.25 can understand.

849.26 Subd. 8. **Protection-related rights.** (a) In addition to the rights required in the assisted
849.27 living bill of rights under section 144J.02, the following rights must be provided to all
849.28 residents. The facility must promote and protect these rights for each resident by making
849.29 residents aware of these rights and ensuring staff are trained to support these rights:

849.30 (1) the right to furnish and decorate the resident's unit within the terms of the lease;

849.31 (2) the right to access food at any time;

849.32 (3) the right to choose visitors and the times of visits;

850.1 (4) the right to choose a roommate if sharing a unit;

850.2 (5) the right to personal privacy including the right to have and use a lockable door on
850.3 the resident's unit. The facility shall provide the locks on the resident's unit. Only a staff
850.4 member with a specific need to enter the unit shall have keys, and advance notice must be
850.5 given to the resident before entrance, when possible;

850.6 (6) the right to engage in chosen activities;

850.7 (7) the right to engage in community life;

850.8 (8) the right to control personal resources; and

850.9 (9) the right to individual autonomy, initiative, and independence in making life choices
850.10 including a daily schedule and with whom to interact.

850.11 (b) The resident's rights in paragraph (a), clauses (2), (3), and (5), may be restricted for
850.12 an individual resident only if determined necessary for health and safety reasons identified
850.13 by the facility through an initial assessment or reassessment under section 144I.15,
850.14 subdivision 9, and documented in the written service plan under section 144I.15, subdivision
850.15 10. Any restrictions of those rights for people served under sections 256B.0915 and 256B.49
850.16 must be documented by the case manager in the resident's coordinated service and support
850.17 plan (CSSP), as defined in sections 256B.0915, subdivision 6, and 256B.49, subdivision
850.18 15.

850.19 Subd. 9. **Payment for services under disability waivers.** For new facilities, home and
850.20 community-based services under section 256B.49 are not available when the new facility
850.21 setting is adjoined to, or on the same property as, an institution as defined in Code of Federal
850.22 Regulations, title 42, section 441.301(c).

850.23 Subd. 10. **No discrimination based on source of payment.** All facilities must, regardless
850.24 of the source of payment and for all persons seeking to reside or residing in the facility:

850.25 (1) provide equal access to quality care; and

850.26 (2) establish, maintain, and implement identical policies and practices regarding residency,
850.27 transfer, and provision and termination of services.

850.28 **EFFECTIVE DATE.** This section is effective August 1, 2021.

851.1 Sec. 12. [144I.11] FACILITY RESPONSIBILITIES; HOUSING AND
851.2 SERVICE-RELATED MATTERS.

851.3 Subdivision 1. Responsibility for housing and services. The facility is directly
851.4 responsible to the resident for all housing and service-related matters provided, irrespective
851.5 of a management contract. Housing and service-related matters include but are not limited
851.6 to the handling of complaints, the provision of notices, and the initiation of any adverse
851.7 action against the resident involving housing or services provided by the facility.

851.8 Subd. 2. Uniform checklist disclosure of services. (a) On and after August 1, 2021, a
851.9 facility must provide to prospective residents, the prospective resident's designated
851.10 representative, and any other person or persons the resident chooses:

851.11 (1) a written checklist listing all services permitted under the facility's license, identifying
851.12 all services the facility offers to provide under the assisted living facility contract, and
851.13 identifying all services allowed under the license that the facility does not provide; and

851.14 (2) an oral explanation of the services offered under the contract.

851.15 (b) The requirements of paragraph (a) must be completed prior to the execution of the
851.16 resident contract.

851.17 (c) The commissioner must, in consultation with all interested stakeholders, design the
851.18 uniform checklist disclosure form for use as provided under paragraph (a).

851.19 Subd. 3. Reservation of rights. Nothing in this chapter:

851.20 (1) requires a resident to utilize any service provided by or through, or made available
851.21 in, a facility;

851.22 (2) prevents a facility from requiring, as a condition of the contract, that the resident pay
851.23 for a package of services even if the resident does not choose to use all or some of the
851.24 services in the package. For residents who are eligible for home and community-based
851.25 waiver services under sections 256B.0915 and 256B.49, payment for services will follow
851.26 the policies of those programs;

851.27 (3) requires a facility to fundamentally alter the nature of the operations of the facility
851.28 in order to accommodate a resident's request; or

851.29 (4) affects the duty of a facility to grant a resident's request for reasonable
851.30 accommodations.

852.1 **Sec. 13. [144I.12] TRANSFER OF RESIDENTS WITHIN FACILITY.**

852.2 (a) A facility must provide for the safe, orderly, and appropriate transfer of residents
852.3 within the facility.

852.4 (b) If an assisted living contract permits resident transfers within the facility, the facility
852.5 must provide at least 30 days' advance notice of the transfer to the resident and the resident's
852.6 designated representative.

852.7 (c) In situations where there is a curtailment, reduction, capital improvement, or change
852.8 in operations within a facility, the facility must minimize the number of transfers needed
852.9 to complete the project or change in operations, consider individual resident needs and
852.10 preferences, and provide reasonable accommodation for individual resident requests regarding
852.11 the room transfer. The facility must provide notice to the Office of Ombudsman for
852.12 Long-Term Care and, when appropriate, the Office of Ombudsman for Mental Health and
852.13 Developmental Disabilities in advance of any notice to residents, residents' designated
852.14 representatives, and families when all of the following circumstances apply:

852.15 (1) the transfers of residents within the facility are being proposed due to curtailment,
852.16 reduction, capital improvements, or change in operations;

852.17 (2) the transfers of residents within the facility are not temporary moves to accommodate
852.18 physical plan upgrades or renovation; and

852.19 (3) the transfers involve multiple residents being moved simultaneously.

852.20 **EFFECTIVE DATE.** This section is effective August 1, 2021.

852.21 **Sec. 14. [144I.13] FACILITY RESPONSIBILITIES; BUSINESS OPERATION.**

852.22 Subdivision 1. **Display of license.** The original current license must be displayed at the
852.23 main entrance of the facility. The facility must provide a copy of the license to any person
852.24 who requests it.

852.25 Subd. 2. **Quality management.** The facility shall engage in quality management
852.26 appropriate to the size of the facility and relevant to the type of services provided. The
852.27 quality management activity means evaluating the quality of care by periodically reviewing
852.28 resident services, complaints made, and other issues that have occurred and determining
852.29 whether changes in services, staffing, or other procedures need to be made in order to ensure
852.30 safe and competent services to residents. Documentation about quality management activity
852.31 must be available for two years. Information about quality management must be available
852.32 to the commissioner at the time of the survey, investigation, or renewal.

853.1 Subd. 3. Facility restrictions. (a) This subdivision does not apply to licensees that are
853.2 Minnesota counties or other units of government.

853.3 (b) A facility or staff person cannot accept a power-of-attorney from residents for any
853.4 purpose, and may not accept appointments as guardians or conservators of residents.

853.5 (c) A facility cannot serve as a resident's representative.

853.6 Subd. 4. Handling resident's finances and property. (a) A facility may assist residents
853.7 with household budgeting, including paying bills and purchasing household goods, but may
853.8 not otherwise manage a resident's property. A facility must provide a resident with receipts
853.9 for all transactions and purchases paid with the resident's funds. When receipts are not
853.10 available, the transaction or purchase must be documented. A facility must maintain records
853.11 of all such transactions.

853.12 (b) A facility or staff person may not borrow a resident's funds or personal or real
853.13 property, nor in any way convert a resident's property to the facility's or staff person's
853.14 possession.

853.15 (c) Nothing in this section precludes a facility or staff from accepting gifts of minimal
853.16 value or precludes the acceptance of donations or bequests made to a facility that are exempt
853.17 from income tax under section 501(c) of the Internal Revenue Code of 1986.

853.18 Subd. 5. Reporting maltreatment of vulnerable adults; abuse prevention plan. (a)
853.19 All facilities must comply with the requirements for the reporting of maltreatment of
853.20 vulnerable adults in section 626.557. Each facility must establish and implement a written
853.21 procedure to ensure that all cases of suspected maltreatment are reported.

853.22 (b) Each facility must develop and implement an individual abuse prevention plan for
853.23 each vulnerable adult. The plan shall contain an individualized review or assessment of the
853.24 person's susceptibility to abuse by another individual, including other vulnerable adults; the
853.25 person's risk of abusing other vulnerable adults; and statements of the specific measures to
853.26 be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes
853.27 of the abuse prevention plan, abuse includes self-abuse.

853.28 Subd. 6. Reporting suspected crime and maltreatment. (a) A facility shall support
853.29 protection and safety through access to the state's systems for reporting suspected criminal
853.30 activity and suspected vulnerable adult maltreatment by:

853.31 (1) posting the 911 emergency number in common areas and near telephones provided
853.32 by the assisted living facility;

854.1 (2) posting information and the reporting number for the Minnesota Adult Abuse
854.2 Reporting Center under section 626.557 to report suspected maltreatment of a vulnerable
854.3 adult; and

854.4 (3) providing reasonable accommodations with information and notices in plain language.

854.5 Subd. 7. **Employee records.** (a) The facility must maintain current records of each paid
854.6 employee, regularly scheduled volunteers providing services, and each individual contractor
854.7 providing services. The records must include the following information:

854.8 (1) evidence of current professional licensure, registration, or certification if licensure,
854.9 registration, or certification is required by this statute or other rules;

854.10 (2) records of orientation, required annual training and infection control training, and
854.11 competency evaluations;

854.12 (3) current job description, including qualifications, responsibilities, and identification
854.13 of staff persons providing supervision;

854.14 (4) documentation of annual performance reviews that identify areas of improvement
854.15 needed and training needs;

854.16 (5) for individuals providing facility services, verification that required health screenings
854.17 under section 144I.034, subdivision 7, have taken place and the dates of those screenings;
854.18 and

854.19 (6) documentation of the background study as required under section 144.057.

854.20 (b) Each employee record must be retained for at least three years after a paid employee,
854.21 volunteer, or contractor ceases to be employed by, provide services at, or be under contract
854.22 with the facility. If a facility ceases operation, employee records must be maintained for
854.23 three years after facility operations cease.

854.24 Subd. 8. **Compliance officer.** Every assisted living facility shall have a compliance
854.25 officer who is a licensed assisted living administrator. An individual licensed as a nursing
854.26 home administrator, an assisted living administrator, or a health services executive shall
854.27 automatically meet the qualifications of a compliance officer.

854.28 Sec. 15. **[144I.14] FACILITY RESPONSIBILITIES; STAFF.**

854.29 Subdivision 1. **Qualifications, training, and competency.** All staff persons providing
854.30 services must be trained and competent in the provision of services consistent with current
854.31 practice standards appropriate to the resident's needs and be informed of the assisted living
854.32 bill of rights under section 144J.02.

855.1 Subd. 2. Licensed health professionals and nurses. (a) Licensed health professionals
855.2 and nurses providing services as employees of a licensed facility must possess a current
855.3 Minnesota license or registration to practice.

855.4 (b) Licensed health professionals and registered nurses must be competent in assessing
855.5 resident needs, planning appropriate services to meet resident needs, implementing services,
855.6 and supervising staff if assigned.

855.7 (c) Nothing in this section limits or expands the rights of nurses or licensed health
855.8 professionals to provide services within the scope of their licenses or registrations, as
855.9 provided by law.

855.10 Subd. 3. Unlicensed personnel. (a) Unlicensed personnel providing services must have:

855.11 (1) successfully completed a training and competency evaluation appropriate to the
855.12 services provided by the facility and the topics listed in subdivision 6, paragraph (b); or

855.13 (2) demonstrated competency by satisfactorily completing a written or oral test on the
855.14 tasks the unlicensed personnel will perform and on the topics listed in subdivision 6,
855.15 paragraph (b); and successfully demonstrated competency of topics in subdivision 6,
855.16 paragraph (b), clauses (5), (7), and (8), by a practical skills test.

855.17 Unlicensed personnel providing basic care services shall not perform delegated nursing or
855.18 therapy tasks.

855.19 (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility
855.20 must:

855.21 (1) have successfully completed training and demonstrated competency by successfully
855.22 completing a written or oral test of the topics in subdivision 6, paragraphs (b) and (c), and
855.23 a practical skills test on tasks listed in subdivision 6, paragraphs (b), clauses (5) and (7),
855.24 and (c), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform;

855.25 (2) satisfy the current requirements of Medicare for training or competency of home
855.26 health aides or nursing assistants, as provided by Code of Federal Regulations, title 42,
855.27 section 483 or 484.36; or

855.28 (3) have, before April 19, 1993, completed a training course for nursing assistants that
855.29 was approved by the commissioner.

855.30 (c) Unlicensed personnel performing therapy or treatment tasks delegated or assigned
855.31 by a licensed health professional must meet the requirements for delegated tasks in
855.32 subdivision 4 and any other training or competency requirements within the licensed health

856.1 professional's scope of practice relating to delegation or assignment of tasks to unlicensed
856.2 personnel.

856.3 Subd. 4. **Delegation of assisted living services.** A registered nurse or licensed health
856.4 professional may delegate tasks only to staff who are competent and possess the knowledge
856.5 and skills consistent with the complexity of the tasks and according to the appropriate
856.6 Minnesota practice act. The assisted living facility must establish and implement a system
856.7 to communicate up-to-date information to the registered nurse or licensed health professional
856.8 regarding the current available staff and their competency so the registered nurse or licensed
856.9 health professional has sufficient information to determine the appropriateness of delegating
856.10 tasks to meet individual resident needs and preferences.

856.11 Subd. 5. **Temporary staff.** When a facility contracts with a temporary staffing agency,
856.12 those individuals must meet the same requirements required by this section for personnel
856.13 employed by the facility and shall be treated as if they are staff of the facility.

856.14 Subd. 6. **Requirements for instructors, training content, and competency evaluations**
856.15 for unlicensed personnel. (a) Instructors and competency evaluators must meet the following
856.16 requirements:

856.17 (1) training and competency evaluations of unlicensed personnel providing basic care
856.18 services must be conducted by individuals with work experience and training in providing
856.19 basic care services; and

856.20 (2) training and competency evaluations of unlicensed personnel providing comprehensive
856.21 assisted living services must be conducted by a registered nurse, or another instructor may
856.22 provide training in conjunction with the registered nurse.

856.23 (b) Training and competency evaluations for all unlicensed personnel must include the
856.24 following:

856.25 (1) documentation requirements for all services provided;

856.26 (2) reports of changes in the resident's condition to the supervisor designated by the
856.27 facility;

856.28 (3) basic infection control, including blood-borne pathogens;

856.29 (4) maintenance of a clean and safe environment;

856.30 (5) appropriate and safe techniques in personal hygiene and grooming, including:

856.31 (i) hair care and bathing;

856.32 (ii) care of teeth, gums, and oral prosthetic devices;

- 857.1 (iii) care and use of hearing aids; and
- 857.2 (iv) dressing and assisting with toileting;
- 857.3 (6) training on the prevention of falls;
- 857.4 (7) standby assistance techniques and how to perform them;
- 857.5 (8) medication, exercise, and treatment reminders;
- 857.6 (9) basic nutrition, meal preparation, food safety, and assistance with eating;
- 857.7 (10) preparation of modified diets as ordered by a licensed health professional;
- 857.8 (11) communication skills that include preserving the dignity of the resident and showing
- 857.9 respect for the resident and the resident's preferences, cultural background, and family;
- 857.10 (12) awareness of confidentiality and privacy;
- 857.11 (13) understanding appropriate boundaries between staff and residents and the resident's
- 857.12 family;
- 857.13 (14) procedures to use in handling various emergency situations; and
- 857.14 (15) awareness of commonly used health technology equipment and assistive devices.
- 857.15 (c) In addition to paragraph (b), training and competency evaluation for unlicensed
- 857.16 personnel providing comprehensive assisted living services must include:
- 857.17 (1) observing, reporting, and documenting resident status;
- 857.18 (2) basic knowledge of body functioning and changes in body functioning, injuries, or
- 857.19 other observed changes that must be reported to appropriate personnel;
- 857.20 (3) reading and recording temperature, pulse, and respirations of the resident;
- 857.21 (4) recognizing physical, emotional, cognitive, and developmental needs of the resident;
- 857.22 (5) safe transfer techniques and ambulation;
- 857.23 (6) range of motioning and positioning; and
- 857.24 (7) administering medications or treatments as required.
- 857.25 (d) When the registered nurse or licensed health professional delegates tasks, that person
- 857.26 must ensure that prior to the delegation the unlicensed personnel is trained in the proper
- 857.27 methods to perform the tasks or procedures for each resident and are able to demonstrate
- 857.28 the ability to competently follow the procedures and perform the tasks. If an unlicensed
- 857.29 personnel has not regularly performed the delegated assisted living task for a period of 24

858.1 consecutive months, the unlicensed personnel must demonstrate competency in the task to
 858.2 the registered nurse or appropriate licensed health professional. The registered nurse or
 858.3 licensed health professional must document instructions for the delegated tasks in the
 858.4 resident's record.

858.5 Subd. 7. **Tuberculosis prevention and control.** A facility must establish and maintain
 858.6 a comprehensive tuberculosis infection control program according to the most current
 858.7 tuberculosis infection control guidelines issued by the United States Centers for Disease
 858.8 Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the
 858.9 CDC's Morbidity and Mortality Weekly Report (MMWR). The program must include a
 858.10 tuberculosis infection control plan that covers all paid and unpaid employees, contractors,
 858.11 students, and volunteers. The Department of Health shall provide technical assistance
 858.12 regarding implementation of the guidelines.

858.13 Subd. 8. **Disaster planning and emergency preparedness plan.** (a) Each facility must
 858.14 meet the following requirements:

858.15 (1) have a written emergency disaster plan that contains a plan for evacuation, addresses
 858.16 elements of sheltering in place, identifies temporary relocation sites, and details staff
 858.17 assignments in the event of a disaster or an emergency;

858.18 (2) post an emergency disaster plan prominently;

858.19 (3) provide building emergency exit diagrams to all residents;

858.20 (4) post emergency exit diagrams on each floor; and

858.21 (5) have a written policy and procedure regarding missing tenant residents.

858.22 (b) Each facility must provide emergency and disaster training to all staff during the
 858.23 initial staff orientation and annually thereafter and must make emergency and disaster
 858.24 training annually available to all residents. Staff who have not received emergency and
 858.25 disaster training are allowed to work only when trained staff are also working on site.

858.26 (c) Each facility must meet any additional requirements adopted in rule.

858.27 Sec. 16. **[144L.15] FACILITY RESPONSIBILITIES WITH RESPECT TO**
 858.28 **RESIDENTS.**

858.29 Subdivision 1. **Assisted living bill of rights; notification to resident.** (a) A facility
 858.30 shall provide the resident and the designated representative a written notice of the rights
 858.31 under section 144J.02 before the initiation of services to that resident. The facility shall

859.1 make all reasonable efforts to provide notice of the rights to the resident and the designated
859.2 representative in a language the resident and designated representative can understand.

859.3 (b) In addition to the text of the bill of rights in section 144J.02, the notice shall also
859.4 contain the following statement describing how to file a complaint.

859.5 "If you want to report suspected maltreatment of a vulnerable adult, you may call the
859.6 Minnesota Adult Abuse Reporting Center at 1-844-880-1574. If you have a complaint about
859.7 the facility or person providing your services, you may contact the Office of Health Facility
859.8 Complaints, Minnesota Department of Health. You may also contact the Office of
859.9 Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and
859.10 Developmental Disabilities."

859.11 (c) The statement must include the telephone number, website address, e-mail address,
859.12 mailing address, and street address of the Office of Health Facility Complaints at the
859.13 Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the
859.14 Office of Ombudsman for Mental Health and Developmental Disabilities. The statement
859.15 must include the facility's name, address, e-mail, telephone number, and name or title of
859.16 the person at the facility to whom problems or complaints may be directed. It must also
859.17 include a statement that the facility will not retaliate because of a complaint.

859.18 (d) A facility must obtain written acknowledgment of the resident's receipt of the bill of
859.19 rights or shall document why an acknowledgment cannot be obtained. The acknowledgment
859.20 may be obtained from the resident and the designated representative. Acknowledgment of
859.21 receipt shall be retained in the resident's record.

859.22 Subd. 2. **Notices in plain language; language accommodations.** A facility must provide
859.23 all notices in plain language that residents can understand and make reasonable
859.24 accommodations for residents who have communication disabilities and those whose primary
859.25 language is a language other than English.

859.26 Subd. 3. **Notice of services for dementia, Alzheimer's disease, or related disorders.** A
859.27 facility that provides services to residents with dementia shall provide in written or electronic
859.28 form, to residents and families or other persons who request it, a description of the training
859.29 program and related training it provides, including the categories of employees trained, the
859.30 frequency of training, and the basic topics covered.

859.31 Subd. 4. **Services oversight and information.** A facility shall provide each resident
859.32 with identifying and contact information about the persons who can assist with health care
859.33 or supportive services being provided. A facility shall keep each resident informed of changes
859.34 in the personnel referenced in this subdivision.

860.1 Subd. 5. **Notice to residents; change in ownership or management.** A facility must
860.2 provide prompt written notice to the resident or designated representative of any change of
860.3 legal name, telephone number, and physical mailing address, which may not be a public or
860.4 private post office box, of:

860.5 (1) the licensee of the facility;

860.6 (2) the manager of the facility, if applicable; and

860.7 (3) the agent authorized to accept legal process on behalf of the facility.

860.8 Subd. 6. **Acceptance of residents.** A facility may not accept a person as a resident unless
860.9 the facility has staff, sufficient in qualifications, competency, and numbers, to adequately
860.10 provide the services agreed to in the service plan and that are within the facility's scope of
860.11 practice.

860.12 Subd. 7. **Referrals.** If a facility reasonably believes that a resident is in need of another
860.13 medical or health service, including a licensed health professional, or social service provider,
860.14 the facility shall:

860.15 (1) determine the resident's preferences with respect to obtaining the service; and

860.16 (2) inform the resident of the resources available, if known, to assist the resident in
860.17 obtaining services.

860.18 Subd. 8. **Initiation of services.** When a facility initiates services and the individualized
860.19 assessment required in subdivision 9 has not been completed, the facility must complete a
860.20 temporary plan and agreement with the resident for services.

860.21 Subd. 9. **Initial assessments and monitoring.** (a) An assisted living facility shall conduct
860.22 a nursing assessment by a registered nurse of the physical and cognitive needs of the
860.23 prospective resident and propose a temporary service plan prior to the date on which a
860.24 prospective resident executes a contract with a facility or the date on which a prospective
860.25 resident moves in, whichever is earlier. If necessitated by either the geographic distance
860.26 between the prospective resident and the facility, or urgent or unexpected circumstances,
860.27 the assessment may be conducted using telecommunication methods based on practice
860.28 standards that meet the resident's needs and reflect person-centered planning and care
860.29 delivery. The nursing assessment must be completed within five days of the start of services.

860.30 (b) Resident reassessment and monitoring must be conducted no more than 14 days after
860.31 initiation of services. Ongoing resident reassessment and monitoring must be conducted as
860.32 needed based on changes in the needs of the resident and cannot exceed 90 days from the
860.33 last date of the assessment.

861.1 (c) Residents who are not receiving any services shall not be required to undergo an
861.2 initial nursing assessment.

861.3 (d) A facility must inform the prospective resident of the availability of and contact
861.4 information for long-term care consultation services under section 256B.0911, prior to the
861.5 date on which a prospective resident executes a contract with a facility or the date on which
861.6 a prospective resident moves in, whichever is earlier.

861.7 **Subd. 10. Service plan, implementation, and revisions to service plan.** (a) No later
861.8 than 14 days after the date that services are first provided, a facility shall finalize a current
861.9 written service plan.

861.10 (b) The service plan and any revisions must include a signature or other authentication
861.11 by the facility and by the resident or the designated representative documenting agreement
861.12 on the services to be provided. The service plan must be revised, if needed, based on resident
861.13 reassessment under subdivision 9. The facility must provide information to the resident
861.14 about changes to the facility's fee for services and how to contact the Office of Ombudsman
861.15 for Long-Term Care.

861.16 (c) The facility must implement and provide all services required by the current service
861.17 plan.

861.18 (d) The service plan and the revised service plan must be entered into the resident's
861.19 record, including notice of a change in a resident's fees when applicable.

861.20 (e) Staff providing services must be informed of the current written service plan.

861.21 (f) The service plan must include:

861.22 (1) a description of the services to be provided, the fees for services, and the frequency
861.23 of each service, according to the resident's current assessment and resident preferences;

861.24 (2) the identification of staff or categories of staff who will provide the services;

861.25 (3) the schedule and methods of monitoring assessments of the resident;

861.26 (4) the schedule and methods of monitoring staff providing services; and

861.27 (5) a contingency plan that includes:

861.28 (i) the action to be taken by the facility and by the resident and the designated
861.29 representative if the scheduled service cannot be provided;

861.30 (ii) information and a method for a resident and the designated representative to contact
861.31 the facility;

862.1 (iii) the names and contact information of persons the resident wishes to have notified
862.2 in an emergency or if there is a significant adverse change in the resident's condition,
862.3 including identification of and information as to who has authority to sign for the resident
862.4 in an emergency; and

862.5 (iv) the circumstances in which emergency medical services are not to be summoned
862.6 consistent with chapters 145B and 145C, and declarations made by the resident under those
862.7 chapters.

862.8 Subd. 11. **Use of restraints.** Residents of assisted living facilities must be free from any
862.9 physical or chemical restraints. Restraints are only permissible if determined necessary for
862.10 health and safety reasons identified by the facility through an initial assessment or
862.11 reassessment, under subdivision 9, and documented in the written service plan under
862.12 subdivision 10.

862.13 Subd. 12. **Request for discontinuation of life-sustaining treatment.** (a) If a resident,
862.14 family member, or other caregiver of the resident requests that an employee or other agent
862.15 of the facility discontinue a life-sustaining treatment, the employee or agent receiving the
862.16 request:

862.17 (1) shall take no action to discontinue the treatment; and

862.18 (2) shall promptly inform the supervisor or other agent of the facility of the resident's
862.19 request.

862.20 (b) Upon being informed of a request for discontinuance of treatment, the facility shall
862.21 promptly:

862.22 (1) inform the resident that the request will be made known to the physician or advanced
862.23 practice registered nurse who ordered the resident's treatment;

862.24 (2) inform the physician or advanced practice registered nurse of the resident's request;
862.25 and

862.26 (3) work with the resident and the resident's physician or advanced practice registered
862.27 nurse to comply with chapter 145C.

862.28 (c) This section does not require the facility to discontinue treatment, except as may be
862.29 required by law or court order.

862.30 (d) This section does not diminish the rights of residents to control their treatments,
862.31 refuse services, or terminate their relationships with the facility.

863.1 (e) This section shall be construed in a manner consistent with chapter 145B or 145C,
863.2 whichever applies, and declarations made by residents under those chapters.

863.3 Subd. 13. **Medical cannabis.** Facilities may exercise the authority and are subject to
863.4 the protections in section 152.34.

863.5 Subd. 14. **Landlord and tenant.** Facilities are subject to and must comply with chapter
863.6 504B.

863.7 Sec. 17. **[144L.16] PROVISION OF SERVICES.**

863.8 Subdivision 1. **Availability of contact person to staff.** (a) Assisted living facilities and
863.9 assisted living facilities that provide dementia care must have a registered nurse available
863.10 for consultation to staff performing delegated nursing tasks and must have an appropriate
863.11 licensed health professional available if performing other delegated services such as therapies.

863.12 (b) The appropriate contact person must be readily available either in person, by
863.13 telephone, or by other means to the staff at times when the staff is providing services.

863.14 Subd. 2. **Supervision of staff; basic care services.** (a) Staff who perform basic care
863.15 services must be supervised periodically where the services are being provided to verify
863.16 that the work is being performed competently and to identify problems and solutions to
863.17 address issues relating to the staff's ability to provide the services. The supervision of the
863.18 unlicensed personnel must be done by staff of the facility having the authority, skills, and
863.19 ability to provide the supervision of unlicensed personnel and who can implement changes
863.20 as needed, and train staff.

863.21 (b) Supervision includes direct observation of unlicensed personnel while the unlicensed
863.22 personnel are providing the services and may also include indirect methods of gaining input
863.23 such as gathering feedback from the resident. Supervisory review of staff must be provided
863.24 at a frequency based on the staff person's competency and performance.

863.25 Subd. 3. **Supervision of staff providing delegated nursing or therapy tasks.** (a) Staff
863.26 who perform delegated nursing or therapy tasks must be supervised by an appropriate
863.27 licensed health professional or a registered nurse per the assisted living facility's policy
863.28 where the services are being provided to verify that the work is being performed competently
863.29 and to identify problems and solutions related to the staff person's ability to perform the
863.30 tasks. Supervision of staff performing medication or treatment administration shall be
863.31 provided by a registered nurse or appropriate licensed health professional and must include
863.32 observation of the staff administering the medication or treatment and the interaction with
863.33 the resident.

864.1 (b) The direct supervision of staff performing delegated tasks must be provided within
864.2 30 days after the date on which the individual begins working for the facility and first
864.3 performs the delegated tasks for residents and thereafter as needed based on performance.
864.4 This requirement also applies to staff who have not performed delegated tasks for one year
864.5 or longer.

864.6 Subd. 4. **Documentation.** A facility must retain documentation of supervision activities
864.7 in the personnel records.

864.8 **Sec. 18. [144I.17] MEDICATION MANAGEMENT.**

864.9 Subdivision 1. **Medication management services.** (a) This section applies only to
864.10 assisted living facilities that provide medication management services.

864.11 (b) An assisted living facility that provides medication management services must
864.12 develop, implement, and maintain current written medication management policies and
864.13 procedures. The policies and procedures must be developed under the supervision and
864.14 direction of a registered nurse, licensed health professional, or pharmacist consistent with
864.15 current practice standards and guidelines.

864.16 (c) The written policies and procedures must address requesting and receiving
864.17 prescriptions for medications; preparing and giving medications; verifying that prescription
864.18 drugs are administered as prescribed; documenting medication management activities;
864.19 controlling and storing medications; monitoring and evaluating medication use; resolving
864.20 medication errors; communicating with the prescriber, pharmacist, and resident and
864.21 designated representative, if any; disposing of unused medications; and educating residents
864.22 and designated representatives about medications. When controlled substances are being
864.23 managed, the policies and procedures must also identify how the provider will ensure security
864.24 and accountability for the overall management, control, and disposition of those substances
864.25 in compliance with state and federal regulations and with subdivision 23.

864.26 Subd. 2. **Provision of medication management services.** (a) For each resident who
864.27 requests medication management services, the assisted living facility shall, prior to providing
864.28 medication management services, have a registered nurse, licensed health professional, or
864.29 authorized prescriber under section 151.37 conduct an assessment to determine what
864.30 medication management services will be provided and how the services will be provided.
864.31 This assessment must be conducted face-to-face with the resident. The assessment must
864.32 include an identification and review of all medications the resident is known to be taking.
864.33 The review and identification must include indications for medications, side effects,
864.34 contraindications, allergic or adverse reactions, and actions to address these issues.

865.1 (b) The assessment must identify interventions needed in management of medications
865.2 to prevent diversion of medication by the resident or others who may have access to the
865.3 medications and provide instructions to the resident and designated representative on
865.4 interventions to manage the resident's medications and prevent diversion of medications.
865.5 For purposes of this section, "diversion of medication" means misuse, theft, or illegal or
865.6 improper disposition of medications.

865.7 Subd. 3. **Individualized medication monitoring and reassessment.** The assisted living
865.8 facility must monitor and reassess the resident's medication management services as needed
865.9 under subdivision 2 when the resident presents with symptoms or other issues that may be
865.10 medication-related and, at a minimum, annually.

865.11 Subd. 4. **Resident refusal.** The assisted living facility must document in the resident's
865.12 record any refusal for an assessment for medication management by the resident. The assisted
865.13 living facility must discuss with the resident the possible consequences of the resident's
865.14 refusal and document the discussion in the resident's record.

865.15 Subd. 5. **Individualized medication management plan.** (a) For each resident receiving
865.16 medication management services, the assisted living facility must prepare and include in
865.17 the service plan a written statement of the medication management services that will be
865.18 provided to the resident. The assisted living facility must develop and maintain a current
865.19 individualized medication management record for each resident based on the resident's
865.20 assessment that must contain the following:

865.21 (1) a statement describing the medication management services that will be provided;

865.22 (2) a description of storage of medications based on the resident's needs and preferences,
865.23 risk of diversion, and consistent with the manufacturer's directions;

865.24 (3) documentation of specific resident instructions relating to the administration of
865.25 medications;

865.26 (4) identification of persons responsible for monitoring medication supplies and ensuring
865.27 that medication refills are ordered on a timely basis;

865.28 (5) identification of medication management tasks that may be delegated to unlicensed
865.29 personnel;

865.30 (6) procedures for staff notifying a registered nurse or appropriate licensed health
865.31 professional when a problem arises with medication management services; and

866.1 (7) any resident-specific requirements relating to documenting medication administration,
866.2 verifications that all medications are administered as prescribed, and monitoring of
866.3 medication use to prevent possible complications or adverse reactions.

866.4 (b) The medication management record must be current and updated when there are any
866.5 changes.

866.6 (c) Medication reconciliation must be completed when a licensed nurse, licensed health
866.7 professional, or authorized prescriber is providing medication management.

866.8 Subd. 6. Administration of medication. Medications may be administered by a nurse,
866.9 physician, or other licensed health practitioner authorized to administer medications or by
866.10 unlicensed personnel who have been delegated medication administration tasks by a
866.11 registered nurse.

866.12 Subd. 7. Delegation of medication administration. When administration of medications
866.13 is delegated to unlicensed personnel, the assisted living facility must ensure that the registered
866.14 nurse has:

866.15 (1) instructed the unlicensed personnel in the proper methods to administer the
866.16 medications, and the unlicensed personnel has demonstrated the ability to competently
866.17 follow the procedures;

866.18 (2) specified, in writing, specific instructions for each resident and documented those
866.19 instructions in the resident's records; and

866.20 (3) communicated with the unlicensed personnel about the individual needs of the
866.21 resident.

866.22 Subd. 8. Documentation of administration of medications. Each medication
866.23 administered by the assisted living facility staff must be documented in the resident's record.
866.24 The documentation must include the signature and title of the person who administered the
866.25 medication. The documentation must include the medication name, dosage, date and time
866.26 administered, and method and route of administration. The staff must document the reason
866.27 why medication administration was not completed as prescribed and document any follow-up
866.28 procedures that were provided to meet the resident's needs when medication was not
866.29 administered as prescribed and in compliance with the resident's medication management
866.30 plan.

866.31 Subd. 9. Documentation of medication setup. Documentation of dates of medication
866.32 setup, name of medication, quantity of dose, times to be administered, route of administration,
866.33 and name of person completing medication setup must be done at the time of setup.

867.1 Subd. 10. Medication management for residents who will be away from home. (a)
867.2 An assisted living facility that is providing medication management services to the resident
867.3 must develop and implement policies and procedures for giving accurate and current
867.4 medications to residents for planned or unplanned times away from home according to the
867.5 resident's individualized medication management plan. The policies and procedures must
867.6 state that:

867.7 (1) for planned time away, the medications must be obtained from the pharmacy or set
867.8 up by the licensed nurse according to appropriate state and federal laws and nursing standards
867.9 of practice;

867.10 (2) for unplanned time away, when the pharmacy is not able to provide the medications,
867.11 a licensed nurse or unlicensed personnel shall give the resident and designated representative
867.12 medications in amounts and dosages needed for the length of the anticipated absence, not
867.13 to exceed seven calendar days;

867.14 (3) the resident or designated representative must be provided written information on
867.15 medications, including any special instructions for administering or handling the medications,
867.16 including controlled substances;

867.17 (4) the medications must be placed in a medication container or containers appropriate
867.18 to the provider's medication system and must be labeled with the resident's name and the
867.19 dates and times that the medications are scheduled; and

867.20 (5) the resident and designated representative must be provided in writing the facility's
867.21 name and information on how to contact the facility.

867.22 (b) For unplanned time away when the licensed nurse is not available, the registered
867.23 nurse may delegate this task to unlicensed personnel if:

867.24 (1) the registered nurse has trained the unlicensed staff and determined the unlicensed
867.25 staff is competent to follow the procedures for giving medications to residents; and

867.26 (2) the registered nurse has developed written procedures for the unlicensed personnel,
867.27 including any special instructions or procedures regarding controlled substances that are
867.28 prescribed for the resident. The procedures must address:

867.29 (i) the type of container or containers to be used for the medications appropriate to the
867.30 provider's medication system;

867.31 (ii) how the container or containers must be labeled;

868.1 (iii) written information about the medications to be given to the resident or designated
868.2 representative;

868.3 (iv) how the unlicensed staff must document in the resident's record that medications
868.4 have been given to the resident and the designated representative, including documenting
868.5 the date the medications were given to the resident or the designated representative and who
868.6 received the medications, the person who gave the medications to the resident, the number
868.7 of medications that were given to the resident, and other required information;

868.8 (v) how the registered nurse shall be notified that medications have been given to the
868.9 resident or designated representative and whether the registered nurse needs to be contacted
868.10 before the medications are given to the resident or the designated representative;

868.11 (vi) a review by the registered nurse of the completion of this task to verify that this task
868.12 was completed accurately by the unlicensed personnel; and

868.13 (vii) how the unlicensed personnel must document in the resident's record any unused
868.14 medications that are returned to the facility, including the name of each medication and the
868.15 doses of each returned medication.

868.16 Subd. 11. **Prescribed and nonprescribed medication.** The assisted living facility must
868.17 determine whether the facility shall require a prescription for all medications the provider
868.18 manages. The assisted living facility must inform the resident or the designated representative
868.19 whether the facility requires a prescription for all over-the-counter and dietary supplements
868.20 before the facility agrees to manage those medications.

868.21 Subd. 12. **Medications; over-the-counter drugs; dietary supplements not**
868.22 **prescribed.** An assisted living facility providing medication management services for
868.23 over-the-counter drugs or dietary supplements must retain those items in the original labeled
868.24 container with directions for use prior to setting up for immediate or later administration.
868.25 The facility must verify that the medications are up to date and stored as appropriate.

868.26 Subd. 13. **Prescriptions.** There must be a current written or electronically recorded
868.27 prescription as defined in section 151.01, subdivision 16a, for all prescribed medications
868.28 that the assisted living facility is managing for the resident.

868.29 Subd. 14. **Renewal of prescriptions.** Prescriptions must be renewed at least every 12
868.30 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions
868.31 for controlled substances must comply with chapter 152.

869.1 Subd. 15. **Verbal prescription orders.** Verbal prescription orders from an authorized
869.2 prescriber must be received by a nurse or pharmacist. The order must be handled according
869.3 to Minnesota Rules, part 6800.6200.

869.4 Subd. 16. **Written or electronic prescription.** When a written or electronic prescription
869.5 is received, it must be communicated to the registered nurse in charge and recorded or placed
869.6 in the resident's record.

869.7 Subd. 17. **Records confidential.** A prescription or order received verbally, in writing,
869.8 or electronically must be kept confidential according to sections 144.291 to 144.298 and
869.9 144A.44.

869.10 Subd. 18. **Medications provided by resident or family members.** When the assisted
869.11 living facility is aware of any medications or dietary supplements that are being used by
869.12 the resident and are not included in the assessment for medication management services,
869.13 the staff must advise the registered nurse and document that in the resident's record.

869.14 Subd. 19. **Storage of medications.** An assisted living facility must store all prescription
869.15 medications in securely locked and substantially constructed compartments according to
869.16 the manufacturer's directions and permit only authorized personnel to have access.

869.17 Subd. 20. **Prescription drugs.** A prescription drug, prior to being set up for immediate
869.18 or later administration, must be kept in the original container in which it was dispensed by
869.19 the pharmacy bearing the original prescription label with legible information including the
869.20 expiration or beyond-use date of a time-dated drug.

869.21 Subd. 21. **Prohibitions.** No prescription drug supply for one resident may be used or
869.22 saved for use by anyone other than the resident.

869.23 Subd. 22. **Disposition of medications.** (a) Any current medications being managed by
869.24 the assisted living facility must be given to the resident or the designated representative
869.25 when the resident's service plan ends or medication management services are no longer part
869.26 of the service plan. Medications for a resident who is deceased or that have been discontinued
869.27 or have expired may be given to the resident or the designated representative for disposal.

869.28 (b) The assisted living facility shall dispose of any medications remaining with the
869.29 facility that are discontinued or expired or upon the termination of the service contract or
869.30 the resident's death according to state and federal regulations for disposition of medications
869.31 and controlled substances.

869.32 (c) Upon disposition, the facility must document in the resident's record the disposition
869.33 of the medication including the medication's name, strength, prescription number as

870.1 applicable, quantity, to whom the medications were given, date of disposition, and names
870.2 of staff and other individuals involved in the disposition.

870.3 Subd. 23. **Loss or spillage.** (a) Assisted living facilities providing medication
870.4 management must develop and implement procedures for loss or spillage of all controlled
870.5 substances defined in Minnesota Rules, part 6800.4220. These procedures must require that
870.6 when a spillage of a controlled substance occurs, a notation must be made in the resident's
870.7 record explaining the spillage and the actions taken. The notation must be signed by the
870.8 person responsible for the spillage and include verification that any contaminated substance
870.9 was disposed of according to state or federal regulations.

870.10 (b) The procedures must require that the facility providing medication management
870.11 investigate any known loss or unaccounted for prescription drugs and take appropriate action
870.12 required under state or federal regulations and document the investigation in required records.

870.13 Sec. 19. **[144L.18] TREATMENT AND THERAPY MANAGEMENT SERVICES.**

870.14 Subdivision 1. **Treatment and therapy management services.** This section applies
870.15 only to assisted living facilities that provide comprehensive assisted living services.

870.16 Subd. 2. **Policies and procedures.** (a) An assisted living facility that provides treatment
870.17 and therapy management services must develop, implement, and maintain up-to-date written
870.18 treatment or therapy management policies and procedures. The policies and procedures
870.19 must be developed under the supervision and direction of a registered nurse or appropriate
870.20 licensed health professional consistent with current practice standards and guidelines.

870.21 (b) The written policies and procedures must address requesting and receiving orders
870.22 or prescriptions for treatments or therapies, providing the treatment or therapy, documenting
870.23 treatment or therapy activities, educating and communicating with residents about treatments
870.24 or therapies they are receiving, monitoring and evaluating the treatment or therapy, and
870.25 communicating with the prescriber.

870.26 Subd. 3. **Individualized treatment or therapy management plan.** For each resident
870.27 receiving management of ordered or prescribed treatments or therapy services, the assisted
870.28 living facility must prepare and include in the service plan a written statement of the treatment
870.29 or therapy services that will be provided to the resident. The facility must also develop and
870.30 maintain a current individualized treatment and therapy management record for each resident
870.31 which must contain at least the following:

870.32 (1) a statement of the type of services that will be provided;

871.1 (2) documentation of specific resident instructions relating to the treatments or therapy
871.2 administration;

871.3 (3) identification of treatment or therapy tasks that will be delegated to unlicensed
871.4 personnel;

871.5 (4) procedures for notifying a registered nurse or appropriate licensed health professional
871.6 when a problem arises with treatments or therapy services; and

871.7 (5) any resident-specific requirements relating to documentation of treatment and therapy
871.8 received, verification that all treatment and therapy was administered as prescribed, and
871.9 monitoring of treatment or therapy to prevent possible complications or adverse reactions.
871.10 The treatment or therapy management record must be current and updated when there are
871.11 any changes.

871.12 Subd. 4. **Administration of treatments and therapy.** Ordered or prescribed treatments
871.13 or therapies must be administered by a nurse, physician, or other licensed health professional
871.14 authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed
871.15 personnel by the licensed health professional according to the appropriate practice standards
871.16 for delegation or assignment. When administration of a treatment or therapy is delegated
871.17 or assigned to unlicensed personnel, the facility must ensure that the registered nurse or
871.18 authorized licensed health professional has:

871.19 (1) instructed the unlicensed personnel in the proper methods with respect to each resident
871.20 and the unlicensed personnel has demonstrated the ability to competently follow the
871.21 procedures;

871.22 (2) specified, in writing, specific instructions for each resident and documented those
871.23 instructions in the resident's record; and

871.24 (3) communicated with the unlicensed personnel about the individual needs of the
871.25 resident.

871.26 Subd. 5. **Documentation of administration of treatments and therapies.** Each treatment
871.27 or therapy administered by an assisted living facility must be in the resident's record. The
871.28 documentation must include the signature and title of the person who administered the
871.29 treatment or therapy and must include the date and time of administration. When treatment
871.30 or therapies are not administered as ordered or prescribed, the provider must document the
871.31 reason why it was not administered and any follow-up procedures that were provided to
871.32 meet the resident's needs.

872.1 Subd. 6. Treatment and therapy orders. There must be an up-to-date written or
872.2 electronically recorded order from an authorized prescriber for all treatments and therapies.
872.3 The order must contain the name of the resident, a description of the treatment or therapy
872.4 to be provided, and the frequency, duration, and other information needed to administer the
872.5 treatment or therapy. Treatment and therapy orders must be renewed at least every 12
872.6 months.

872.7 Subd. 7. Right to outside service provider; other payors. Under section 144J.02, a
872.8 resident is free to retain therapy and treatment services from an off-site service provider.
872.9 Assisted living facilities must make every effort to assist residents in obtaining information
872.10 regarding whether the Medicare program, the medical assistance program under chapter
872.11 256B, or another public program will pay for any or all of the services.

872.12 **Sec. 20. [144I.19] RESIDENT RECORD REQUIREMENTS.**

872.13 Subdivision 1. Resident record. (a) The facility must maintain records for each resident
872.14 for whom it is providing services. Entries in the resident records must be current, legible,
872.15 permanently recorded, dated, and authenticated with the name and title of the person making
872.16 the entry.

872.17 (b) Resident records, whether written or electronic, must be protected against loss,
872.18 tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable
872.19 relevant federal and state laws. The facility shall establish and implement written procedures
872.20 to control use, storage, and security of resident's records and establish criteria for release
872.21 of resident information.

872.22 (c) The facility may not disclose to any other person any personal, financial, or medical
872.23 information about the resident, except:

872.24 (1) as may be required by law;

872.25 (2) to employees or contractors of the facility, another facility, other health care
872.26 practitioner or provider, or inpatient facility needing information in order to provide services
872.27 to the resident, but only the information that is necessary for the provision of services;

872.28 (3) to persons authorized in writing by the resident or the resident's representative to
872.29 receive the information, including third-party payers; and

872.30 (4) to representatives of the commissioner authorized to survey or investigate facilities
872.31 under this chapter or federal laws.

873.1 Subd. 2. Access to records. The facility must ensure that the appropriate records are
873.2 readily available to employees and contractors authorized to access the records. Resident
873.3 records must be maintained in a manner that allows for timely access, printing, or
873.4 transmission of the records. The records must be made readily available to the commissioner
873.5 upon request.

873.6 Subd. 3. Contents of resident record. Contents of a resident record include the following
873.7 for each resident:

873.8 (1) identifying information, including the resident's name, date of birth, address, and
873.9 telephone number;

873.10 (2) the name, address, and telephone number of an emergency contact, family members,
873.11 designated representative, if any, or others as identified;

873.12 (3) names, addresses, and telephone numbers of the resident's health and medical service
873.13 providers, if known;

873.14 (4) health information, including medical history, allergies, and when the provider is
873.15 managing medications, treatments or therapies that require documentation, and other relevant
873.16 health records;

873.17 (5) the resident's advance directives, if any;

873.18 (6) copies of any health care directives, guardianships, powers of attorney, or
873.19 conservatorships;

873.20 (7) the facility's current and previous assessments and service plans;

873.21 (8) all records of communications pertinent to the resident's services;

873.22 (9) documentation of significant changes in the resident's status and actions taken in
873.23 response to the needs of the resident, including reporting to the appropriate supervisor or
873.24 health care professional;

873.25 (10) documentation of incidents involving the resident and actions taken in response to
873.26 the needs of the resident, including reporting to the appropriate supervisor or health care
873.27 professional;

873.28 (11) documentation that services have been provided as identified in the service plan;

873.29 (12) documentation that the resident has received and reviewed the assisted living bill
873.30 of rights;

873.31 (13) documentation of complaints received and any resolution;

874.1 (14) a discharge summary, including service termination notice and related
874.2 documentation, when applicable; and

874.3 (15) other documentation required under this chapter and relevant to the resident's
874.4 services or status.

874.5 Subd. 4. **Transfer of resident records.** If a resident transfers to another facility or
874.6 another health care practitioner or provider, or is admitted to an inpatient facility, the facility,
874.7 upon request of the resident or the resident's representative, shall take steps to ensure a
874.8 coordinated transfer including sending a copy or summary of the resident's record to the
874.9 new facility or the resident, as appropriate.

874.10 Subd. 5. **Record retention.** Following the resident's discharge or termination of services,
874.11 a facility must retain a resident's record for at least five years or as otherwise required by
874.12 state or federal regulations. Arrangements must be made for secure storage and retrieval of
874.13 resident records if the facility ceases to operate.

874.14 Sec. 21. **[144I.20] ORIENTATION AND ANNUAL TRAINING REQUIREMENTS.**

874.15 Subdivision 1. **Orientation of staff and supervisors.** All staff providing and supervising
874.16 direct services must complete an orientation to facility licensing requirements and regulations
874.17 before providing services to residents. The orientation may be incorporated into the training
874.18 required under subdivision 6. The orientation need only be completed once for each staff
874.19 person and is not transferable to another facility.

874.20 Subd. 2. **Content.** (a) The orientation must contain the following topics:

874.21 (1) an overview of this chapter;

874.22 (2) an introduction and review of the facility's policies and procedures related to the
874.23 provision of assisted living services by the individual staff person;

874.24 (3) handling of emergencies and use of emergency services;

874.25 (4) compliance with and reporting of the maltreatment of vulnerable adults under section
874.26 626.557, including information on the Minnesota Adult Abuse Reporting Center;

874.27 (5) assisted living bill of rights under section 144J.02;

874.28 (6) protection-related rights under section 144I.10, subdivision 8, and staff responsibilities
874.29 related to ensuring the exercise and protection of those rights;

874.30 (7) the principles of person-centered service planning and delivery and how they apply
874.31 to direct support services provided by the staff person;

875.1 (8) handling of residents' complaints, reporting of complaints, and where to report
875.2 complaints, including information on the Office of Health Facility Complaints;

875.3 (9) consumer advocacy services of the Office of Ombudsman for Long-Term Care,
875.4 Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care
875.5 Ombudsman at the Department of Human Services, county-managed care advocates, or
875.6 other relevant advocacy services; and

875.7 (10) a review of the types of assisted living services the employee will be providing and
875.8 the facility's category of licensure.

875.9 (b) In addition to the topics in paragraph (a), orientation may also contain training on
875.10 providing services to residents with hearing loss. Any training on hearing loss provided
875.11 under this subdivision must be high quality and research based, may include online training,
875.12 and must include training on one or more of the following topics:

875.13 (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence,
875.14 and the challenges it poses to communication;

875.15 (2) health impacts related to untreated age-related hearing loss, such as increased
875.16 incidence of dementia, falls, hospitalizations, isolation, and depression; or

875.17 (3) information about strategies and technology that may enhance communication and
875.18 involvement, including communication strategies, assistive listening devices, hearing aids,
875.19 visual and tactile alerting devices, communication access in real time, and closed captions.

875.20 Subd. 3. **Verification and documentation of orientation.** Each facility shall retain
875.21 evidence in the employee record of each staff person having completed the orientation
875.22 required by this section.

875.23 Subd. 4. **Orientation to resident.** Staff providing services must be oriented specifically
875.24 to each individual resident and the services to be provided. This orientation may be provided
875.25 in person, orally, in writing, or electronically.

875.26 Subd. 5. **Training required relating to dementia.** All direct care staff and supervisors
875.27 providing direct services must receive training that includes a current explanation of
875.28 Alzheimer's disease and related disorders, effective approaches to use to problem solve
875.29 when working with a resident's challenging behaviors, and how to communicate with
875.30 residents who have dementia or related memory disorders.

875.31 Subd. 6. **Required annual training.** (a) All staff that perform direct services must
875.32 complete at least eight hours of annual training for each 12 months of employment. The

876.1 training may be obtained from the facility or another source and must include topics relevant
876.2 to the provision of assisted living services. The annual training must include:

876.3 (1) training on reporting of maltreatment of vulnerable adults under section 626.557;

876.4 (2) review of the assisted living bill of rights in section 144J.02;

876.5 (3) review of infection control techniques used in the home and implementation of
876.6 infection control standards including a review of hand washing techniques; the need for and

876.7 use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials

876.8 and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable

876.9 equipment; disinfecting environmental surfaces; and reporting communicable diseases;

876.10 (4) effective approaches to use to problem solve when working with a resident's

876.11 challenging behaviors, and how to communicate with residents who have Alzheimer's

876.12 disease or related disorders;

876.13 (5) review of the facility's policies and procedures relating to the provision of assisted

876.14 living services and how to implement those policies and procedures;

876.15 (6) review of protection-related rights as stated in section 144I.10, subdivision 8, and

876.16 staff responsibilities related to ensuring the exercise and protection of those rights; and

876.17 (7) the principles of person-centered service planning and delivery and how they apply

876.18 to direct support services provided by the staff person.

876.19 (b) In addition to the topics in paragraph (a), annual training may also contain training

876.20 on providing services to residents with hearing loss. Any training on hearing loss provided

876.21 under this subdivision must be high quality and research based, may include online training,

876.22 and must include training on one or more of the following topics:

876.23 (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence,

876.24 and challenges it poses to communication;

876.25 (2) the health impacts related to untreated age-related hearing loss, such as increased

876.26 incidence of dementia, falls, hospitalizations, isolation, and depression; or

876.27 (3) information about strategies and technology that may enhance communication and

876.28 involvement, including communication strategies, assistive listening devices, hearing aids,

876.29 visual and tactile alerting devices, communication access in real time, and closed captions.

876.30 Subd. 7. **Documentation.** A facility must retain documentation in the employee records

876.31 of staff who have satisfied the orientation and training requirements of this section.

877.1 Subd. 8. **Implementation.** A facility must implement all orientation and training topics
877.2 covered in this section.

877.3 Sec. 22. **[144I.21] TRAINING IN DEMENTIA CARE REQUIRED.**

877.4 (a) Assisted living facilities and assisted living facilities with dementia care must meet
877.5 the following training requirements:

877.6 (1) supervisors of direct-care staff must have at least eight hours of initial training on
877.7 topics specified under paragraph (b) within 120 working hours of the employment start
877.8 date, and must have at least two hours of training on topics related to dementia care for each
877.9 12 months of employment thereafter;

877.10 (2) direct-care employees must have completed at least eight hours of initial training on
877.11 topics specified under paragraph (b) within 160 working hours of the employment start
877.12 date. Until this initial training is complete, an employee must not provide direct care unless
877.13 there is another employee on site who has completed the initial eight hours of training on
877.14 topics related to dementia care and who can act as a resource and assist if issues arise. A
877.15 trainer of the requirements under paragraph (b) or a supervisor meeting the requirements
877.16 in clause (1) must be available for consultation with the new employee until the training
877.17 requirement is complete. Direct-care employees must have at least two hours of training on
877.18 topics related to dementia for each 12 months of employment thereafter;

877.19 (3) staff who do not provide direct care, including maintenance, housekeeping, and food
877.20 service staff, must have at least four hours of initial training on topics specified under
877.21 paragraph (b) within 160 working hours of the employment start date, and must have at
877.22 least two hours of training on topics related to dementia care for each 12 months of
877.23 employment thereafter; and

877.24 (4) new employees may satisfy the initial training requirements by producing written
877.25 proof of previously completed required training within the past 18 months.

877.26 (b) Areas of required training include:

877.27 (1) an explanation of Alzheimer's disease and related disorders;

877.28 (2) assistance with activities of daily living;

877.29 (3) problem solving with challenging behaviors; and

877.30 (4) communication skills.

878.1 (c) The facility shall provide to consumers in written or electronic form a description of
878.2 the training program, the categories of employees trained, the frequency of training, and
878.3 the basic topics covered.

878.4 **Sec. 23. [144I.22] CONTROLLING INDIVIDUAL RESTRICTIONS.**

878.5 Subdivision 1. **Restrictions.** The controlling individual of a facility may not include
878.6 any person who was a controlling individual of any other nursing home, assisted living
878.7 facility, or assisted living facility with dementia care during any period of time in the previous
878.8 two-year period:

878.9 (1) during which time of control the nursing home, assisted living facility, or assisted
878.10 living facility with dementia care incurred the following number of uncorrected or repeated
878.11 violations:

878.12 (i) two or more uncorrected violations or one or more repeated violations that created
878.13 an imminent risk to direct resident care or safety; or

878.14 (ii) four or more uncorrected violations or two or more repeated violations of any nature,
878.15 including Level 2, Level 3, and Level 4 violations as defined in section 144I.31; or

878.16 (2) who, during that period, was convicted of a felony or gross misdemeanor that relates
878.17 to the operation of the nursing home, assisted living facility, or assisted living facility with
878.18 dementia care, or directly affects resident safety or care.

878.19 Subd. 2. **Exception.** Subdivision 1 does not apply to any controlling individual of the
878.20 facility who had no legal authority to affect or change decisions related to the operation of
878.21 the nursing home, assisted living facility, or assisted living facility with dementia care that
878.22 incurred the uncorrected violations.

878.23 Subd. 3. **Stay of adverse action required by controlling individual restrictions.** (a)
878.24 In lieu of revoking, suspending, or refusing to renew the license of a facility where a
878.25 controlling individual was disqualified by subdivision 1, clause (1), the commissioner may
878.26 issue an order staying the revocation, suspension, or nonrenewal of the facility's license.

878.27 The order may but need not be contingent upon the facility's compliance with restrictions
878.28 and conditions imposed on the license to ensure the proper operation of the facility and to
878.29 protect the health, safety, comfort, treatment, and well-being of the residents in the facility.

878.30 The decision to issue an order for a stay must be made within 90 days of the commissioner's
878.31 determination that a controlling individual of the facility is disqualified by subdivision 1,
878.32 clause (1), from operating a facility.

879.1 (b) In determining whether to issue a stay and to impose conditions and restrictions, the
879.2 commissioner must consider the following factors:

879.3 (1) the ability of the controlling individual to operate other facilities in accordance with
879.4 the licensure rules and laws;

879.5 (2) the conditions in the nursing home, assisted living facility, or assisted living facility
879.6 with dementia care that received the number and type of uncorrected or repeated violations
879.7 described in subdivision 1, clause (1); and

879.8 (3) the conditions and compliance history of each of the nursing homes, assisted living
879.9 facilities, and assisted living facilities with dementia care owned or operated by the
879.10 controlling individuals.

879.11 (c) The commissioner's decision to exercise the authority under this subdivision in lieu
879.12 of revoking, suspending, or refusing to renew the license of the facility is not subject to
879.13 administrative or judicial review.

879.14 (d) The order for the stay of revocation, suspension, or nonrenewal of the facility license
879.15 must include any conditions and restrictions on the license that the commissioner deems
879.16 necessary based on the factors listed in paragraph (b).

879.17 (e) Prior to issuing an order for stay of revocation, suspension, or nonrenewal, the
879.18 commissioner shall inform the controlling individual in writing of any conditions and
879.19 restrictions that will be imposed. The controlling individual shall, within ten working days,
879.20 notify the commissioner in writing of a decision to accept or reject the conditions and
879.21 restrictions. If the facility rejects any of the conditions and restrictions, the commissioner
879.22 must either modify the conditions and restrictions or take action to suspend, revoke, or not
879.23 renew the facility's license.

879.24 (f) Upon issuance of the order for a stay of revocation, suspension, or nonrenewal, the
879.25 controlling individual shall be responsible for compliance with the conditions and restrictions.
879.26 Any time after the conditions and restrictions have been in place for 180 days, the controlling
879.27 individual may petition the commissioner for removal or modification of the conditions and
879.28 restrictions. The commissioner must respond to the petition within 30 days of receipt of the
879.29 written petition. If the commissioner denies the petition, the controlling individual may
879.30 request a hearing under the provisions of chapter 14. Any hearing shall be limited to a
879.31 determination of whether the conditions and restrictions shall be modified or removed. At
879.32 the hearing, the controlling individual bears the burden of proof.

880.1 (g) The failure of the controlling individual to comply with the conditions and restrictions
880.2 contained in the order for stay shall result in the immediate removal of the stay and the
880.3 commissioner shall take action to suspend, revoke, or not renew the license.

880.4 (h) The conditions and restrictions are effective for two years after the date they are
880.5 imposed.

880.6 (i) Nothing in this subdivision shall be construed to limit in any way the commissioner's
880.7 ability to impose other sanctions against a facility licensee under the standards in state or
880.8 federal law whether or not a stay of revocation, suspension, or nonrenewal is issued.

880.9 **Sec. 24. [144I.23] MANAGEMENT AGREEMENTS; GENERAL REQUIREMENTS.**

880.10 Subdivision 1. **Notification.** (a) If the proposed or current licensee uses a manager, the
880.11 licensee must have a written management agreement that is consistent with this chapter.

880.12 (b) The proposed or current licensee must notify the commissioner of its use of a manager
880.13 upon:

880.14 (1) initial application for a license;

880.15 (2) retention of a manager following initial application;

880.16 (3) change of managers; and

880.17 (4) modification of an existing management agreement.

880.18 (c) The proposed or current licensee must provide to the commissioner a written
880.19 management agreement, including an organizational chart showing the relationship between
880.20 the proposed or current licensee, management company, and all related organizations.

880.21 (d) The written management agreement must be submitted:

880.22 (1) 60 days before:

880.23 (i) the initial licensure date;

880.24 (ii) the proposed change of ownership date; or

880.25 (iii) the effective date of the management agreement; or

880.26 (2) 30 days before the effective date of any amendment to an existing management
880.27 agreement.

880.28 (e) The proposed licensee or the current licensee must notify the residents and their
880.29 representatives 60 days before entering into a new management agreement.

880.30 (f) A proposed licensee must submit a management agreement.

- 881.1 Subd. 2. **Management agreement; licensee.** (a) The licensee is legally responsible for:
- 881.2 (1) the daily operations and provisions of services in the facility;
- 881.3 (2) ensuring the facility is operated in a manner consistent with all applicable laws and
- 881.4 rules;
- 881.5 (3) ensuring the manager acts in conformance with the management agreement; and
- 881.6 (4) ensuring the manager does not present as, or give the appearance that the manager
- 881.7 is the licensee.
- 881.8 (b) The licensee must not give the manager responsibilities that are so extensive that the
- 881.9 licensee is relieved of daily responsibility for the daily operations and provision of services
- 881.10 in the assisted living facility. If the licensee does so, the commissioner must determine that
- 881.11 a change of ownership has occurred.
- 881.12 (c) The licensee and manager must act in accordance with the terms of the management
- 881.13 agreement. If the commissioner determines they are not, then the department may impose
- 881.14 enforcement remedies.
- 881.15 (d) The licensee may enter into a management agreement only if the management
- 881.16 agreement creates a principal/agent relationship between the licensee and manager.
- 881.17 (e) The manager shall not subcontract the manager's responsibilities to a third party.
- 881.18 Subd. 3. **Terms of agreement.** A management agreement at a minimum must:
- 881.19 (1) describe the responsibilities of the licensee and manager, including items, services,
- 881.20 and activities to be provided;
- 881.21 (2) require the licensee's governing body, board of directors, or similar authority to
- 881.22 appoint the administrator;
- 881.23 (3) provide for the maintenance and retention of all records in accordance with this
- 881.24 chapter and other applicable laws;
- 881.25 (4) allow unlimited access by the commissioner to documentation and records according
- 881.26 to applicable laws or regulations;
- 881.27 (5) require the manager to immediately send copies of inspections and notices of
- 881.28 noncompliance to the licensee;
- 881.29 (6) state that the licensee is responsible for reviewing, acknowledging, and signing all
- 881.30 facility initial and renewal license applications;

882.1 (7) state that the manager and licensee shall review the management agreement annually
882.2 and notify the commissioner of any change according to applicable regulations;

882.3 (8) acknowledge that the licensee is the party responsible for complying with all laws
882.4 and rules applicable to the facility;

882.5 (9) require the licensee to maintain ultimate responsibility over personnel issues relating
882.6 to the operation of the facility and care of the residents including but not limited to staffing
882.7 plans, hiring, and performance management of employees, orientation, and training;

882.8 (10) state the manager will not present as, or give the appearance that the manager is
882.9 the licensee; and

882.10 (11) state that a duly authorized manager may execute resident leases or agreements on
882.11 behalf of the licensee, but all such resident leases or agreements must be between the licensee
882.12 and the resident.

882.13 Subd. 4. **Commissioner review.** The commissioner may review a management agreement
882.14 at any time. Following the review, the department may require:

882.15 (1) the proposed or current licensee or manager to provide additional information or
882.16 clarification;

882.17 (2) any changes necessary to:

882.18 (i) bring the management agreement into compliance with this chapter; and

882.19 (ii) ensure that the licensee has not been relieved of the legal responsibility for the daily
882.20 operations of the facility; and

882.21 (3) the licensee to participate in monthly meetings and quarterly on-site visits to the
882.22 facility.

882.23 Subd. 5. **Resident funds.** (a) If the management agreement delegates day-to-day
882.24 management of resident funds to the manager, the licensee:

882.25 (1) retains all fiduciary and custodial responsibility for funds that have been deposited
882.26 with the facility by the resident;

882.27 (2) is directly accountable to the resident for such funds; and

882.28 (3) must ensure any party responsible for holding or managing residents' personal funds
882.29 is bonded or obtains insurance in sufficient amounts to specifically cover losses of resident
882.30 funds and provides proof of bond or insurance.

883.1 (b) If responsibilities for the day-to-day management of the resident funds are delegated
883.2 to the manager, the manager must:

883.3 (1) provide the licensee with a monthly accounting of the resident funds; and

883.4 (2) meet all legal requirements related to holding and accounting for resident funds.

883.5 **Sec. 25. [144I.24] MINIMUM SITE, PHYSICAL ENVIRONMENT, AND FIRE**
883.6 **SAFETY REQUIREMENTS.**

883.7 Subdivision 1. **Requirements.** (a) Effective August 1, 2021, the following are required
883.8 for all assisted living facilities and assisted living facilities with dementia care:

883.9 (1) public utilities must be available, and working or inspected and approved water and
883.10 septic systems are in place;

883.11 (2) the location is publicly accessible to fire department services and emergency medical
883.12 services;

883.13 (3) the location's topography provides sufficient natural drainage and is not subject to
883.14 flooding;

883.15 (4) all-weather roads and walks must be provided within the lot lines to the primary
883.16 entrance and the service entrance, including employees' and visitors' parking at the site; and

883.17 (5) the location must include space for outdoor activities for residents.

883.18 (b) An assisted living facility with a dementia care unit must also meet the following
883.19 requirements:

883.20 (1) a hazard vulnerability assessment or safety risk must be performed on and around
883.21 the property. The hazards indicated on the assessment must be assessed and mitigated to
883.22 protect the residents from harm; and

883.23 (2) the facility shall be protected throughout by an approved supervised automatic
883.24 sprinkler system by August 1, 2029.

883.25 **Subd. 2. Fire protection and physical environment. (a) Effective December 31, 2019,**
883.26 **each assisted living facility and assisted living facility with dementia care must have a**
883.27 **comprehensive fire protection system that includes:**

883.28 (1) protection throughout by an approved supervised automatic sprinkler system according
883.29 to building code requirements established in Minnesota Rules, part 1305.0903, or smoke
883.30 detectors in each occupied room installed and maintained in accordance with the National
883.31 Fire Protection Association (NFPA) Standard 72;

884.1 (2) portable fire extinguishers installed and tested in accordance with the NFPA Standard
884.2 10; and

884.3 (3) the physical environment, including walls, floors, ceiling, all furnishings, grounds,
884.4 systems, and equipment must be kept in a continuous state of good repair and operation
884.5 with regard to the health, safety, comfort, and well-being of the residents in accordance
884.6 with a maintenance and repair program.

884.7 (b) Beginning August 1, 2021, fire drills shall be conducted in accordance with the
884.8 residential board and care requirements in the Life Safety Code.

884.9 Subd. 3. **Local laws apply.** Assisted living facilities shall comply with all applicable
884.10 state and local governing laws, regulations, standards, ordinances, and codes for fire safety,
884.11 building, and zoning requirements.

884.12 Subd. 4. **Assisted living facilities; design.** (a) After July 31, 2021, all assisted living
884.13 facilities with six or more residents must meet the provisions relevant to assisted living
884.14 facilities of the most current edition of the Facility Guidelines Institute "Guidelines for
884.15 Design and Construction of Residential Health, Care and Support Facilities" and of adopted
884.16 rules. This minimum design standard shall be met for all new licenses, new construction,
884.17 modifications, renovations, alterations, change of use, or additions. In addition to the
884.18 guidelines, assisted living facilities, and assisted living facilities with dementia care shall
884.19 provide the option of a bath in addition to a shower for all residents.

884.20 (b) The commissioner shall establish an implementation timeline for mandatory usage
884.21 of the latest published guidelines. However, the commissioner shall not enforce the latest
884.22 published guidelines before six months after the date of publication.

884.23 Subd. 5. **Assisted living facilities; life safety code.** (a) After August 1, 2021, all assisted
884.24 living facilities with six or more residents shall meet the applicable provisions of the most
884.25 current edition of the NFPA Standard 101, Life Safety Code, Residential Board and Care
884.26 Occupancies chapter. This minimum design standard shall be met for all new licenses, new
884.27 construction, modifications, renovations, alterations, change of use, or additions.

884.28 (b) The commissioner shall establish an implementation timeline for mandatory usage
884.29 of the latest published Life Safety Code. However, the commissioner shall not enforce the
884.30 latest published guidelines before six months after the date of publication.

884.31 Subd. 6. **Assisted living facilities with dementia care units; life safety code.** (a)
884.32 Beginning August 1, 2021, all assisted living facilities with dementia care units shall meet
884.33 the applicable provisions of the most current edition of the NFPA Standard 101, Life Safety

885.1 Code, Healthcare (limited care) chapter. This minimum design standard shall be met for all
885.2 new licenses, new construction, modifications, renovations, alterations, change of use or
885.3 additions.

885.4 (b) The commissioner shall establish an implementation timeline for mandatory usage
885.5 of the newest-published Life Safety Code. However, the commissioner shall not enforce
885.6 the newly-published guidelines before 6 months after the date of publication.

885.7 Subd. 7. **New construction; plans.** (a) For all new licensure and construction beginning
885.8 on or after August 1, 2021, the following must be provided to the commissioner:

885.9 (1) architectural and engineering plans and specifications for new construction must be
885.10 prepared and signed by architects and engineers who are registered in Minnesota. Final
885.11 working drawings and specifications for proposed construction must be submitted to the
885.12 commissioner for review and approval;

885.13 (2) final architectural plans and specifications must include elevations and sections
885.14 through the building showing types of construction, and must indicate dimensions and
885.15 assignments of rooms and areas, room finishes, door types and hardware, elevations and
885.16 details of nurses' work areas, utility rooms, toilet and bathing areas, and large-scale layouts
885.17 of dietary and laundry areas. Plans must show the location of fixed equipment and sections
885.18 and details of elevators, chutes, and other conveying systems. Fire walls and smoke partitions
885.19 must be indicated. The roof plan must show all mechanical installations. The site plan must
885.20 indicate the proposed and existing buildings, topography, roadways, walks and utility service
885.21 lines; and

885.22 (3) final mechanical and electrical plans and specifications must address the complete
885.23 layout and type of all installations, systems, and equipment to be provided. Heating plans
885.24 must include heating elements, piping, thermostatic controls, pumps, tanks, heat exchangers,
885.25 boilers, breeching and accessories. Ventilation plans must include room air quantities, ducts,
885.26 fire and smoke dampers, exhaust fans, humidifiers, and air handling units. Plumbing plans
885.27 must include the fixtures and equipment fixture schedule; water supply and circulating
885.28 piping, pumps, tanks, riser diagrams, and building drains; the size, location, and elevation
885.29 of water and sewer services; and the building fire protection systems. Electrical plans must
885.30 include fixtures and equipment, receptacles, switches, power outlets, circuits, power and
885.31 light panels, transformers, and service feeders. Plans must show location of nurse call signals,
885.32 cable lines, fire alarm stations, and fire detectors and emergency lighting.

885.33 (b) Unless construction is begun within one year after approval of the final working
885.34 drawing and specifications, the drawings must be resubmitted for review and approval.

886.1 (c) The commissioner must be notified within 30 days before completion of construction
886.2 so that the commissioner can make arrangements for a final inspection by the commissioner.

886.3 (d) At least one set of complete life safety plans, including changes resulting from
886.4 remodeling or alterations, must be kept on file in the facility.

886.5 Subd. 8. **Variations or waivers.** (a) A facility may request that the commissioner grant
886.6 a variance or waiver from the provisions of this section. A request for a waiver must be
886.7 submitted to the commissioner in writing. Each request must contain:

886.8 (1) the specific requirement for which the variance or waiver is requested;

886.9 (2) the reasons for the request;

886.10 (3) the alternative measures that will be taken if a variance or waiver is granted;

886.11 (4) the length of time for which the variance or waiver is requested; and

886.12 (5) other relevant information deemed necessary by the commissioner to properly evaluate
886.13 the request for the waiver.

886.14 (b) The decision to grant or deny a variance or waiver must be based on the
886.15 commissioner's evaluation of the following criteria:

886.16 (1) whether the waiver will adversely affect the health, treatment, comfort, safety, or
886.17 well-being of a patient;

886.18 (2) whether the alternative measures to be taken, if any, are equivalent to or superior to
886.19 those prescribed in this section; and

886.20 (3) whether compliance with the requirements would impose an undue burden on the
886.21 applicant.

886.22 (c) The commissioner must notify the applicant in writing of the decision. If a variance
886.23 or waiver is granted, the notification must specify the period of time for which the variance
886.24 or waiver is effective and the alternative measures or conditions, if any, to be met by the
886.25 applicant.

886.26 (d) Alternative measures or conditions attached to a variance or waiver have the force
886.27 and effect of this chapter and are subject to the issuance of correction orders and fines in
886.28 accordance with sections 144I.30, subdivision 7, and 144I.31. The amount of fines for a
886.29 violation of this section is that specified for the specific requirement for which the variance
886.30 or waiver was requested.

887.1 (e) A request for the renewal of a variance or waiver must be submitted in writing at
887.2 least 45 days before its expiration date. Renewal requests must contain the information
887.3 specified in paragraph (b). A variance or waiver must be renewed by the department if the
887.4 applicant continues to satisfy the criteria in paragraph (a) and demonstrates compliance
887.5 with the alternative measures or conditions imposed at the time the original variance or
887.6 waiver was granted.

887.7 (f) The department must deny, revoke, or refuse to renew a variance or waiver if it is
887.8 determined that the criteria in paragraph (a) are not met. The applicant must be notified in
887.9 writing of the reasons for the decision and informed of the right to appeal the decision.

887.10 (g) An applicant may contest the denial, revocation, or refusal to renew a variance or
887.11 waiver by requesting a contested case hearing under chapter 14. The applicant must submit,
887.12 within 15 days of the receipt of the department's decision, a written request for a hearing.
887.13 The request for hearing must set forth in detail the reasons why the applicant contends the
887.14 decision of the department should be reversed or modified. At the hearing, the applicant
887.15 has the burden of proving by a preponderance of the evidence that the applicant satisfied
887.16 the criteria specified in paragraph (b), except in a proceeding challenging the revocation of
887.17 a variance or waiver.

887.18 **Sec. 26. [144I.25] RESIDENCY AND SERVICES CONTRACT REQUIREMENTS.**

887.19 Subdivision 1. **Contract required.** (a) An assisted living facility or assisted living facility
887.20 with dementia care may not offer or provide housing or services to a resident unless it has
887.21 executed a written contract with the resident.

887.22 (b) The contract must:

887.23 (1) be signed by both:

887.24 (i) the resident or the designated representative; and

887.25 (ii) the licensee or an agent of the facility; and

887.26 (2) contain all the terms concerning the provision of:

887.27 (i) housing; and

887.28 (ii) services, whether provided directly by the facility or by management agreement.

887.29 (c) A facility must:

887.30 (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term
887.31 Care a complete unsigned copy of its contract; and

888.1 (2) give a complete copy of any signed contract and any addendums, and all supporting
888.2 documents and attachments, to the resident or the designated representative promptly after
888.3 a contract and any addendum has been signed by the resident or the designated representative.

888.4 (d) A contract under this section is a consumer contract under sections 325G.29 to
888.5 325G.37.

888.6 (e) Before or at the time of execution of the contract, the facility must offer the resident
888.7 the opportunity to identify a designated or resident representative or both in writing in the
888.8 contract. The contract must contain a page or space for the name and contact information
888.9 of the designated or resident representative or both and a box the resident must initial if the
888.10 resident declines to name a designated or resident representative. Notwithstanding paragraph
888.11 (f), the resident has the right at any time to rescind the declination or add or change the
888.12 name and contact information of the designated or resident representative.

888.13 (f) The resident must agree in writing to any additions or amendments to the contract.
888.14 Upon agreement between the resident or resident's designated representative and the facility,
888.15 a new contract or an addendum to the existing contract must be executed and signed.

888.16 Subd. 2. **Contents and contract; contact information.** (a) The contract must include
888.17 in a conspicuous place and manner on the contract the legal name and the license number
888.18 of the facility.

888.19 (b) The contract must include the name, telephone number, and physical mailing address,
888.20 which may not be a public or private post office box, of:

888.21 (1) the facility and contracted service provider when applicable;

888.22 (2) the licensee of the facility;

888.23 (3) the managing agent of the facility, if applicable; and

888.24 (4) at least one natural person who is authorized to accept service of process on behalf
888.25 of the facility.

888.26 (c) The contract must include:

888.27 (1) a description of all the terms and conditions of the contract, including a description
888.28 of and any limitations to the housing and/or services to be provided for the contracted
888.29 amount;

888.30 (2) a delineation of the cost and nature of any other services to be provided for an
888.31 additional fee;

889.1 (3) a delineation and description of any additional fees the resident may be required to
889.2 pay if the resident's condition changes during the term of the contract;

889.3 (4) a delineation of the grounds under which the resident may be discharged, evicted,
889.4 or transferred or have services terminated; and

889.5 (5) billing and payment procedures and requirements.

889.6 (d) The contract must include a description of the facility's complaint resolution process
889.7 available to residents, including the name and contact information of the person representing
889.8 the facility who is designated to handle and resolve complaints.

889.9 (e) The contract must include a clear and conspicuous notice of:

889.10 (1) the right under section 144J.09 to challenge a discharge, eviction, or transfer or
889.11 service termination;

889.12 (2) the facility's policy regarding transfer of residents within the facility, under what
889.13 circumstances a transfer may occur, and whether or not consent of the resident being asked
889.14 to transfer is required;

889.15 (3) contact information for the Office of Ombudsman for Long-Term Care, the
889.16 Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health
889.17 Facility Complaints;

889.18 (4) the resident's right to obtain services from an unaffiliated service provider;

889.19 (5) a description of the assisted living facility's policies related to medical assistance
889.20 waivers under sections 256B.0915 and 256B.49, including:

889.21 (i) whether the provider is enrolled with the commissioner of human services to provide
889.22 customized living services under medical assistance waivers;

889.23 (ii) whether there is a limit on the number of people residing at the assisted living facility
889.24 who can receive customized living services at any point in time. If so, the limit must be
889.25 provided;

889.26 (iii) whether the assisted living facility requires a resident to pay privately for a period
889.27 of time prior to accepting payment under medical assistance waivers, and if so, the length
889.28 of time that private payment is required;

889.29 (iv) a statement that medical assistance waivers provide payment for services, but do
889.30 not cover the cost of rent;

890.1 (v) a statement that residents may be eligible for assistance with rent through the housing
890.2 support program; and

890.3 (vi) a description of the rent requirements for people who are eligible for medical
890.4 assistance waivers but who are not eligible for assistance through the housing support
890.5 program;

890.6 (6) the contact information to obtain long-term care consulting services under section
890.7 256B.0911; and

890.8 (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center.

890.9 (f) The contract must include a description of the facility's complaint resolution process
890.10 available to residents, including the name and contact information of the person representing
890.11 the facility who is designated to handle and resolve complaints.

890.12 Subd. 3. **Additional contract requirements.** (a) A restriction of a resident's rights under
890.13 this subdivision is allowed only if determined necessary for health and safety reasons
890.14 identified by the facility's registered nurse in an initial assessment or reassessment, under
890.15 section 144I.15, subdivision 9, and documented in the written service plan under section
890.16 144I.15, subdivision 10. Any restrictions of those rights for individuals served under sections
890.17 256B.0915 and 256B.49 must be documented in the resident's coordinated service and
890.18 support plan (CSSP), as defined under sections 256B.0915, subdivision 6, and 256B.49,
890.19 subdivision 15.

890.20 (b) The contract must include a statement:

890.21 (1) regarding the ability of a resident to furnish and decorate the resident's unit within
890.22 the terms of the lease;

890.23 (2) regarding the resident's right to access food at any time;

890.24 (3) regarding a resident's right to choose the resident's visitors and times of visits;

890.25 (4) regarding the resident's right to choose a roommate if sharing a unit; and

890.26 (5) notifying the resident of the resident's right to have and use a lockable door to the
890.27 resident's unit. The landlord shall provide the locks on the unit. Only a staff member with
890.28 a specific need to enter the unit shall have keys, and advance notice must be given to the
890.29 resident before entrance, when possible.

890.30 Subd. 4. **Filing.** The contract and related documents executed by each resident or the
890.31 designated representative must be maintained by the facility in files from the date of execution
890.32 until three years after the contract is terminated or expires. The contracts and all associated

891.1 documents will be available for on-site inspection by the commissioner at any time. The
891.2 documents shall be available for viewing or copies shall be made available to the resident
891.3 and the designated representative at any time.

891.4 Subd. 5. **Waivers of liability prohibited.** The contract must not include a waiver of
891.5 facility liability for the health and safety or personal property of a resident. The contract
891.6 must not include any provision that the facility knows or should know to be deceptive,
891.7 unlawful, or unenforceable under state or federal law, nor include any provision that requires
891.8 or implies a lesser standard of care or responsibility than is required by law.

891.9 Sec. 27. **[144I.27] PLANNED CLOSURES.**

891.10 Subdivision 1. **Closure plan required.** In the event that a facility elects to voluntarily
891.11 close the facility, the facility must notify the commissioner and the Office of Ombudsman
891.12 for Long-Term Care in writing by submitting a proposed closure plan.

891.13 Subd. 2. **Content of closure plan.** The facility's proposed closure plan must include:

891.14 (1) the procedures and actions the facility will implement to notify residents of the
891.15 closure, including a copy of the written notice to be given to residents, designated
891.16 representatives, resident representatives, or family;

891.17 (2) the procedures and actions the facility will implement to ensure all residents receive
891.18 appropriate termination planning in accordance with section 144J.10, subdivisions 1 to 6,
891.19 and final accountings and returns under section 144J.10, subdivision 7;

891.20 (3) assessments of the needs and preferences of individual residents; and

891.21 (4) procedures and actions the facility will implement to maintain compliance with this
891.22 chapter until all residents have relocated.

891.23 Subd. 3. **Commissioner's approval required prior to implementation.** (a) The plan
891.24 shall be subject to the commissioner's approval and subdivision 6. The facility shall take
891.25 no action to close the residence prior to the commissioner's approval of the plan. The
891.26 commissioner shall approve or otherwise respond to the plan as soon as practicable.

891.27 (b) The commissioner of health may require the facility to work with a transitional team
891.28 comprised of department staff, staff of the Office of Ombudsman for Long-Term Care, and
891.29 other professionals the commissioner deems necessary to assist in the proper relocation of
891.30 residents.

891.31 Subd. 4. **Termination planning and final accounting requirements.** Prior to
891.32 termination, the facility must follow the termination planning requirements under section

892.1 144J.10, subdivisions 1 to 6, and final accounting and return requirements under section
892.2 144J.10, subdivision 7, for residents. The facility must implement the plan approved by the
892.3 commissioner and ensure that arrangements for relocation and continued care that meet
892.4 each resident's social, emotional, and health needs are effectuated prior to closure.

892.5 Subd. 5. **Notice to residents.** After the commissioner has approved the relocation plan
892.6 and at least 60 calendar days before closing, except as provided under subdivision 6, the
892.7 facility must notify residents, designated representatives, and resident representatives or, if
892.8 a resident has no designated representative or resident representative, a family member, if
892.9 known, of the closure, the proposed date of closure, the contact information of the
892.10 ombudsman for long-term care, and that the facility will follow the termination planning
892.11 requirements under section 144J.10, subdivisions 1 to 6, and final accounting and return
892.12 requirements under section 144J.10, subdivision 7.

892.13 Subd. 6. **Emergency closures.** (a) In the event the facility must close because the
892.14 commissioner deems the facility can no longer remain open, the facility must meet all
892.15 requirements in subdivisions 1 to 5, except for any requirements the commissioner finds
892.16 would endanger the health and safety of residents. In the event the commissioner determines
892.17 a closure must occur with less than 60 calendar days' notice, the facility shall provide notice
892.18 to residents as soon as practicable or as directed by the commissioner.

892.19 (b) Upon request from the commissioner, a facility must provide the commissioner with
892.20 any documentation related to the appropriateness of its relocation plan, or to any assertion
892.21 that the facility lacks the funds to comply with subdivision 1 to 5, or that remaining open
892.22 would otherwise endanger the health and safety of residents pursuant to paragraph (a).

892.23 Subd. 7. **Other rights.** Nothing in this section or section 144J.08 or 144J.10 affects the
892.24 rights and remedies available under chapter 504B, except to the extent those rights or
892.25 remedies are inconsistent with this section.

892.26 Subd. 8. **Fine.** The commissioner may impose a fine for failure to follow the requirements
892.27 of this section or section 144J.08 or 144J.10.

892.28 **Sec. 28. [144I.28] RELOCATIONS WITHIN ASSISTED LIVING LOCATION.**

892.29 Subdivision 1. **Notice required before relocation within location.** (a) A facility must:

892.30 (1) notify a resident and the resident's representative, if any, at least 14 calendar days
892.31 prior to a proposed nonemergency relocation to a different room at the same location; and

892.32 (2) obtain consent from the resident and the resident's representative, if any.

893.1 (b) A resident must be allowed to stay in the resident's room. If a resident consents to a
893.2 move, any needed reasonable modifications must be made to the new room to accommodate
893.3 the resident's disabilities.

893.4 Subd. 2. **Evaluation.** A facility shall evaluate the resident's individual needs before
893.5 deciding whether the room the resident will be moved to fits the resident's psychological,
893.6 cognitive, and health care needs, including the accessibility of the bathroom.

893.7 Subd. 3. **Restriction on relocation.** A person who has been a private-pay resident for
893.8 at least one year and resides in a private room, and whose payments subsequently will be
893.9 made under the medical assistance program under chapter 256B, may not be relocated to a
893.10 shared room without the consent of the resident or the resident's representative, if any.

893.11 **EFFECTIVE DATE.** This section is effective August 1, 2021.

893.12 Sec. 29. **[144I.29] COMMISSIONER OVERSIGHT AND AUTHORITY.**

893.13 Subdivision 1. **Regulations.** The commissioner shall regulate facilities pursuant to this
893.14 chapter. The regulations shall include the following:

893.15 (1) provisions to assure, to the extent possible, the health, safety, well-being, and
893.16 appropriate treatment of residents while respecting individual autonomy and choice;

893.17 (2) requirements that facilities furnish the commissioner with specified information
893.18 necessary to implement this chapter;

893.19 (3) standards of training of facility personnel;

893.20 (4) standards for provision of services;

893.21 (5) standards for medication management;

893.22 (6) standards for supervision of services;

893.23 (7) standards for resident evaluation or assessment;

893.24 (8) standards for treatments and therapies;

893.25 (9) requirements for the involvement of a resident's health care provider, the
893.26 documentation of the health care provider's orders, if required, and the resident's service
893.27 plan;

893.28 (10) the maintenance of accurate, current resident records;

893.29 (11) the establishment of levels of licenses based on services provided; and

893.30 (12) provisions to enforce these regulations and the assisted living bill of rights.

894.1 Subd. 2. **Regulatory functions.** (a) The commissioner shall:

894.2 (1) license, survey, and monitor without advance notice facilities in accordance with
894.3 this chapter;

894.4 (2) survey every provisional licensee within one year of the provisional license issuance
894.5 date subject to the provisional licensee providing licensed services to residents;

894.6 (3) survey facility licensees annually;

894.7 (4) investigate complaints of facilities;

894.8 (5) issue correction orders and assess civil penalties;

894.9 (6) take action as authorized in section 144I.33; and

894.10 (7) take other action reasonably required to accomplish the purposes of this chapter.

894.11 (b) Beginning August 1, 2021, the commissioner shall review blueprints for all new
894.12 facility construction and must approve the plans before construction may be commenced.

894.13 (c) The commissioner shall provide on-site review of the construction to ensure that all
894.14 physical environment standards are met before the facility license is complete.

894.15 Sec. 30. **[144I.30] SURVEYS AND INVESTIGATIONS.**

894.16 Subdivision 1. **Regulatory powers.** (a) The Department of Health is the exclusive state
894.17 agency charged with the responsibility and duty of surveying and investigating all facilities
894.18 required to be licensed under this chapter. The commissioner of health shall enforce all
894.19 sections of this chapter and the rules adopted under this chapter.

894.20 (b) The commissioner, upon request of the facility, must be given access to relevant
894.21 information, records, incident reports, and other documents in the possession of the facility
894.22 if the commissioner considers them necessary for the discharge of responsibilities. For
894.23 purposes of surveys and investigations and securing information to determine compliance
894.24 with licensure laws and rules, the commissioner need not present a release, waiver, or
894.25 consent to the individual. The identities of residents must be kept private as defined in
894.26 section 13.02, subdivision 12.

894.27 Subd. 2. **Surveys.** The commissioner shall conduct surveys of each assisted living facility
894.28 and assisted living facility with dementia care. The commissioner shall conduct a survey
894.29 of each facility on a frequency of at least once each year. The commissioner may conduct
894.30 surveys more frequently than once a year based on the license level, the provider's compliance
894.31 history, the number of clients served, or other factors as determined by the department

895.1 deemed necessary to ensure the health, safety, and welfare of residents and compliance with
895.2 the law.

895.3 Subd. 3. **Follow-up surveys.** The commissioner may conduct follow-up surveys to
895.4 determine if the facility has corrected deficient issues and systems identified during a survey
895.5 or complaint investigation. Follow-up surveys may be conducted via phone, e-mail, fax,
895.6 mail, or onsite reviews. Follow-up surveys, other than complaint investigations, shall be
895.7 concluded with an exit conference and written information provided on the process for
895.8 requesting a reconsideration of the survey results.

895.9 Subd. 4. **Scheduling surveys.** Surveys and investigations shall be conducted without
895.10 advance notice to the facilities. Surveyors may contact the facility on the day of a survey
895.11 to arrange for someone to be available at the survey site. The contact does not constitute
895.12 advance notice. The surveyor must provide presurvey notification to the Office of
895.13 Ombudsman for Long-Term Care.

895.14 Subd. 5. **Information provided by facility.** The facility shall provide accurate and
895.15 truthful information to the department during a survey, investigation, or other licensing
895.16 activities.

895.17 Subd. 6. **Providing resident records.** Upon request of a surveyor, facilities shall provide
895.18 a list of current and past residents or designated representatives that includes addresses and
895.19 telephone numbers and any other information requested about the services to residents
895.20 within a reasonable period of time.

895.21 Subd. 7. **Correction orders.** (a) A correction order may be issued whenever the
895.22 commissioner finds upon survey or during a complaint investigation that a facility, a
895.23 managerial official, or an employee of the provider is not in compliance with this chapter.
895.24 The correction order shall cite the specific statute and document areas of noncompliance
895.25 and the time allowed for correction.

895.26 (b) The commissioner shall mail or e-mail copies of any correction order to the facility
895.27 within 30 calendar days after the survey exit date. A copy of each correction order and
895.28 copies of any documentation supplied to the commissioner shall be kept on file by the
895.29 facility and public documents shall be made available for viewing by any person upon
895.30 request. Copies may be kept electronically.

895.31 (c) By the correction order date, the facility must document in the facility's records any
895.32 action taken to comply with the correction order. The commissioner may request a copy of
895.33 this documentation and the facility's action to respond to the correction order in future
895.34 surveys, upon a complaint investigation, and as otherwise needed.

896.1 Subd. 8. **Required follow-up surveys.** For facilities that have Level 3 or Level 4
896.2 violations under section 144I.31, the department shall conduct a follow-up survey within
896.3 90 calendar days of the survey. When conducting a follow-up survey, the surveyor shall
896.4 focus on whether the previous violations have been corrected and may also address any
896.5 new violations that are observed while evaluating the corrections that have been made.

896.6 Sec. 31. **[144I.31] VIOLATIONS AND FINES.**

896.7 Subdivision 1. **Fine amounts.** (a) Fines and enforcement actions under this subdivision
896.8 may be assessed based on the level and scope of the violations described in subdivision 2
896.9 as follows and imposed immediately with no opportunity to correct the violation prior to
896.10 imposition:

896.11 (1) Level 1, no fines or enforcement;

896.12 (2) Level 2, a fine of \$500 per violation;

896.13 (3) Level 3, a fine of \$3,000 per violation per incident plus \$100 for each resident affected
896.14 by the violation;

896.15 (4) Level 4, a fine of \$5,000 per incident plus \$200 for each resident; and

896.16 (5) for maltreatment violations as defined in the Minnesota Vulnerable Adults Act in
896.17 section 626.557 including abuse, neglect, financial exploitation, and drug diversion that are
896.18 determined against the facility, an immediate fine shall be imposed of \$5,000 per incident,
896.19 plus \$200 for each resident affected by the violation.

896.20 Subd. 2. **Level and scope of violation.** Correction orders for violations are categorized
896.21 by both level and scope, and fines shall be assessed as follows:

896.22 (1) level of violation:

896.23 (i) Level 1 is a violation that has no potential to cause more than a minimal impact on
896.24 the resident and does not affect health or safety;

896.25 (ii) Level 2 is a violation that did not harm a resident's health or safety but had the
896.26 potential to have harmed a resident's health or safety, but was not likely to cause serious
896.27 injury, impairment, or death;

896.28 (iii) Level 3 is a violation that harmed a resident's health or safety, not including serious
896.29 injury, impairment, or death, or a violation that has the potential to lead to serious injury,
896.30 impairment, or death; and

896.31 (iv) Level 4 is a violation that results in serious injury, impairment, or death; and

897.1 (2) scope of violation:

897.2 (i) isolated, when one or a limited number of residents are affected or one or a limited
897.3 number of staff are involved or the situation has occurred only occasionally;

897.4 (ii) pattern, when more than a limited number of residents are affected, more than a
897.5 limited number of staff are involved, or the situation has occurred repeatedly but is not
897.6 found to be pervasive; and

897.7 (iii) widespread, when problems are pervasive or represent a systemic failure that has
897.8 affected or has the potential to affect a large portion or all of the residents.

897.9 Subd. 3. **Notice of noncompliance.** If the commissioner finds that the applicant or a
897.10 facility has not corrected violations by the date specified in the correction order or conditional
897.11 license resulting from a survey or complaint investigation, the commissioner shall provide
897.12 a notice of noncompliance with a correction order by e-mailing the notice of noncompliance
897.13 to the facility. The noncompliance notice must list the violations not corrected.

897.14 Subd. 4. **Immediate fine; payment.** (a) For every violation, the commissioner may
897.15 issue an immediate fine. The licensee must still correct the violation in the time specified.
897.16 The issuance of an immediate fine may occur in addition to any enforcement mechanism
897.17 authorized under section 144I.33. The immediate fine may be appealed as allowed under
897.18 this section.

897.19 (b) The licensee must pay the fines assessed on or before the payment date specified. If
897.20 the licensee fails to fully comply with the order, the commissioner may issue a second fine
897.21 or suspend the license until the licensee complies by paying the fine. A timely appeal shall
897.22 stay payment of the fine until the commissioner issues a final order.

897.23 (c) A licensee shall promptly notify the commissioner in writing when a violation
897.24 specified in the order is corrected. If upon reinspection the commissioner determines that
897.25 a violation has not been corrected as indicated by the order, the commissioner may issue
897.26 an additional fine. The commissioner shall notify the licensee by mail to the last known
897.27 address in the licensing record that a second fine has been assessed. The licensee may appeal
897.28 the second fine as provided under this subdivision.

897.29 (d) A facility that has been assessed a fine under this section has a right to a
897.30 reconsideration or hearing under this section and chapter 14.

897.31 Subd. 5. **Facility cannot avoid payment.** When a fine has been assessed, the licensee
897.32 may not avoid payment by closing, selling, or otherwise transferring the license to a third
897.33 party. In such an event, the licensee shall be liable for payment of the fine.

898.1 Subd. 6. **Additional penalties.** In addition to any fine imposed under this section, the
898.2 commissioner may assess a penalty amount based on costs related to an investigation that
898.3 results in a final order assessing a fine or other enforcement action authorized by this chapter.

898.4 Subd. 7. **Deposit of fines.** Fines collected under this section shall be deposited in the
898.5 state government special revenue fund and credited to an account separate from the revenue
898.6 collected under section 144A.472. Subject to an appropriation by the legislature, the revenue
898.7 from the fines collected must be used by the commissioner for special projects to improve
898.8 home care in Minnesota as recommended by the advisory council established in section
898.9 144A.4799.

898.10 Sec. 32. **[144I.32] RECONSIDERATION OF CORRECTION ORDERS AND FINES.**

898.11 Subdivision 1. **Reconsideration process required.** The commissioner shall make
898.12 available to facilities a correction order reconsideration process. This process may be used
898.13 to challenge the correction order issued, including the level and scope described in section
898.14 144I.31, and any fine assessed. When a licensee requests reconsideration of a correction
898.15 order, the correction order is not stayed while it is under reconsideration. The department
898.16 shall post information on its website that the licensee requested reconsideration of the
898.17 correction order and that the review is pending.

898.18 Subd. 2. **Reconsideration process.** A facility may request from the commissioner, in
898.19 writing, a correction order reconsideration regarding any correction order issued to the
898.20 facility. The written request for reconsideration must be received by the commissioner
898.21 within 15 calendar days of the correction order receipt date. The correction order
898.22 reconsideration shall not be reviewed by any surveyor, investigator, or supervisor that
898.23 participated in writing or reviewing the correction order being disputed. The correction
898.24 order reconsiderations may be conducted in person, by telephone, by another electronic
898.25 form, or in writing, as determined by the commissioner. The commissioner shall respond
898.26 in writing to the request from a facility for a correction order reconsideration within 60 days
898.27 of the date the facility requests a reconsideration. The commissioner's response shall identify
898.28 the commissioner's decision regarding each citation challenged by the facility.

898.29 Subd. 3. **Findings.** The findings of a correction order reconsideration process shall be
898.30 one or more of the following:

898.31 (1) supported in full: the correction order is supported in full, with no deletion of findings
898.32 to the citation;

899.1 (2) supported in substance: the correction order is supported, but one or more findings
899.2 are deleted or modified without any change in the citation;

899.3 (3) correction order cited an incorrect licensing requirement: the correction order is
899.4 amended by changing the correction order to the appropriate statute and/or rule;

899.5 (4) correction order was issued under an incorrect citation: the correction order is amended
899.6 to be issued under the more appropriate correction order citation;

899.7 (5) the correction order is rescinded;

899.8 (6) fine is amended: it is determined that the fine assigned to the correction order was
899.9 applied incorrectly; or

899.10 (7) the level or scope of the citation is modified based on the reconsideration.

899.11 Subd. 4. **Updating the correction order website.** If the correction order findings are
899.12 changed by the commissioner, the commissioner shall update the correction order website.

899.13 Subd. 5. **Provisional licensees.** This section does not apply to provisional licensees.

899.14 **Sec. 33. [144I.33] ENFORCEMENT.**

899.15 Subdivision 1. **Conditions.** (a) The commissioner may refuse to grant a provisional
899.16 license, refuse to grant a license as a result of a change in ownership, renew a license,
899.17 suspend or revoke a license, or impose a conditional license if the owner, controlling
899.18 individual, or employee of an assisted living facility or assisted living facility with dementia
899.19 care:

899.20 (1) is in violation of, or during the term of the license has violated, any of the requirements
899.21 in this chapter or adopted rules;

899.22 (2) permits, aids, or abets the commission of any illegal act in the provision of assisted
899.23 living services;

899.24 (3) performs any act detrimental to the health, safety, and welfare of a resident;

899.25 (4) obtains the license by fraud or misrepresentation;

899.26 (5) knowingly made or makes a false statement of a material fact in the application for
899.27 a license or in any other record or report required by this chapter;

899.28 (6) denies representatives of the department access to any part of the facility's books,
899.29 records, files, or employees;

900.1 (7) interferes with or impedes a representative of the department in contacting the facility's
900.2 residents;

900.3 (8) interferes with or impedes a representative of the department in the enforcement of
900.4 this chapter or has failed to fully cooperate with an inspection, survey, or investigation by
900.5 the department;

900.6 (9) destroys or makes unavailable any records or other evidence relating to the assisted
900.7 living facility's compliance with this chapter;

900.8 (10) refuses to initiate a background study under section 144.057 or 245A.04;

900.9 (11) fails to timely pay any fines assessed by the commissioner;

900.10 (12) violates any local, city, or township ordinance relating to housing or services;

900.11 (13) has repeated incidents of personnel performing services beyond their competency
900.12 level; or

900.13 (14) has operated beyond the scope of the facility's license category.

900.14 (b) A violation by a contractor providing the services of the facility is a violation by
900.15 facility.

900.16 Subd. 2. **Terms to suspension or conditional license.** (a) A suspension or conditional
900.17 license designation may include terms that must be completed or met before a suspension
900.18 or conditional license designation is lifted. A conditional license designation may include
900.19 restrictions or conditions that are imposed on the facility. Terms for a suspension or
900.20 conditional license may include one or more of the following and the scope of each will be
900.21 determined by the commissioner:

900.22 (1) requiring a consultant to review, evaluate, and make recommended changes to the
900.23 facility's practices and submit reports to the commissioner at the cost of the facility;

900.24 (2) requiring supervision of the facility or staff practices at the cost of the facility by an
900.25 unrelated person who has sufficient knowledge and qualifications to oversee the practices
900.26 and who will submit reports to the commissioner;

900.27 (3) requiring the facility or employees to obtain training at the cost of the facility;

900.28 (4) requiring the facility to submit reports to the commissioner;

900.29 (5) prohibiting the facility from admitting any new residents for a specified period of
900.30 time; or

901.1 (6) any other action reasonably required to accomplish the purpose of this subdivision
901.2 and subdivision 1.

901.3 (b) A facility subject to this subdivision may continue operating during the period of
901.4 time residents are being transferred to another service provider.

901.5 Subd. 3. **Immediate temporary suspension.** (a) In addition to any other remedies
901.6 provided by law, the commissioner may, without a prior contested case hearing, immediately
901.7 temporarily suspend a license or prohibit delivery of housing or services by a facility for
901.8 not more than 90 calendar days or issue a conditional license, if the commissioner determines
901.9 that there are:

901.10 (1) Level 4 violations; or

901.11 (2) violations that pose an imminent risk of harm to the health or safety of residents.

901.12 (b) For purposes of this subdivision, "Level 4" has the meaning given in section 144I.31.

901.13 (c) A notice stating the reasons for the immediate temporary suspension or conditional
901.14 license and informing the licensee of the right to an expedited hearing under subdivision
901.15 11 must be delivered by personal service to the address shown on the application or the last
901.16 known address of the licensee. The licensee may appeal an order immediately temporarily
901.17 suspending a license or issuing a conditional license. The appeal must be made in writing
901.18 by certified mail or personal service. If mailed, the appeal must be postmarked and sent to
901.19 the commissioner within five calendar days after the licensee receives notice. If an appeal
901.20 is made by personal service, it must be received by the commissioner within five calendar
901.21 days after the licensee received the order.

901.22 (d) A licensee whose license is immediately temporarily suspended must comply with
901.23 the requirements for notification and transfer of residents in subdivision 9. The requirements
901.24 in subdivision 9 remain if an appeal is requested.

901.25 Subd. 4. **Mandatory revocation.** Notwithstanding the provisions of subdivision 7,
901.26 paragraph (a), the commissioner must revoke a license if a controlling individual of the
901.27 facility is convicted of a felony or gross misdemeanor that relates to operation of the facility
901.28 or directly affects resident safety or care. The commissioner shall notify the facility and the
901.29 Office of Ombudsman for Long-Term Care 30 calendar days in advance of the date of
901.30 revocation.

901.31 Subd. 5. **Mandatory proceedings.** (a) The commissioner must initiate proceedings
901.32 within 60 calendar days of notification to suspend or revoke a facility's license or must

902.1 refuse to renew a facility's license if within the preceding two years the facility has incurred
902.2 the following number of uncorrected or repeated violations:

902.3 (1) two or more uncorrected violations or one or more repeated violations that created
902.4 an imminent risk to direct resident care or safety; or

902.5 (2) four or more uncorrected violations or two or more repeated violations of any nature
902.6 for which the fines are in the four highest daily fine categories prescribed in rule.

902.7 (b) Notwithstanding paragraph (a), the commissioner is not required to revoke, suspend,
902.8 or refuse to renew a facility's license if the facility corrects the violation.

902.9 Subd. 6. **Notice to residents.** (a) Within five business days after proceedings are initiated
902.10 by the commissioner to revoke or suspend a facility's license, or a decision by the
902.11 commissioner not to renew a living facility's license, the controlling individual of the facility
902.12 or a designee must provide to the commissioner and the ombudsman for long-term care the
902.13 names of residents and the names and addresses of the residents' guardians, designated
902.14 representatives, and family contacts.

902.15 (b) The controlling individual or designees of the facility must provide updated
902.16 information each month until the proceeding is concluded. If the controlling individual or
902.17 designee of the facility fails to provide the information within this time, the facility is subject
902.18 to the issuance of:

902.19 (1) a correction order; and

902.20 (2) a penalty assessment by the commissioner in rule.

902.21 (c) Notwithstanding subdivisions 16 and 17, any correction order issued under this
902.22 subdivision must require that the facility immediately comply with the request for information
902.23 and that, as of the date of the issuance of the correction order, the facility shall forfeit to the
902.24 state a \$500 fine the first day of noncompliance and an increase in the \$500 fine by \$100
902.25 increments for each day the noncompliance continues.

902.26 (d) Information provided under this subdivision may be used by the commissioner or
902.27 the ombudsman for long-term care only for the purpose of providing affected consumers
902.28 information about the status of the proceedings.

902.29 (e) Within ten business days after the commissioner initiates proceedings to revoke,
902.30 suspend, or not renew a facility license, the commissioner must send a written notice of the
902.31 action and the process involved to each resident of the facility and the resident's designated
902.32 representative or, if there is no designated representative and if known, a family member
902.33 or interested person.

903.1 (f) The commissioner shall provide the ombudsman for long-term care with monthly
903.2 information on the department's actions and the status of the proceedings.

903.3 Subd. 7. **Notice to facility.** (a) Prior to any suspension, revocation, or refusal to renew
903.4 a license, the facility shall be entitled to notice and a hearing as provided by sections 14.57
903.5 to 14.69. The hearing must commence within 60 calendar days after the proceedings are
903.6 initiated. In addition to any other remedy provided by law, the commissioner may, without
903.7 a prior contested case hearing, temporarily suspend a license or prohibit delivery of services
903.8 by a provider for not more than 90 calendar days, or issue a conditional license if the
903.9 commissioner determines that there are Level 3 violations that do not pose an imminent
903.10 risk of harm to the health or safety of the facility residents, provided:

903.11 (1) advance notice is given to the facility;

903.12 (2) after notice, the facility fails to correct the problem;

903.13 (3) the commissioner has reason to believe that other administrative remedies are not
903.14 likely to be effective; and

903.15 (4) there is an opportunity for a contested case hearing within 30 calendar days unless
903.16 there is an extension granted by an administrative law judge.

903.17 (b) If the commissioner determines there are Level 4 violations or violations that pose
903.18 an imminent risk of harm to the health or safety of the facility residents, the commissioner
903.19 may immediately temporarily suspend a license, prohibit delivery of services by a facility,
903.20 or issue a conditional license without meeting the requirements of paragraph (a), clauses
903.21 (1) to (4).

903.22 For the purposes of this subdivision, "Level 3" and "Level 4" have the meanings given in
903.23 section 144I.31.

903.24 Subd. 8. **Request for hearing.** A request for hearing must be in writing and must:

903.25 (1) be mailed or delivered to the commissioner or the commissioner's designee;

903.26 (2) contain a brief and plain statement describing every matter or issue contested; and

903.27 (3) contain a brief and plain statement of any new matter that the applicant or assisted
903.28 living facility believes constitutes a defense or mitigating factor.

903.29 Subd. 9. **Plan required.** (a) The process of suspending, revoking, or refusing to renew
903.30 a license must include a plan for transferring affected residents' cares to other providers by
903.31 the facility that will be monitored by the commissioner. Within three calendar days of being
903.32 notified of the final revocation, refusal to renew, or suspension, the licensee shall provide

904.1 the commissioner, the lead agencies as defined in section 256B.0911, county adult protection
904.2 and case managers, and the ombudsman for long-term care with the following information:

904.3 (1) a list of all residents, including full names and all contact information on file;

904.4 (2) a list of each resident's representative or emergency contact person, including full
904.5 names and all contact information on file;

904.6 (3) the location or current residence of each resident;

904.7 (4) the payor sources for each resident, including payor source identification numbers;

904.8 and

904.9 (5) for each resident, a copy of the resident's service plan and a list of the types of services
904.10 being provided.

904.11 (b) The revocation, refusal to renew, or suspension notification requirement is satisfied
904.12 by mailing the notice to the address in the license record. The licensee shall cooperate with
904.13 the commissioner and the lead agencies, county adult protection and county managers, and
904.14 the ombudsman for long-term care during the process of transferring care of residents to
904.15 qualified providers. Within three calendar days of being notified of the final revocation,
904.16 refusal to renew, or suspension action, the facility must notify and disclose to each of the
904.17 residents, or the resident's representative or emergency contact persons, that the commissioner
904.18 is taking action against the facility's license by providing a copy of the revocation or
904.19 suspension notice issued by the commissioner. If the facility does not comply with the
904.20 disclosure requirements in this section, the commissioner shall notify the residents, designated
904.21 representatives, or emergency contact persons about the actions being taken. Lead agencies,
904.22 county adult protection and county managers, and the Office of Ombudsman for Long-Term
904.23 Care may also provide this information. The revocation, refusal to renew, or suspension
904.24 notice is public data except for any private data contained therein.

904.25 (c) A facility subject to this subdivision may continue operating while residents are being
904.26 transferred to other service providers.

904.27 Subd. 10. **Hearing.** Within 15 business days of receipt of the licensee's timely appeal
904.28 of a sanction under this section, other than for a temporary suspension, the commissioner
904.29 shall request assignment of an administrative law judge. The commissioner's request must
904.30 include a proposed date, time, and place of hearing. A hearing must be conducted by an
904.31 administrative law judge pursuant to Minnesota Rules, parts 1400.8505 to 1400.8612, within
904.32 90 calendar days of the request for assignment, unless an extension is requested by either
904.33 party and granted by the administrative law judge for good cause or for purposes of discussing

905.1 settlement. In no case shall one or more extensions be granted for a total of more than 90
905.2 calendar days unless there is a criminal action pending against the licensee. If, while a
905.3 licensee continues to operate pending an appeal of an order for revocation, suspension, or
905.4 refusal to renew a license, the commissioner identifies one or more new violations of law
905.5 that meet the requirements of Level 3 or Level 4 violations as defined in section 144I.31,
905.6 the commissioner shall act immediately to temporarily suspend the license.

905.7 Subd. 11. **Expedited hearing.** (a) Within five business days of receipt of the licensee's
905.8 timely appeal of a temporary suspension or issuance of a conditional license, the
905.9 commissioner shall request assignment of an administrative law judge. The request must
905.10 include a proposed date, time, and place of a hearing. A hearing must be conducted by an
905.11 administrative law judge pursuant to Minnesota Rules, parts 1400.8505 to 1400.8612, within
905.12 30 calendar days of the request for assignment, unless an extension is requested by either
905.13 party and granted by the administrative law judge for good cause. The commissioner shall
905.14 issue a notice of hearing by certified mail or personal service at least ten business days
905.15 before the hearing. Certified mail to the last known address is sufficient. The scope of the
905.16 hearing shall be limited solely to the issue of whether the temporary suspension or issuance
905.17 of a conditional license should remain in effect and whether there is sufficient evidence to
905.18 conclude that the licensee's actions or failure to comply with applicable laws are Level 3
905.19 or Level 4 violations as defined in section 144I.31, or that there were violations that posed
905.20 an imminent risk of harm to the resident's health and safety.

905.21 (b) The administrative law judge shall issue findings of fact, conclusions, and a
905.22 recommendation within ten business days from the date of hearing. The parties shall have
905.23 ten calendar days to submit exceptions to the administrative law judge's report. The record
905.24 shall close at the end of the ten-day period for submission of exceptions. The commissioner's
905.25 final order shall be issued within ten business days from the close of the record. When an
905.26 appeal of a temporary immediate suspension or conditional license is withdrawn or dismissed,
905.27 the commissioner shall issue a final order affirming the temporary immediate suspension
905.28 or conditional license within ten calendar days of the commissioner's receipt of the
905.29 withdrawal or dismissal. The licensee is prohibited from operation during the temporary
905.30 suspension period.

905.31 (c) When the final order under paragraph (b) affirms an immediate suspension, and a
905.32 final licensing sanction is issued under subdivisions 1 and 2 and the licensee appeals that
905.33 sanction, the licensee is prohibited from operation pending a final commissioner's order
905.34 after the contested case hearing conducted under chapter 14.

906.1 (d) A licensee whose license is temporarily suspended must comply with the requirements
906.2 for notification and transfer of residents under subdivision 9. These requirements remain if
906.3 an appeal is requested.

906.4 Subd. 12. **Time limits for appeals.** To appeal the assessment of civil penalties under
906.5 section 144I.31, and an action against a license under this section, a licensee must request
906.6 a hearing no later than 15 business days after the licensee receives notice of the action.

906.7 Subd. 13. **Owners and managerial officials; refusal to grant license.** (a) The owner
906.8 and managerial officials of a facility whose Minnesota license has not been renewed or that
906.9 has been revoked because of noncompliance with applicable laws or rules shall not be
906.10 eligible to apply for nor will be granted an assisted living facility license or an assisted
906.11 living facility with dementia care license, or be given status as an enrolled personal care
906.12 assistance provider agency or personal care assistant by the Department of Human Services
906.13 under section 256B.0659, for five years following the effective date of the nonrenewal or
906.14 revocation. If the owner and/or managerial officials already have enrollment status, the
906.15 enrollment will be terminated by the Department of Human Services.

906.16 (b) The commissioner shall not issue a license to a facility for five years following the
906.17 effective date of license nonrenewal or revocation if the owner or managerial official,
906.18 including any individual who was an owner or managerial official of another licensed
906.19 provider, had a Minnesota license that was not renewed or was revoked as described in
906.20 paragraph (a).

906.21 (c) Notwithstanding subdivision 1, the commissioner shall not renew, or shall suspend
906.22 or revoke, the license of a facility that includes any individual as an owner or managerial
906.23 official who was an owner or managerial official of a facility whose Minnesota license was
906.24 not renewed or was revoked as described in paragraph (a) for five years following the
906.25 effective date of the nonrenewal or revocation.

906.26 (d) The commissioner shall notify the facility 30 calendar days in advance of the date
906.27 of nonrenewal, suspension, or revocation of the license. Within ten business days after the
906.28 receipt of the notification, the facility may request, in writing, that the commissioner stay
906.29 the nonrenewal, revocation, or suspension of the license. The facility shall specify the
906.30 reasons for requesting the stay; the steps that will be taken to attain or maintain compliance
906.31 with the licensure laws and regulations; any limits on the authority or responsibility of the
906.32 owners or managerial officials whose actions resulted in the notice of nonrenewal, revocation,
906.33 or suspension; and any other information to establish that the continuing affiliation with
906.34 these individuals will not jeopardize resident health, safety, or well-being. The commissioner

907.1 shall determine whether the stay will be granted within 30 calendar days of receiving the
907.2 facility's request. The commissioner may propose additional restrictions or limitations on
907.3 the facility's license and require that granting the stay be contingent upon compliance with
907.4 those provisions. The commissioner shall take into consideration the following factors when
907.5 determining whether the stay should be granted:

907.6 (1) the threat that continued involvement of the owners and managerial officials with
907.7 the facility poses to resident health, safety, and well-being;

907.8 (2) the compliance history of the facility; and

907.9 (3) the appropriateness of any limits suggested by the facility.

907.10 If the commissioner grants the stay, the order shall include any restrictions or limitation on
907.11 the provider's license. The failure of the facility to comply with any restrictions or limitations
907.12 shall result in the immediate removal of the stay and the commissioner shall take immediate
907.13 action to suspend, revoke, or not renew the license.

907.14 Subd. 14. **Relicensing.** If a facility license is revoked, a new application for license may
907.15 be considered by the commissioner when the conditions upon which the revocation was
907.16 based have been corrected and satisfactory evidence of this fact has been furnished to the
907.17 commissioner. A new license may be granted after an inspection has been made and the
907.18 facility has complied with all provisions of this chapter and adopted rules.

907.19 Subd. 15. **Informal conference.** At any time, the applicant or facility and the
907.20 commissioner may hold an informal conference to exchange information, clarify issues, or
907.21 resolve issues.

907.22 Subd. 16. **Injunctive relief.** In addition to any other remedy provided by law, the
907.23 commissioner may bring an action in district court to enjoin a person who is involved in
907.24 the management, operation, or control of a facility or an employee of the facility from
907.25 illegally engaging in activities regulated by sections under this chapter. The commissioner
907.26 may bring an action under this subdivision in the district court in Ramsey County or in the
907.27 district in which the facility is located. The court may grant a temporary restraining order
907.28 in the proceeding if continued activity by the person who is involved in the management,
907.29 operation, or control of a facility, or by an employee of the facility, would create an imminent
907.30 risk of harm to a resident.

907.31 Subd. 17. **Subpoena.** In matters pending before the commissioner under this chapter,
907.32 the commissioner may issue subpoenas and compel the attendance of witnesses and the
907.33 production of all necessary papers, books, records, documents, and other evidentiary material.

908.1 If a person fails or refuses to comply with a subpoena or order of the commissioner to appear
908.2 or testify regarding any matter about which the person may be lawfully questioned or to
908.3 produce any papers, books, records, documents, or evidentiary materials in the matter to be
908.4 heard, the commissioner may apply to the district court in any district, and the court shall
908.5 order the person to comply with the commissioner's order or subpoena. The commissioner
908.6 of health may administer oaths to witnesses or take their affirmation. Depositions may be
908.7 taken in or outside the state in the manner provided by law for taking depositions in civil
908.8 actions. A subpoena or other process or paper may be served on a named person anywhere
908.9 in the state by an officer authorized to serve subpoenas in civil actions, with the same fees
908.10 and mileage and in the same manner as prescribed by law for a process issued out of a
908.11 district court. A person subpoenaed under this subdivision shall receive the same fees,
908.12 mileage, and other costs that are paid in proceedings in district court.

908.13 Sec. 34. [144I.34] INNOVATION VARIANCE.

908.14 Subdivision 1. **Definition; granting variances.** (a) For purposes of this section,
908.15 "innovation variance" means a specified alternative to a requirement of this chapter.

908.16 (b) An innovation variance may be granted to allow a facility to offer services of a type
908.17 or in a manner that is innovative, will not impair the services provided, will not adversely
908.18 affect the health, safety, or welfare of the residents, and is likely to improve the services
908.19 provided. The innovative variance cannot change any of the resident's rights under the
908.20 assisted living bill of rights under section 144J.02.

908.21 Subd. 2. **Conditions.** The commissioner may impose conditions on granting an innovation
908.22 variance that the commissioner considers necessary.

908.23 Subd. 3. **Duration and renewal.** The commissioner may limit the duration of any
908.24 innovation variance and may renew a limited innovation variance.

908.25 Subd. 4. **Applications; innovation variance.** An application for innovation variance
908.26 from the requirements of this chapter may be made at any time, must be made in writing to
908.27 the commissioner, and must specify the following:

908.28 (1) the statute or rule from which the innovation variance is requested;

908.29 (2) the time period for which the innovation variance is requested;

908.30 (3) the specific alternative action that the licensee proposes;

908.31 (4) the reasons for the request; and

909.1 (5) justification that an innovation variance will not impair the services provided, will
909.2 not adversely affect the health, safety, or welfare of residents, and is likely to improve the
909.3 services provided.

909.4 The commissioner may require additional information from the facility before acting on
909.5 the request.

909.6 Subd. 5. **Grants and denials.** The commissioner shall grant or deny each request for
909.7 an innovation variance in writing within 45 days of receipt of a complete request. Notice
909.8 of a denial shall contain the reasons for the denial. The terms of a requested innovation
909.9 variance may be modified upon agreement between the commissioner and the facility.

909.10 Subd. 6. **Violation of innovation variances.** A failure to comply with the terms of an
909.11 innovation variance shall be deemed to be a violation of this chapter.

909.12 Subd. 7. **Revocation or denial of renewal.** The commissioner shall revoke or deny
909.13 renewal of an innovation variance if:

909.14 (1) it is determined that the innovation variance is adversely affecting the health, safety,
909.15 or welfare of the residents;

909.16 (2) the facility has failed to comply with the terms of the innovation variance;

909.17 (3) the facility notifies the commissioner in writing that it wishes to relinquish the
909.18 innovation variance and be subject to the statute previously varied; or

909.19 (4) the revocation or denial is required by a change in law.

909.20 Sec. 35. **[144L.35] RESIDENT QUALITY OF CARE AND OUTCOMES**
909.21 **IMPROVEMENT TASK FORCE.**

909.22 Subdivision 1. **Establishment.** The commissioner shall establish a resident quality of
909.23 care and outcomes improvement task force to examine and make recommendations, on an
909.24 ongoing basis, on how to apply proven safety and quality improvement practices and
909.25 infrastructure to settings and providers that provide long-term services and supports.

909.26 Subd. 2. **Membership.** The task force shall include representation from:

909.27 (1) nonprofit Minnesota-based organizations dedicated to patient safety or innovation
909.28 in health care safety and quality;

909.29 (2) Department of Health staff with expertise in issues related to safety and adverse
909.30 health events;

909.31 (3) consumer organizations;

- 910.1 (4) direct care providers or their representatives;
- 910.2 (5) organizations representing long-term care providers and home care providers in
- 910.3 Minnesota;
- 910.4 (6) the ombudsman for long-term care or a designee;
- 910.5 (7) national patient safety experts; and
- 910.6 (8) other experts in the safety and quality improvement field.

910.7 The task force shall have at least one public member who either is or has been a resident in

910.8 an assisted living setting and one public member who has or had a family member living

910.9 in an assisted living setting. The membership shall be voluntary except that public members

910.10 may be reimbursed under section 15.059, subdivision 3.

910.11 Subd. 3. **Recommendations.** The task force shall periodically provide recommendations

910.12 to the commissioner and the legislature on changes needed to promote safety and quality

910.13 improvement practices in long-term care settings and with long-term care providers. The

910.14 task force shall meet no fewer than four times per year. The task force shall be established

910.15 by July 1, 2020.

910.16 Sec. 36. **[144I.36] EXPEDITED RULEMAKING AUTHORIZED.**

910.17 (a) The commissioner shall adopt rules for all assisted living facilities that promote

910.18 person-centered planning and service and optimal quality of life, and that ensure resident

910.19 rights are protected, resident choice is allowed, and public health and safety is ensured.

910.20 (b) On July 1, 2019, the commissioner shall begin expedited rulemaking using the process

910.21 in section 14.389, except that the rulemaking process is exempt from section 14.389,

910.22 subdivision 5.

910.23 (c) The commissioner shall adopt rules that include but are not limited to the following:

- 910.24 (1) staffing minimums and ratios for each level of licensure to best protect the health
- 910.25 and safety of residents no matter their vulnerability;
- 910.26 (2) training prerequisites and ongoing training for administrators and caregiving staff;
- 910.27 (3) requirements for licensees to ensure minimum nutrition and dietary standards required
- 910.28 by section 144I.10 are provided;
- 910.29 (4) procedures for discharge planning and ensuring resident appeal rights;
- 910.30 (5) core dementia care requirements and training in all levels of licensure;

911.1 (6) requirements for assisted living facilities with dementia care in terms of training,
 911.2 care standards, noticing changes of condition, assessments, and health care;

911.3 (7) preadmission criteria, initial assessments, and continuing assessments;

911.4 (8) emergency disaster and preparedness plans;

911.5 (9) uniform checklist disclosure of services;

911.6 (10) uniform consumer information guide elements and other data collected; and

911.7 (11) uniform assessment tool.

911.8 (d) The commissioner shall publish the proposed rules by December 31, 2019, and shall
 911.9 publish final rules by December 31, 2020.

911.10 Sec. 37. **TRANSITION PERIOD.**

911.11 (a) From July 1, 2019, to June 30, 2020, the commissioner shall engage in the expedited
 911.12 rulemaking process.

911.13 (b) From July 1, 2020, to July 31, 2021, the commissioner shall prepare for the new
 911.14 assisted living facility and assisted living facility with dementia care licensure by hiring
 911.15 staff, developing forms, and communicating with stakeholders about the new facility
 911.16 licensing.

911.17 (c) Effective August 1, 2021, all existing housing with services establishments providing
 911.18 home care services under Minnesota Statutes, chapter 144A, must convert their registration
 911.19 to licensure under Minnesota Statutes, chapter 144I.

911.20 (d) Effective August 1, 2021, all new assisted living facilities and assisted living facilities
 911.21 with dementia care must be licensed by the commissioner.

911.22 (e) Effective August 1, 2021, all assisted living facilities and assisted living facilities
 911.23 with dementia care must be licensed by the commissioner.

911.24 Sec. 38. **REPEALER.**

911.25 Minnesota Statutes 2018, sections 144D.01; 144D.015; 144D.02; 144D.025; 144D.03;
 911.26 144D.04; 144D.045; 144D.05; 144D.06; 144D.065; 144D.066; 144D.07; 144D.08; 144D.09;
 911.27 144D.10; 144D.11; 144G.01; 144G.02; 144G.03; 144G.04; 144G.05; and 144G.06, are
 911.28 repealed effective August 1, 2021.

ARTICLE 17

**DEMENTIA CARE SERVICES FOR ASSISTED LIVING FACILITIES WITH
DEMENTIA CARE****Section 1. [144I.37] ADDITIONAL REQUIREMENTS FOR ASSISTED LIVING
FACILITIES WITH DEMENTIA CARE.**

Subdivision 1. Applicability. This section applies only to assisted living facilities with dementia care.

Subd. 2. Demonstrated capacity. (a) The applicant must have the ability to provide services in a manner that is consistent with the requirements in this section. The commissioner shall consider the following criteria, including, but not limited to:

(1) the experience of the applicant in managing residents with dementia or previous long-term care experience; and

(2) the compliance history of the applicant in the operation of any care facility licensed, certified, or registered under federal or state law.

(b) If the applicant does not have experience in managing residents with dementia, the applicant must employ a consultant for at least the first six months of operation. The consultant must meet the requirements in paragraph (a), clause (1), and make recommendations on providing dementia care services consistent with the requirements of this chapter. The consultant must have experience in dementia care operations. The applicant must implement the recommendations of the consultant and document an acceptable plan which may be reviewed by the commissioner upon request to address the consultant's identified concerns. The commissioner may review and approve the selection of the consultant.

(c) The commissioner shall conduct an on-site inspection prior to the issuance of an assisted living facility with dementia care license to ensure compliance with the physical environment requirements.

(d) The label "Assisted Living Facility with Dementia Care" must be identified on the license.

Subd. 3. Relinquishing license. The licensee must notify the commissioner in writing at least 60 calendar days prior to the voluntary relinquishment of an assisted living facility with dementia care license. For voluntary relinquishment, the facility must:

(1) give all residents and their designated representatives 45 calendar days' notice. The notice must include:

- 913.1 (i) the proposed effective date of the relinquishment;
- 913.2 (ii) changes in staffing;
- 913.3 (iii) changes in services including the elimination or addition of services; and
- 913.4 (iv) staff training that shall occur when the relinquishment becomes effective;
- 913.5 (2) submit a transitional plan to the commissioner demonstrating how the current residents
- 913.6 shall be evaluated and assessed to reside in other housing settings that are not an assisted
- 913.7 living facility with dementia care, that are physically unsecured, or that would require
- 913.8 move-out or transfer to other settings;
- 913.9 (3) change service or care plans as appropriate to address any needs the residents may
- 913.10 have with the transition;
- 913.11 (4) notify the commissioner when the relinquishment process has been completed; and
- 913.12 (5) revise advertising materials and disclosure information to remove any reference that
- 913.13 the facility is an assisted living facility with dementia care.

913.14 **Sec. 2. [144I.38] RESPONSIBILITIES OF ADMINISTRATION FOR ASSISTED**

913.15 **LIVING FACILITIES WITH DEMENTIA CARE.**

913.16 Subdivision 1. **General.** The licensee of an assisted living facility with dementia care

913.17 is responsible for the care and housing of the persons with dementia and the provision of

913.18 person-centered care that promotes each resident's dignity, independence, and comfort. This

913.19 includes the supervision, training, and overall conduct of the staff.

913.20 Subd. 2. **Additional requirements.** (a) The licensee must follow the assisted living

913.21 license requirements and the criteria in this section.

913.22 (b) The administrator of an assisted living facility with dementia care license must

913.23 complete and document that at least ten hours of the required annual continuing educational

913.24 requirements relate to the care of individuals with dementia. Continuing education credits

913.25 must be obtained through commissioner-approved sources that may include college courses,

913.26 preceptor credits, self-directed activities, course instructor credits, corporate training,

913.27 in-service training, professional association training, web-based training, correspondence

913.28 courses, telecourses, seminars, and workshops.

913.29 Subd. 3. **Policies.** (a) In addition to the policies and procedures required in the licensing

913.30 of assisted living facilities, the assisted living facility with dementia care licensee must

913.31 develop and implement policies and procedures that address the:

914.1 (1) philosophy of how services are provided based upon the assisted living facility
 914.2 licensee's values, mission, and promotion of person-centered care and how the philosophy
 914.3 shall be implemented;

914.4 (2) evaluation of behavioral symptoms and design of supports for intervention plans;

914.5 (3) wandering and egress prevention that provides detailed instructions to staff in the
 914.6 event a resident elopes;

914.7 (4) assessment of residents for the use and effects of medications, including psychotropic
 914.8 medications;

914.9 (5) staff training specific to dementia care;

914.10 (6) description of life enrichment programs and how activities are implemented;

914.11 (7) description of family support programs and efforts to keep the family engaged;

914.12 (8) limiting the use of public address and intercom systems for emergencies and
 914.13 evacuation drills only;

914.14 (9) transportation coordination and assistance to and from outside medical appointments;
 914.15 and

914.16 (10) safekeeping of resident's possessions.

914.17 (b) The policies and procedures must be provided to residents and the resident's
 914.18 representative at the time of move-in.

914.19 **Sec. 3. [144I.39] STAFFING AND STAFF TRAINING.**

914.20 Subdivision 1. **General.** (a) An assisted living facility with dementia care must provide
 914.21 residents with dementia-trained staff who have been instructed in the person-centered care
 914.22 approach. All direct care and other community staff assigned to care for dementia residents
 914.23 must be specially trained to work with residents with Alzheimer's disease and other
 914.24 dementias.

914.25 (b) Only staff trained as specified in subdivisions 2 and 3 shall be assigned to care for
 914.26 dementia residents.

914.27 (c) Staffing levels must be sufficient to meet the scheduled and unscheduled needs of
 914.28 residents. Staffing levels during nighttime hours shall be based on the sleep patterns and
 914.29 needs of residents.

915.1 (d) In an emergency situation when trained staff are not available to provide services,
915.2 the facility may assign staff who have not completed the required training. The particular
915.3 emergency situation must be documented and must address:

915.4 (1) the nature of the emergency;

915.5 (2) how long the emergency lasted; and

915.6 (3) the names and positions of staff that provided coverage.

915.7 Subd. 2. **Staffing requirements.** (a) The licensee must ensure that staff who provide
915.8 support to residents with dementia have a basic understanding and fundamental knowledge
915.9 of the residents' emotional and unique health care needs using person-centered planning
915.10 delivery. Direct care dementia-trained staff and other staff must be trained on the topics
915.11 identified during the expedited rulemaking process. These requirements are in addition to
915.12 the licensing requirements for training.

915.13 (b) Failure to comply with paragraph (a) or subdivision 1 will result in a fine under
915.14 section 144I.31.

915.15 Subd. 3. **Supervising staff training.** Persons providing or overseeing staff training must
915.16 have experience and knowledge in the care of individuals with dementia.

915.17 Subd. 4. **Preservice and in-service training.** Preservice and in-service training may
915.18 include various methods of instruction, such as classroom style, web-based training, video,
915.19 or one-to-one training. The licensee must have a method for determining and documenting
915.20 each staff person's knowledge and understanding of the training provided. All training must
915.21 be documented.

915.22 Sec. 4. **[144I.40] SERVICES FOR RESIDENTS WITH DEMENTIA.**

915.23 Subdivision 1. **Dementia care services.** (a) In addition to the minimum services required
915.24 of assisted living facilities, an assisted living facility with dementia care must also provide
915.25 the following services:

915.26 (1) assistance with activities of daily living that address the needs of each resident with
915.27 dementia due to cognitive or physical limitations. These services must meet or be in addition
915.28 to the requirements in the licensing rules for the facility. Services must be provided in a
915.29 person-centered manner that promotes resident choice, dignity, and sustains the resident's
915.30 abilities;

915.31 (2) health care services provided according to the licensing statutes and rules of the
915.32 facility;

916.1 (3) a daily meal program for nutrition and hydration must be provided and available
916.2 throughout each resident's waking hours. The individualized nutritional plan for each resident
916.3 must be documented in the resident's service or care plan. In addition, an assisted living
916.4 facility with dementia care must provide meaningful activities that promote or help sustain
916.5 the physical and emotional well-being of residents. The activities must be person-directed
916.6 and available during residents' waking hours.

916.7 (b) Each resident must be evaluated for activities according to the licensing rules of the
916.8 facility. In addition, the evaluation must address the following:

916.9 (1) past and current interests;

916.10 (2) current abilities and skills;

916.11 (3) emotional and social needs and patterns;

916.12 (4) physical abilities and limitations;

916.13 (5) adaptations necessary for the resident to participate; and

916.14 (6) identification of activities for behavioral interventions.

916.15 (c) An individualized activity plan must be developed for each resident based on their
916.16 activity evaluation. The plan must reflect the resident's activity preferences and needs.

916.17 (d) A selection of daily structured and non-structured activities must be provided and
916.18 included on the resident's activity service or care plan as appropriate. Daily activity options
916.19 based on resident evaluation may include but are not limited to:

916.20 (1) occupation or chore related tasks;

916.21 (2) scheduled and planned events such as entertainment or outings;

916.22 (3) spontaneous activities for enjoyment or those that may help defuse a behavior;

916.23 (4) one-to-one activities that encourage positive relationships between residents and
916.24 staff such as telling a life story, reminiscing, or playing music;

916.25 (5) spiritual, creative, and intellectual activities;

916.26 (6) sensory stimulation activities;

916.27 (7) physical activities that enhance or maintain a resident's ability to ambulate or move;

916.28 and

916.29 (8) outdoor activities.

917.1 (e) Behavioral symptoms that negatively impact the resident and others in the assisted
 917.2 living facility must be evaluated and included on the service or care plan. The staff must
 917.3 initiate and coordinate outside consultation or acute care when indicated.

917.4 (f) Support must be offered to family and other significant relationships on a regularly
 917.5 scheduled basis but not less than quarterly.

917.6 (g) Access to secured outdoor space and walkways that allow residents to enter and
 917.7 return without staff assistance must be provided.

917.8 **ARTICLE 18**

917.9 **ASSISTED LIVING LICENSURE CONFORMING CHANGES**

917.10 Section 1. Minnesota Statutes 2018, section 144.051, subdivision 4, is amended to read:

917.11 Subd. 4. **Data classification; public data.** For providers regulated pursuant to sections
 917.12 144A.43 to 144A.482 and chapter 1444I, the following data collected, created, or maintained
 917.13 by the commissioner are classified as public data as defined in section 13.02, subdivision
 917.14 15:

917.15 (1) all application data on licensees, license numbers, and license status;

917.16 (2) licensing information about licenses previously held under this chapter;

917.17 (3) correction orders, including information about compliance with the order and whether
 917.18 the fine was paid;

917.19 (4) final enforcement actions pursuant to chapter 14;

917.20 (5) orders for hearing, findings of fact, and conclusions of law; and

917.21 (6) when the licensee and department agree to resolve the matter without a hearing, the
 917.22 agreement and specific reasons for the agreement are public data.

917.23 Sec. 2. Minnesota Statutes 2018, section 144.051, subdivision 5, is amended to read:

917.24 Subd. 5. **Data classification; confidential data.** For providers regulated pursuant to
 917.25 sections 144A.43 to 144A.482 and chapter 144I, the following data collected, created, or
 917.26 maintained by the Department of Health are classified as confidential data on individuals
 917.27 as defined in section 13.02, subdivision 3: active investigative data relating to the
 917.28 investigation of potential violations of law by a licensee including data from the survey
 917.29 process before the correction order is issued by the department.

918.1 Sec. 3. Minnesota Statutes 2018, section 144.051, subdivision 6, is amended to read:

918.2 Subd. 6. **Release of private or confidential data.** For providers regulated pursuant to
918.3 sections 144A.43 to 144A.482 and chapter 144I, the department may release private or
918.4 confidential data, except Social Security numbers, to the appropriate state, federal, or local
918.5 agency and law enforcement office to enhance investigative or enforcement efforts or further
918.6 a public health protective process. Types of offices include Adult Protective Services, Office
918.7 of the Ombudsman for Long-Term Care and Office of the Ombudsman for Mental Health
918.8 and Developmental Disabilities, the health licensing boards, Department of Human Services,
918.9 county or city attorney's offices, police, and local or county public health offices.

918.10 Sec. 4. Minnesota Statutes 2018, section 144.057, subdivision 1, is amended to read:

918.11 Subdivision 1. **Background studies required.** The commissioner of health shall contract
918.12 with the commissioner of human services to conduct background studies of:

918.13 (1) individuals providing services ~~which~~ that have direct contact, as defined under section
918.14 245C.02, subdivision 11, with patients and residents in hospitals, boarding care homes,
918.15 outpatient surgical centers licensed under sections 144.50 to 144.58; nursing homes and
918.16 home care agencies licensed under chapter 144A; ~~residential care homes licensed under~~
918.17 ~~chapter 144B~~; assisted living facilities, and assisted living facilities with dementia care
918.18 licensed under chapter 144I, and board and lodging establishments that are registered to
918.19 provide supportive or health supervision services under section 157.17;

918.20 (2) individuals specified in section 245C.03, subdivision 1, who perform direct contact
918.21 services in a nursing home, assisted living facilities, and assisted living facilities with
918.22 dementia care licensed under chapter 144I, or a home care agency licensed under chapter
918.23 144A or a boarding care home licensed under sections 144.50 to 144.58. If the individual
918.24 under study resides outside Minnesota, the study must include a check for substantiated
918.25 findings of maltreatment of adults and children in the individual's state of residence when
918.26 the information is made available by that state, and must include a check of the National
918.27 Crime Information Center database;

918.28 (3) ~~beginning July 1, 1999~~, all other employees in assisted living facilities licensed under
918.29 chapter 144I, nursing homes licensed under chapter 144A, and boarding care homes licensed
918.30 under sections 144.50 to 144.58. A disqualification of an individual in this section shall
918.31 disqualify the individual from positions allowing direct contact or access to patients or
918.32 residents receiving services. "Access" means physical access to a client or the client's
918.33 personal property without continuous, direct supervision as defined in section 245C.02,

919.1 subdivision 8, when the employee's employment responsibilities do not include providing
919.2 direct contact services;

919.3 (4) individuals employed by a supplemental nursing services agency, as defined under
919.4 section 144A.70, who are providing services in health care facilities; and

919.5 (5) controlling persons of a supplemental nursing services agency, as defined under
919.6 section 144A.70.

919.7 If a facility or program is licensed by the Department of Human Services and subject to
919.8 the background study provisions of chapter 245C and is also licensed by the Department
919.9 of Health, the Department of Human Services is solely responsible for the background
919.10 studies of individuals in the jointly licensed programs.

919.11 Sec. 5. Minnesota Statutes 2018, section 144A.04, subdivision 5, is amended to read:

919.12 Subd. 5. **Administrators.** ~~(a)~~ Each nursing home must employ an administrator who
919.13 must be licensed or permitted as a nursing home administrator by the Board of ~~Examiners~~
919.14 ~~for Nursing Home Administrators~~ Executives for Long Term Services and Supports. The
919.15 nursing home may share the services of a licensed administrator. The administrator must
919.16 maintain a ~~sufficient~~ an on-site presence in the facility to effectively manage the facility in
919.17 compliance with applicable rules and regulations. The administrator must establish procedures
919.18 and delegate authority for on-site operations in the administrator's absence, but is ultimately
919.19 responsible for the management of the facility. Each nursing home must have posted at all
919.20 times the name of the administrator and the name of the person in charge on the premises
919.21 in the absence of the licensed administrator.

919.22 ~~(b) Notwithstanding sections 144A.18 to 144A.27, a nursing home with a director of~~
919.23 ~~nursing serving as an unlicensed nursing home administrator as of March 1, 2001, may~~
919.24 ~~continue to have a director of nursing serve in that capacity, provided the director of nursing~~
919.25 ~~has passed the state law and rules examination administered by the Board of Examiners for~~
919.26 ~~Nursing Home Administrators and maintains evidence of completion of 20 hours of~~
919.27 ~~continuing education each year on topics pertinent to nursing home administration.~~

919.28 Sec. 6. Minnesota Statutes 2018, section 144A.20, subdivision 1, is amended to read:

919.29 Subdivision 1. **Criteria.** The Board of ~~Examiners~~ Executives may issue licenses to
919.30 qualified persons as nursing home administrators, and shall establish qualification criteria
919.31 for nursing home administrators. No license shall be issued to a person as a nursing home
919.32 administrator unless that person:

920.1 (1) is at least 21 years of age ~~and otherwise suitably qualified;~~

920.2 (2) has satisfactorily met standards set by the Board of ~~Examiners~~ Executives, which
 920.3 standards shall be designed to assure that nursing home administrators will be individuals
 920.4 who, by training or experience are qualified to serve as nursing home administrators; and

920.5 (3) has passed an examination approved by the board and designed to test for competence
 920.6 in the ~~subject matters~~ standards referred to in clause (2), or has been approved by the Board
 920.7 of ~~Examiners~~ Executives through the development and application of other appropriate
 920.8 techniques.

920.9 Sec. 7. Minnesota Statutes 2018, section 144A.24, is amended to read:

920.10 **144A.24 DUTIES OF THE BOARD.**

920.11 The Board of ~~Examiners~~ Executives shall:

920.12 (1) develop and enforce standards for nursing home administrator licensing, which
 920.13 standards shall be designed to assure that nursing home administrators will be individuals
 920.14 of good character who, by training or experience, are suitably qualified to serve as nursing
 920.15 home administrators;

920.16 (2) develop appropriate techniques, including examinations and investigations, for
 920.17 determining whether applicants and licensees meet the board's standards;

920.18 (3) issue licenses and permits to those individuals who are found to meet the board's
 920.19 standards;

920.20 (4) establish and implement procedures designed to assure that individuals licensed as
 920.21 nursing home administrators will comply with the board's standards;

920.22 (5) receive and investigate complaints and take appropriate action consistent with chapter
 920.23 214, to revoke or suspend the license or permit of a nursing home administrator or acting
 920.24 administrator who fails to comply with sections 144A.18 to 144A.27 or the board's standards;

920.25 (6) conduct a continuing study and investigation of nursing homes, and the administrators
 920.26 of nursing homes within the state, with a view to the improvement of the standards imposed
 920.27 for the licensing of administrators and improvement of the procedures and methods used
 920.28 for enforcement of the board's standards; and

920.29 (7) approve or conduct courses of instruction or training designed to prepare individuals
 920.30 for licensing in accordance with the board's standards. ~~Courses designed to meet license
 920.31 renewal requirements shall be designed solely to improve professional skills and shall not~~

921.1 ~~include classroom attendance requirements exceeding 50 hours per year.~~ The board may
 921.2 approve courses conducted within or without this state.

921.3 Sec. 8. Minnesota Statutes 2018, section 144A.26, is amended to read:

921.4 **144A.26 RECIPROCITY WITH OTHER STATES AND EQUIVALENCY OF**
 921.5 **HEALTH SERVICES EXECUTIVE.**

921.6 Subdivision 1. **Reciprocity.** The Board of ~~Examiners~~ Executives may issue a nursing
 921.7 home administrator's license, without examination, to any person who holds a current license
 921.8 as a nursing home administrator from another jurisdiction if the board finds that the standards
 921.9 for licensure in the other jurisdiction are at least the substantial equivalent of those prevailing
 921.10 in this state and that the applicant is otherwise qualified.

921.11 Subd. 2. **Health services executive license.** The Board of Executives may issue a health
 921.12 services executive license to any person who (1) has been validated by the National
 921.13 Association of Long Term Care Administrator Boards as a health services executive, and
 921.14 (2) has met the education and practice requirements for the minimum qualifications of a
 921.15 nursing home administrator, assisted living administrator, and home and community-based
 921.16 service provider. Licensure decisions made by the board under this subdivision are final.

921.17 Sec. 9. Minnesota Statutes 2018, section 144A.44, subdivision 1, is amended to read:

921.18 Subdivision 1. **Statement of rights.** (a) A ~~person~~ client who receives home care services
 921.19 in the community or in an assisted living facility licensed under chapter 144I has these
 921.20 rights:

921.21 (1) ~~the right to~~ receive written information, in plain language, about rights before
 921.22 receiving services, including what to do if rights are violated;

921.23 (2) ~~the right to~~ receive care and services according to a suitable and up-to-date plan, and
 921.24 subject to accepted health care, medical or nursing standards and person-centered care, to
 921.25 take an active part in developing, modifying, and evaluating the plan and services;

921.26 (3) ~~the right to~~ be told before receiving services the type and disciplines of staff who
 921.27 will be providing the services, the frequency of visits proposed to be furnished, other choices
 921.28 that are available for addressing home care needs, and the potential consequences of refusing
 921.29 these services;

921.30 (4) ~~the right to~~ be told in advance of any recommended changes by the provider in the
 921.31 service plan and to take an active part in any decisions about changes to the service plan;

- 922.1 (5) ~~the right to~~ refuse services or treatment;
- 922.2 (6) ~~the right to~~ know, before receiving services or during the initial visit, any limits to
 922.3 the services available from a home care provider;
- 922.4 (7) ~~the right to~~ be told before services are initiated what the provider charges for the
 922.5 services; to what extent payment may be expected from health insurance, public programs,
 922.6 or other sources, if known; and what charges the client may be responsible for paying;
- 922.7 (8) ~~the right to~~ know that there may be other services available in the community,
 922.8 including other home care services and providers, and to know where to find information
 922.9 about these services;
- 922.10 (9) ~~the right to~~ choose freely among available providers and to change providers after
 922.11 services have begun, within the limits of health insurance, long-term care insurance, medical
 922.12 assistance, ~~or other health programs,~~ or public programs;
- 922.13 (10) ~~the right to~~ have personal, financial, and medical information kept private, and to
 922.14 be advised of the provider's policies and procedures regarding disclosure of such information;
- 922.15 (11) ~~the right to~~ access the client's own records and written information from those
 922.16 records in accordance with sections 144.291 to 144.298;
- 922.17 (12) ~~the right to~~ be served by people who are properly trained and competent to perform
 922.18 their duties;
- 922.19 (13) ~~the right to~~ be treated with courtesy and respect, and to have the client's property
 922.20 treated with respect;
- 922.21 (14) ~~the right to~~ be free from physical and verbal abuse, neglect, financial exploitation,
 922.22 and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment
 922.23 of Minors Act;
- 922.24 (15) ~~the right to~~ reasonable, advance notice of changes in services or charges;
- 922.25 (16) ~~the right to~~ know the provider's reason for termination of services;
- 922.26 (17) ~~the right to~~ at least ~~ten~~ 30 calendar days' advance notice of the termination of a
 922.27 service or housing by a provider, except in cases where:
- 922.28 (i) the client engages in conduct that significantly alters the terms of the service plan
 922.29 with the home care provider;
- 922.30 (ii) the client, person who lives with the client, or others create an abusive or unsafe
 922.31 work environment for the person providing home care services; or

923.1 (iii) an emergency or a significant change in the client's condition has resulted in service
923.2 needs that exceed the current service plan and that cannot be safely met by the home care
923.3 provider;

923.4 (18) ~~the right to~~ a coordinated transfer when there will be a change in the provider of
923.5 services;

923.6 (19) ~~the right to~~ complain to staff and others of the client's choice about services that
923.7 are provided, or fail to be provided, and the lack of courtesy or respect to the client or the
923.8 client's property and the right to recommend changes in policies and services, free from
923.9 retaliation including the threat of termination of services;

923.10 (20) ~~the right to~~ know how to contact an individual associated with the home care provider
923.11 who is responsible for handling problems and to have the home care provider investigate
923.12 and attempt to resolve the grievance or complaint;

923.13 (21) ~~the right to~~ know the name and address of the state or county agency to contact for
923.14 additional information or assistance; ~~and~~

923.15 (22) ~~the right to~~ assert these rights personally, or have them asserted by the client's
923.16 representative or by anyone on behalf of the client, without retaliation; and

923.17 (23) place an electronic monitoring device in the client's or resident's space in compliance
923.18 with state requirements.

923.19 (b) When providers violate the rights in this section, they are subject to the fines and
923.20 license actions in sections 144A.474, subdivision 11, and 144A.475.

923.21 (c) Providers must do all of the following:

923.22 (1) encourage and assist in the fullest possible exercise of these rights;

923.23 (2) provide the names and telephone numbers of individuals and organizations that
923.24 provide advocacy and legal services for clients and residents seeking to assert their rights;

923.25 (3) make every effort to assist clients or residents in obtaining information regarding
923.26 whether Medicare, medical assistance, other health programs, or public programs will pay
923.27 for services;

923.28 (4) make reasonable accommodations for people who have communication disabilities,
923.29 or those who speak a language other than English; and

923.30 (5) provide all information and notices in plain language and in terms the client or
923.31 resident can understand.

924.1 (d) No provider may require or request a client or resident to waive any of the rights
 924.2 listed in this section at any time or for any reasons, including as a condition of initiating
 924.3 services or entering into an assisted living facility contract.

924.4 Sec. 10. Minnesota Statutes 2018, section 144A.471, subdivision 7, is amended to read:

924.5 Subd. 7. **Comprehensive home care license provider.** Home care services that may
 924.6 be provided with a comprehensive home care license include any of the basic home care
 924.7 services listed in subdivision 6, and one or more of the following:

924.8 (1) services of an advanced practice nurse, registered nurse, licensed practical nurse,
 924.9 physical therapist, respiratory therapist, occupational therapist, speech-language pathologist,
 924.10 dietitian or nutritionist, or social worker;

924.11 (2) tasks delegated to unlicensed personnel by a registered nurse or assigned by a licensed
 924.12 health professional within the person's scope of practice;

924.13 (3) medication management services;

924.14 (4) hands-on assistance with transfers and mobility;

924.15 (5) treatment and therapies;

924.16 (6) assisting clients with eating when the clients have complicating eating problems as
 924.17 identified in the client record or through an assessment such as difficulty swallowing,
 924.18 recurrent lung aspirations, or requiring the use of a tube or parenteral or intravenous
 924.19 instruments to be fed; or

924.20 ~~(6)~~ (7) providing other complex or specialty health care services.

924.21 Sec. 11. Minnesota Statutes 2018, section 144A.471, subdivision 9, is amended to read:

924.22 Subd. 9. **Exclusions from home care licensure.** The following are excluded from home
 924.23 care licensure and are not required to provide the home care bill of rights:

924.24 (1) an individual or business entity providing only coordination of home care that includes
 924.25 one or more of the following:

924.26 (i) determination of whether a client needs home care services, or assisting a client in
 924.27 determining what services are needed;

924.28 (ii) referral of clients to a home care provider;

924.29 (iii) administration of payments for home care services; or

924.30 (iv) administration of a health care home established under section 256B.0751;

925.1 (2) an individual who is not an employee of a licensed home care provider if the
925.2 individual:

925.3 (i) only provides services as an independent contractor to one or more licensed home
925.4 care providers;

925.5 (ii) provides no services under direct agreements or contracts with clients; and

925.6 (iii) is contractually bound to perform services in compliance with the contracting home
925.7 care provider's policies and service plans;

925.8 (3) a business that provides staff to home care providers, such as a temporary employment
925.9 agency, if the business:

925.10 (i) only provides staff under contract to licensed or exempt providers;

925.11 (ii) provides no services under direct agreements with clients; and

925.12 (iii) is contractually bound to perform services under the contracting home care provider's
925.13 direction and supervision;

925.14 (4) any home care services conducted by and for the adherents of any recognized church
925.15 or religious denomination for its members through spiritual means, or by prayer for healing;

925.16 (5) an individual who only provides home care services to a relative;

925.17 (6) an individual not connected with a home care provider that provides assistance with
925.18 basic home care needs if the assistance is provided primarily as a contribution and not as a
925.19 business;

925.20 (7) an individual not connected with a home care provider that shares housing with and
925.21 provides primarily housekeeping or homemaking services to an elderly or disabled person
925.22 in return for free or reduced-cost housing;

925.23 (8) an individual or provider providing home-delivered meal services;

925.24 (9) an individual providing senior companion services and other older American volunteer
925.25 programs (OAVP) established under the Domestic Volunteer Service Act of 1973, United
925.26 States Code, title 42, chapter 66;

925.27 ~~(10) an employee of a nursing home or home care provider licensed under this chapter~~
925.28 ~~or an employee of a boarding care home licensed under sections 144.50 to 144.56 when~~
925.29 ~~responding to occasional emergency calls from individuals residing in a residential setting~~
925.30 ~~that is attached to or located on property contiguous to the nursing home, boarding care~~
925.31 ~~home, or location where home care services are also provided;~~

926.1 ~~(11) an employee of a nursing home or home care provider licensed under this chapter~~
926.2 ~~or an employee of a boarding care home licensed under sections 144.50 to 144.56 when~~
926.3 ~~providing occasional minor services free of charge to individuals residing in a residential~~
926.4 ~~setting that is attached to or located on property contiguous to the nursing home, boarding~~
926.5 ~~care home, or location where home care services are also provided;~~

926.6 (12) a member of a professional corporation organized under chapter 319B that does
926.7 not regularly offer or provide home care services as defined in section 144A.43, subdivision
926.8 3;

926.9 (13) the following organizations established to provide medical or surgical services that
926.10 do not regularly offer or provide home care services as defined in section 144A.43,
926.11 subdivision 3: a business trust organized under sections 318.01 to 318.04, a nonprofit
926.12 corporation organized under chapter 317A, a partnership organized under chapter 323, or
926.13 any other entity determined by the commissioner;

926.14 (14) an individual or agency that provides medical supplies or durable medical equipment,
926.15 except when the provision of supplies or equipment is accompanied by a home care service;

926.16 (15) a physician licensed under chapter 147;

926.17 (16) an individual who provides home care services to a person with a developmental
926.18 disability who lives in a place of residence with a family, foster family, or primary caregiver;

926.19 (17) a business that only provides services that are primarily instructional and not medical
926.20 services or health-related support services;

926.21 (18) an individual who performs basic home care services for no more than 14 hours
926.22 each calendar week to no more than one client;

926.23 (19) an individual or business licensed as hospice as defined in sections 144A.75 to
926.24 144A.755 who is not providing home care services independent of hospice service;

926.25 (20) activities conducted by the commissioner of health or a community health board
926.26 as defined in section 145A.02, subdivision 5, including communicable disease investigations
926.27 or testing; or

926.28 (21) administering or monitoring a prescribed therapy necessary to control or prevent a
926.29 communicable disease, or the monitoring of an individual's compliance with a health directive
926.30 as defined in section 144.4172, subdivision 6.

926.31 **EFFECTIVE DATE.** The amendments to clauses (10) and (11) are effective July 1,
926.32 2021.

927.1 Sec. 12. Minnesota Statutes 2018, section 144A.472, subdivision 7, is amended to read:

927.2 Subd. 7. **Fees; application, change of ownership, ~~and~~ renewal, and failure to**
 927.3 **notify.** (a) An initial applicant seeking temporary home care licensure must submit the
 927.4 following application fee to the commissioner along with a completed application:

927.5 (1) for a basic home care provider, \$2,100; or

927.6 (2) for a comprehensive home care provider, \$4,200.

927.7 (b) A home care provider who is filing a change of ownership as required under
 927.8 subdivision 5 must submit the following application fee to the commissioner, along with
 927.9 the documentation required for the change of ownership:

927.10 (1) for a basic home care provider, \$2,100; or

927.11 (2) for a comprehensive home care provider, \$4,200.

927.12 (c) For the period ending June 30, 2018, a home care provider who is seeking to renew
 927.13 the provider's license shall pay a fee to the commissioner based on revenues derived from
 927.14 the provision of home care services during the calendar year prior to the year in which the
 927.15 application is submitted, according to the following schedule:

927.16 **License Renewal Fee**

927.17	Provider Annual Revenue	Fee
927.18	greater than \$1,500,000	\$6,625
927.19	greater than \$1,275,000 and no more than	
927.20	\$1,500,000	\$5,797
927.21	greater than \$1,100,000 and no more than	
927.22	\$1,275,000	\$4,969
927.23	greater than \$950,000 and no more than	
927.24	\$1,100,000	\$4,141
927.25	greater than \$850,000 and no more than \$950,000	\$3,727
927.26	greater than \$750,000 and no more than \$850,000	\$3,313
927.27	greater than \$650,000 and no more than \$750,000	\$2,898
927.28	greater than \$550,000 and no more than \$650,000	\$2,485
927.29	greater than \$450,000 and no more than \$550,000	\$2,070
927.30	greater than \$350,000 and no more than \$450,000	\$1,656
927.31	greater than \$250,000 and no more than \$350,000	\$1,242
927.32	greater than \$100,000 and no more than \$250,000	\$828
927.33	greater than \$50,000 and no more than \$100,000	\$500
927.34	greater than \$25,000 and no more than \$50,000	\$400
927.35	no more than \$25,000	\$200

928.1 (d) For the period between July 1, 2018, and June 30, 2020, a home care provider who
 928.2 is seeking to renew the provider's license shall pay a fee to the commissioner in an amount
 928.3 that is ten percent higher than the applicable fee in paragraph (c). A home care provider's
 928.4 fee shall be based on revenues derived from the provision of home care services during the
 928.5 calendar year prior to the year in which the application is submitted.

928.6 (e) Beginning July 1, 2020, a home care provider who is seeking to renew the provider's
 928.7 license shall pay a fee to the commissioner based on revenues derived from the provision
 928.8 of home care services during the calendar year prior to the year in which the application is
 928.9 submitted, according to the following schedule:

928.10 **License Renewal Fee**

928.11	Provider Annual Revenue	Fee
928.12	greater than \$1,500,000	\$7,651
928.13	greater than \$1,275,000 and no more than	
928.14	\$1,500,000	\$6,695
928.15	greater than \$1,100,000 and no more than	
928.16	\$1,275,000	\$5,739
928.17	greater than \$950,000 and no more than	
928.18	\$1,100,000	\$4,783
928.19	greater than \$850,000 and no more than \$950,000	\$4,304
928.20	greater than \$750,000 and no more than \$850,000	\$3,826
928.21	greater than \$650,000 and no more than \$750,000	\$3,347
928.22	greater than \$550,000 and no more than \$650,000	\$2,870
928.23	greater than \$450,000 and no more than \$550,000	\$2,391
928.24	greater than \$350,000 and no more than \$450,000	\$1,913
928.25	greater than \$250,000 and no more than \$350,000	\$1,434
928.26	greater than \$100,000 and no more than \$250,000	\$957
928.27	greater than \$50,000 and no more than \$100,000	\$577
928.28	greater than \$25,000 and no more than \$50,000	\$462
928.29	no more than \$25,000	\$231

928.30 (f) If requested, the home care provider shall provide the commissioner information to
 928.31 verify the provider's annual revenues or other information as needed, including copies of
 928.32 documents submitted to the Department of Revenue.

928.33 (g) At each annual renewal, a home care provider may elect to pay the highest renewal
 928.34 fee for its license category, and not provide annual revenue information to the commissioner.

928.35 (h) A temporary license or license applicant, or temporary licensee or licensee that
 928.36 knowingly provides the commissioner incorrect revenue amounts for the purpose of paying

929.1 a lower license fee, shall be subject to a civil penalty in the amount of double the fee the
929.2 provider should have paid.

929.3 (i) The fee for failure to comply with the notification requirements in section 144A.473,
929.4 subdivision 2, paragraph (c), is \$1,000.

929.5 ~~(i)~~ (j) Fees and penalties collected under this section shall be deposited in the state
929.6 treasury and credited to the state government special revenue fund. All fees are
929.7 nonrefundable. Fees collected under paragraphs (c), (d), and (e) are nonrefundable even if
929.8 received before July 1, 2017, for temporary licenses or licenses being issued effective July
929.9 1, 2017, or later.

929.10 (k) Fines collected under this subdivision shall be deposited in a dedicated special revenue
929.11 account. On an annual basis, the balance in the special revenue account will be appropriated
929.12 to the commissioner to implement the recommendations of the advisory council established
929.13 in section 144A.4799. Fines collected in state fiscal years 2018 and 2019 shall be deposited
929.14 in the dedicated special revenue account as described in this section.

929.15 **EFFECTIVE DATE.** This section is effective the day following final enactment.

929.16 Sec. 13. Minnesota Statutes 2018, section 144A.474, subdivision 9, is amended to read:

929.17 Subd. 9. **Follow-up surveys.** For providers that have Level 3 or Level 4 violations under
929.18 subdivision 11, or any violations determined to be widespread, the department shall conduct
929.19 a follow-up survey within 90 calendar days of the survey. When conducting a follow-up
929.20 survey, the surveyor will focus on whether the previous violations have been corrected and
929.21 may also address any new violations that are observed while evaluating the corrections that
929.22 have been made. ~~If a new violation is identified on a follow-up survey, no fine will be~~
929.23 ~~imposed unless it is not corrected on the next follow-up survey.~~

929.24 Sec. 14. Minnesota Statutes 2018, section 144A.474, subdivision 11, is amended to read:

929.25 Subd. 11. **Fines.** (a) Fines and enforcement actions under this subdivision may be assessed
929.26 based on the level and scope of the violations described in paragraph ~~(e)~~ (b) and imposed
929.27 immediately with no opportunity to correct the violation first as follows:

929.28 (1) Level 1, no fines or enforcement;

929.29 (2) Level 2, ~~fines ranging from \$0 to~~ a fine of \$500 per violation, in addition to any of
929.30 the enforcement mechanisms authorized in section 144A.475 for widespread violations;

930.1 (3) Level 3, ~~fining ranging from \$500 to \$1,000~~ a fine of \$3,000 per incident plus \$100
930.2 for each resident affected by the violation, in addition to any of the enforcement mechanisms
930.3 authorized in section 144A.475; ~~and~~

930.4 (4) Level 4, ~~fining ranging from \$1,000 to~~ a fine of \$5,000 per incident plus \$200 for
930.5 each resident affected by the violation, in addition to any of the enforcement mechanisms
930.6 authorized in section 144A.475;

930.7 (5) for maltreatment violations as defined in section 626.557 including abuse, neglect,
930.8 financial exploitation, and drug diversion, that are determined against the provider, an
930.9 immediate fine shall be imposed of \$5,000 per incident plus \$200 for each resident affected
930.10 by the violation; and

930.11 (6) the fines in clauses (1) to (4) are increased and immediate fine imposition is authorized
930.12 for both surveys and investigations conducted.

930.13 (b) Correction orders for violations are categorized by both level and scope and fines
930.14 shall be assessed as follows:

930.15 (1) level of violation:

930.16 (i) Level 1 is a violation that has no potential to cause more than a minimal impact on
930.17 the client and does not affect health or safety;

930.18 (ii) Level 2 is a violation that did not harm a client's health or safety but had the potential
930.19 to have harmed a client's health or safety, but was not likely to cause serious injury,
930.20 impairment, or death;

930.21 (iii) Level 3 is a violation that harmed a client's health or safety, not including serious
930.22 injury, impairment, or death, or a violation that has the potential to lead to serious injury,
930.23 impairment, or death; and

930.24 (iv) Level 4 is a violation that results in serious injury, impairment, or death;

930.25 (2) scope of violation:

930.26 (i) isolated, when one or a limited number of clients are affected or one or a limited
930.27 number of staff are involved or the situation has occurred only occasionally;

930.28 (ii) pattern, when more than a limited number of clients are affected, more than a limited
930.29 number of staff are involved, or the situation has occurred repeatedly but is not found to be
930.30 pervasive; and

930.31 (iii) widespread, when problems are pervasive or represent a systemic failure that has
930.32 affected or has the potential to affect a large portion or all of the clients.

931.1 (c) If the commissioner finds that the applicant or a home care provider ~~required to be~~
 931.2 ~~licensed under sections 144A.43 to 144A.482~~ has not corrected violations by the date
 931.3 specified in the correction order or conditional license resulting from a survey or complaint
 931.4 investigation, the commissioner ~~may impose a fine.~~ A shall provide a notice of
 931.5 noncompliance with a correction order ~~must be mailed~~ by e-mail to the applicant's or
 931.6 provider's last known e-mail address. The noncompliance notice must list the violations not
 931.7 corrected.

931.8 (d) For every violation identified by the commissioner, the commissioner shall issue an
 931.9 immediate fine pursuant to paragraph (a), clause (6). The license holder must still correct
 931.10 the violation in the time specified. The issuance of an immediate fine can occur in addition
 931.11 to any enforcement mechanism authorized under section 144A.475. The immediate fine
 931.12 may be appealed as allowed under this subdivision.

931.13 ~~(d)~~ (e) The license holder must pay the fines assessed on or before the payment date
 931.14 specified. If the license holder fails to fully comply with the order, the commissioner may
 931.15 issue a second fine or suspend the license until the license holder complies by paying the
 931.16 fine. A timely appeal shall stay payment of the fine until the commissioner issues a final
 931.17 order.

931.18 ~~(e)~~ (f) A license holder shall promptly notify the commissioner in writing when a violation
 931.19 specified in the order is corrected. If upon reinspection the commissioner determines that
 931.20 a violation has not been corrected as indicated by the order, the commissioner may issue a
 931.21 second fine. The commissioner shall notify the license holder by mail to the last known
 931.22 address in the licensing record that a second fine has been assessed. The license holder may
 931.23 appeal the second fine as provided under this subdivision.

931.24 ~~(f)~~ (g) A home care provider that has been assessed a fine under this subdivision has a
 931.25 right to a reconsideration or a hearing under this section and chapter 14.

931.26 ~~(g)~~ (h) When a fine has been assessed, the license holder may not avoid payment by
 931.27 closing, selling, or otherwise transferring the licensed program to a third party. In such an
 931.28 event, the license holder shall be liable for payment of the fine.

931.29 ~~(h)~~ (i) In addition to any fine imposed under this section, the commissioner may assess
 931.30 a penalty amount based on costs related to an investigation that results in a final order
 931.31 assessing a fine or other enforcement action authorized by this chapter.

931.32 ~~(i)~~ (j) Fines collected under this subdivision shall be deposited in ~~the state government~~
 931.33 a dedicated special revenue fund and credited to an account separate from the revenue
 931.34 ~~collected under section 144A.472. Subject to an appropriation by the legislature, the revenue~~

932.1 ~~from the fines collected must be used by the commissioner for special projects to improve~~
 932.2 ~~home care in Minnesota as recommended by~~ account. On an annual basis, the balance in
 932.3 the special revenue account shall be appropriated to the commissioner to implement the
 932.4 recommendations of the advisory council established in section 144A.4799. Fines collected
 932.5 in state fiscal years 2018 and 2019 shall be deposited in the dedicated special revenue
 932.6 account as described in this section.

932.7 Sec. 15. Minnesota Statutes 2018, section 144A.475, subdivision 3b, is amended to read:

932.8 Subd. 3b. **Expedited hearing.** (a) Within five business days of receipt of the license
 932.9 holder's timely appeal of a temporary suspension or issuance of a conditional license, the
 932.10 commissioner shall request assignment of an administrative law judge. The request must
 932.11 include a proposed date, time, and place of a hearing. A hearing must be conducted by an
 932.12 administrative law judge pursuant to Minnesota Rules, parts 1400.8505 to 1400.8612, within
 932.13 30 calendar days of the request for assignment, unless an extension is requested by either
 932.14 party and granted by the administrative law judge for good cause. The commissioner shall
 932.15 issue a notice of hearing by certified mail or personal service at least ten business days
 932.16 before the hearing. Certified mail to the last known address is sufficient. The scope of the
 932.17 hearing shall be limited solely to the issue of whether the temporary suspension or issuance
 932.18 of a conditional license should remain in effect and whether there is sufficient evidence to
 932.19 conclude that the licensee's actions or failure to comply with applicable laws are level 3 or
 932.20 4 violations as defined in section 144A.474, subdivision 11, paragraph (b), or that there
 932.21 were violations that posed an imminent risk of harm to the health and safety of persons in
 932.22 the provider's care.

932.23 (b) The administrative law judge shall issue findings of fact, conclusions, and a
 932.24 recommendation within ten business days from the date of hearing. The parties shall have
 932.25 ten calendar days to submit exceptions to the administrative law judge's report. The record
 932.26 shall close at the end of the ten-day period for submission of exceptions. The commissioner's
 932.27 final order shall be issued within ten business days from the close of the record. When an
 932.28 appeal of a temporary immediate suspension or conditional license is withdrawn or dismissed,
 932.29 the commissioner shall issue a final order affirming the temporary immediate suspension
 932.30 or conditional license within ten calendar days of the commissioner's receipt of the
 932.31 withdrawal or dismissal. The license holder is prohibited from operation during the temporary
 932.32 suspension period.

932.33 (c) When the final order under paragraph (b) affirms an immediate suspension, and a
 932.34 final licensing sanction is issued under subdivisions 1 and 2 and the licensee appeals that

933.1 sanction, the licensee is prohibited from operation pending a final commissioner's order
 933.2 after the contested case hearing conducted under chapter 14.

933.3 (d) A licensee whose license is temporarily suspended must comply with the requirements
 933.4 for notification and transfer of clients in subdivision 5. These requirements remain if an
 933.5 appeal is requested.

933.6 Sec. 16. Minnesota Statutes 2018, section 144A.475, subdivision 5, is amended to read:

933.7 Subd. 5. **Plan required.** (a) The process of ~~suspending or~~ revoking, or refusing to renew
 933.8 a license must include a plan for transferring affected ~~clients~~ clients' care to other providers
 933.9 by the home care provider, which will be monitored by the commissioner. Within three
 933.10 ~~business~~ calendar days of being notified of the ~~final~~ revocation, refusal to renew, or
 933.11 ~~suspension action,~~ the home care provider shall provide the commissioner, the lead agencies
 933.12 as defined in section 256B.0911, county adult protection and case managers, and the
 933.13 ombudsman for long-term care with the following information:

933.14 (1) a list of all clients, including full names and all contact information on file;

933.15 (2) a list of each client's representative or emergency contact person, including full names
 933.16 and all contact information on file;

933.17 (3) the location or current residence of each client;

933.18 (4) the payor sources for each client, including payor source identification numbers; and

933.19 (5) for each client, a copy of the client's service plan, and a list of the types of services
 933.20 being provided.

933.21 (b) The revocation, refusal to renew, or suspension notification requirement is satisfied
 933.22 by mailing the notice to the address in the license record. The home care provider shall
 933.23 cooperate with the commissioner and the lead agencies, county adult protection and county
 933.24 managers, and the ombudsman for long term care during the process of transferring care of
 933.25 clients to qualified providers. Within three ~~business~~ calendar days of being notified of the
 933.26 final revocation, refusal to renew, or suspension action, the home care provider must notify
 933.27 and disclose to each of the home care provider's clients, or the client's representative or
 933.28 emergency contact persons, that the commissioner is taking action against the home care
 933.29 provider's license by providing a copy of the revocation, refusal to renew, or suspension
 933.30 notice issued by the commissioner. If the provider does not comply with the disclosure
 933.31 requirements in this section, the commissioner shall notify the clients, client representatives,
 933.32 or emergency contact persons about the action being taken. Lead agencies, county adult
 933.33 protection and county managers, and the Office of Ombudsman for Long-Term Care may

934.1 also provide this information. The revocation, refusal to renew, or suspension notice is
934.2 public data except for any private data contained therein.

934.3 (c) A home care provider subject to this subdivision may continue operating during the
934.4 period of time home care clients are being transferred to other providers.

934.5 Sec. 17. Minnesota Statutes 2018, section 144A.476, subdivision 1, is amended to read:

934.6 Subdivision 1. **Prior criminal convictions; owner and managerial officials.** (a) Before
934.7 the commissioner issues a temporary license, issues a license as a result of an approved
934.8 change in ownership, or renews a license, an owner or managerial official is required to
934.9 complete a background study under section 144.057. No person may be involved in the
934.10 management, operation, or control of a home care provider if the person has been disqualified
934.11 under chapter 245C. If an individual is disqualified under section 144.057 or chapter 245C,
934.12 the individual may request reconsideration of the disqualification. If the individual requests
934.13 reconsideration and the commissioner sets aside or rescinds the disqualification, the individual
934.14 is eligible to be involved in the management, operation, or control of the provider. If an
934.15 individual has a disqualification under section 245C.15, subdivision 1, and the disqualification
934.16 is affirmed, the individual's disqualification is barred from a set aside, and the individual
934.17 must not be involved in the management, operation, or control of the provider.

934.18 (b) For purposes of this section, owners of a home care provider subject to the background
934.19 check requirement are those individuals whose ownership interest provides sufficient
934.20 authority or control to affect or change decisions related to the operation of the home care
934.21 provider. An owner includes a sole proprietor, a general partner, or any other individual
934.22 whose individual ownership interest can affect the management and direction of the policies
934.23 of the home care provider.

934.24 (c) For the purposes of this section, managerial officials subject to the background check
934.25 requirement are individuals who provide direct contact as defined in section 245C.02,
934.26 subdivision 11, or individuals who have the responsibility for the ongoing management or
934.27 direction of the policies, services, or employees of the home care provider. Data collected
934.28 under this subdivision shall be classified as private data on individuals under section 13.02,
934.29 subdivision 12.

934.30 (d) The department shall not issue any license if the applicant or owner or managerial
934.31 official has been unsuccessful in having a background study disqualification set aside under
934.32 section 144.057 and chapter 245C; if the owner or managerial official, as an owner or
934.33 managerial official of another home care provider, was substantially responsible for the
934.34 other home care provider's failure to substantially comply with sections 144A.43 to

935.1 144A.482; or if an owner that has ceased doing business, either individually or as an owner
 935.2 of a home care provider, was issued a correction order for failing to assist clients in violation
 935.3 of this chapter.

935.4 Sec. 18. Minnesota Statutes 2018, section 144A.4791, subdivision 10, is amended to read:

935.5 Subd. 10. **Termination of service plan.** (a) If a home care provider terminates a service
 935.6 plan with a client, and the client continues to need home care services, the home care provider
 935.7 shall provide the client and the client's representative, if any, with a 30-day written notice
 935.8 of termination which includes the following information:

935.9 (1) the effective date of termination;

935.10 (2) the reason for termination;

935.11 (3) a list of known licensed home care providers in the client's immediate geographic
 935.12 area;

935.13 (4) a statement that the home care provider will participate in a coordinated transfer of
 935.14 care of the client to another home care provider, health care provider, or caregiver, as
 935.15 required by the home care bill of rights, section 144A.44, subdivision 1, clause (17);

935.16 (5) the name and contact information of a person employed by the home care provider
 935.17 with whom the client may discuss the notice of termination; and

935.18 (6) if applicable, a statement that the notice of termination of home care services does
 935.19 not constitute notice of termination of the housing with services contract with a housing
 935.20 with services establishment.

935.21 (b) When the home care provider voluntarily discontinues services to all clients, the
 935.22 home care provider must notify the commissioner, lead agencies, and ombudsman for
 935.23 long-term care about its clients and comply with the requirements in this subdivision.

935.24 Sec. 19. Minnesota Statutes 2018, section 144A.4799, is amended to read:

935.25 **144A.4799 DEPARTMENT OF HEALTH LICENSED HOME CARE PROVIDER**
 935.26 **ADVISORY COUNCIL.**

935.27 Subdivision 1. **Membership.** The commissioner of health shall appoint eight persons
 935.28 to a home care and assisted living program advisory council consisting of the following:

935.29 (1) three public members as defined in section 214.02 who shall be ~~either~~ persons who
 935.30 are currently receiving home care services ~~or~~, persons who have received home care services
 935.31 within five years of the application date, persons who have family members receiving home

936.1 care services, or persons who have family members who have received home care services
936.2 within five years of the application date;

936.3 (2) three Minnesota home care licensees representing basic and comprehensive levels
936.4 of licensure who may be a managerial official, an administrator, a supervising registered
936.5 nurse, or an unlicensed personnel performing home care tasks;

936.6 (3) one member representing the Minnesota Board of Nursing; ~~and~~

936.7 (4) one member representing the office of ombudsman for long-term care; and

936.8 (5) beginning July 1, 2021, one member of a county health and human services or county
936.9 adult protection office.

936.10 Subd. 2. **Organizations and meetings.** The advisory council shall be organized and
936.11 administered under section 15.059 with per diems and costs paid within the limits of available
936.12 appropriations. Meetings will be held quarterly and hosted by the department. Subcommittees
936.13 may be developed as necessary by the commissioner. Advisory council meetings are subject
936.14 to the Open Meeting Law under chapter 13D.

936.15 Subd. 3. **Duties.** (a) At the commissioner's request, the advisory council shall provide
936.16 advice regarding regulations of Department of Health licensed home care providers in this
936.17 chapter, including advice on the following:

936.18 (1) community standards for home care practices;

936.19 (2) enforcement of licensing standards and whether certain disciplinary actions are
936.20 appropriate;

936.21 (3) ways of distributing information to licensees and consumers of home care;

936.22 (4) training standards;

936.23 (5) identifying emerging issues and opportunities in ~~the home care field, including;~~

936.24 (6) identifying the use of technology in home and telehealth capabilities;

936.25 ~~(6)~~ (7) allowable home care licensing modifications and exemptions, including a method
936.26 for an integrated license with an existing license for rural licensed nursing homes to provide
936.27 limited home care services in an adjacent independent living apartment building owned by
936.28 the licensed nursing home; and

936.29 ~~(7)~~ (8) recommendations for studies using the data in section 62U.04, subdivision 4,
936.30 including but not limited to studies concerning costs related to dementia and chronic disease

937.1 among an elderly population over 60 and additional long-term care costs, as described in
 937.2 section 62U.10, subdivision 6.

937.3 (b) The advisory council shall perform other duties as directed by the commissioner.

937.4 (c) The advisory council shall annually ~~review the balance of the account in the state~~
 937.5 ~~government special revenue fund described in section 144A.474, subdivision 11, paragraph~~
 937.6 ~~(i), and make annual recommendations by January 15 directly to the chairs and ranking~~
 937.7 ~~minority members of the legislative committees with jurisdiction over health and human~~
 937.8 ~~services regarding appropriations to the commissioner for the purposes in section 144A.474,~~
 937.9 ~~subdivision 11, paragraph (i). The recommendations shall address ways the commissioner~~
 937.10 ~~may improve protection of the public under existing statutes and laws and include but are~~
 937.11 ~~not limited to projects that create and administer training of licensees and their employees~~
 937.12 ~~to improve residents lives, supporting ways that licensees can improve and enhance quality~~
 937.13 ~~care, ways to provide technical assistance to licensees to improve compliance; information~~
 937.14 ~~technology and data projects that analyze and communicate information about trends of~~
 937.15 ~~violations or lead to ways of improving client care; communications strategies to licensees~~
 937.16 ~~and the public; and other projects or pilots that benefit clients, families, and the public.~~

937.17 Sec. 20. Minnesota Statutes 2018, section 256I.03, subdivision 15, is amended to read:

937.18 Subd. 15. **Supportive housing.** "Supportive housing" means housing ~~with support~~
 937.19 ~~services according to the continuum of care coordinated assessment system established~~
 937.20 ~~under Code of Federal Regulations, title 24, section 578.3 that is not time-limited and~~
 937.21 ~~provides or coordinates services necessary for a resident to maintain housing stability.~~

937.22 Sec. 21. Minnesota Statutes 2018, section 256I.04, subdivision 2a, is amended to read:

937.23 Subd. 2a. **License required; staffing qualifications.** (a) Except as provided in paragraph
 937.24 (b), an agency may not enter into an agreement with an establishment to provide housing
 937.25 support unless:

937.26 (1) the establishment is licensed by the Department of Health as a hotel and restaurant;
 937.27 a board and lodging establishment; a boarding care home before March 1, 1985; or a
 937.28 supervised living facility, and the service provider for residents of the facility is licensed
 937.29 under chapter 245A. However, an establishment licensed by the Department of Health to
 937.30 provide lodging need not also be licensed to provide board if meals are being supplied to
 937.31 residents under a contract with a food vendor who is licensed by the Department of Health;

938.1 (2) the residence is: (i) licensed by the commissioner of human services under Minnesota
938.2 Rules, parts 9555.5050 to 9555.6265; (ii) certified by a county human services agency prior
938.3 to July 1, 1992, using the standards under Minnesota Rules, parts 9555.5050 to 9555.6265;
938.4 (iii) licensed by the commissioner under Minnesota Rules, parts 2960.0010 to 2960.0120,
938.5 with a variance under section 245A.04, subdivision 9; or (iv) licensed under section 245D.02,
938.6 subdivision 4a, as a community residential setting by the commissioner of human services;
938.7 or

938.8 (3) the ~~establishment~~ facility is ~~registered~~ licensed under ~~chapter 144D~~ chapter 144I and
938.9 provides three meals a day.

938.10 (b) The requirements under paragraph (a) do not apply to establishments exempt from
938.11 state licensure because they are:

938.12 (1) located on Indian reservations and subject to tribal health and safety requirements;
938.13 or

938.14 (2) ~~a supportive housing establishment that has an approved habitability inspection and~~
938.15 ~~an individual lease agreement and that serves people who have experienced long-term~~
938.16 ~~homelessness and were referred through a coordinated assessment in section 256I.03,~~
938.17 ~~subdivision 15~~ supportive housing establishments where an individual has an approved
938.18 habitability inspection and an individual lease agreement.

938.19 (c) Supportive housing establishments that serve individuals who have experienced
938.20 long-term homelessness and emergency shelters must participate in the homeless management
938.21 information system and a coordinated assessment system as defined by the commissioner.

938.22 (d) Effective July 1, 2016, an agency shall not have an agreement with a provider of
938.23 housing support unless all staff members who have direct contact with recipients:

938.24 (1) have skills and knowledge acquired through one or more of the following:

938.25 (i) a course of study in a health- or human services-related field leading to a bachelor
938.26 of arts, bachelor of science, or associate's degree;

938.27 (ii) one year of experience with the target population served;

938.28 (iii) experience as a mental health certified peer specialist according to section 256B.0615;

938.29 or

938.30 (iv) meeting the requirements for unlicensed personnel under sections 144A.43 to
938.31 144A.483;

939.1 (2) hold a current driver's license appropriate to the vehicle driven if transporting
939.2 recipients;

939.3 (3) complete training on vulnerable adults mandated reporting and child maltreatment
939.4 mandated reporting, where applicable; and

939.5 (4) complete housing support orientation training offered by the commissioner.

939.6 Sec. 22. Minnesota Statutes 2018, section 325F.72, subdivision 1, is amended to read:

939.7 Subdivision 1. **Persons to whom disclosure is required.** ~~Housing with services~~
939.8 ~~establishments, as defined in sections 144D.01 to 144D.07, that secure, segregate, or provide~~
939.9 ~~a special program or special unit for residents with a diagnosis of probable Alzheimer's~~
939.10 ~~disease or a related disorder or that advertise, market, or otherwise promote the establishment~~
939.11 ~~as providing specialized care for Alzheimer's disease or a related disorder are considered a~~
939.12 ~~"special care unit."~~ All special care units assisted living facilities with dementia care, as
939.13 defined in section 144I.01, shall provide a written disclosure to the following:

939.14 (1) the commissioner of health, if requested;

939.15 (2) the Office of Ombudsman for Long-Term Care; and

939.16 (3) each person seeking placement within a residence, or the person's authorized
939.17 representative, before an agreement to provide the care is entered into.

939.18 Sec. 23. Minnesota Statutes 2018, section 325F.72, subdivision 2, is amended to read:

939.19 Subd. 2. **Content.** Written disclosure shall include, but is not limited to, the following:

939.20 (1) a statement of the overall philosophy and how it reflects the special needs of residents
939.21 with Alzheimer's disease or other dementias;

939.22 (2) the criteria for determining who may reside in the ~~special~~ dementia care unit;

939.23 (3) the process used for assessment and establishment of the service plan or agreement,
939.24 including how the plan is responsive to changes in the resident's condition;

939.25 (4) staffing credentials, job descriptions, and staff duties and availability, including any
939.26 training specific to dementia;

939.27 (5) physical environment as well as design and security features that specifically address
939.28 the needs of residents with Alzheimer's disease or other dementias;

939.29 (6) frequency and type of programs and activities for residents ~~of the special care unit~~;

939.30 (7) involvement of families in resident care and availability of family support programs;

- 940.1 (8) fee schedules for additional services to the residents ~~of the special care unit~~; and
 940.2 (9) a statement that residents will be given a written notice 30 calendar days prior to
 940.3 changes in the fee schedule.

940.4 Sec. 24. Minnesota Statutes 2018, section 626.5572, subdivision 6, is amended to read:

940.5 Subd. 6. **Facility.** (a) "Facility" means a hospital or other entity required to be licensed
 940.6 under sections 144.50 to 144.58; a nursing home required to be licensed to serve adults
 940.7 under section 144A.02; a facility or service required to be licensed under chapter 245A; an
 940.8 assisted living facility required to be licensed under chapter 144I; a home care provider
 940.9 licensed or required to be licensed under sections 144A.43 to 144A.482; a hospice provider
 940.10 licensed under sections 144A.75 to 144A.755; or a person or organization that offers,
 940.11 provides, or arranges for personal care assistance services under the medical assistance
 940.12 program as authorized under sections 256B.0625, subdivision 19a, 256B.0651 to 256B.0654,
 940.13 256B.0659, or 256B.85.

940.14 (b) For services identified in paragraph (a) that are provided in the vulnerable adult's
 940.15 own home or in another unlicensed location, the term "facility" refers to the provider, person,
 940.16 or organization that offers, provides, or arranges for personal care services, and does not
 940.17 refer to the vulnerable adult's home or other location at which services are rendered.

940.18 Sec. 25. **REVISOR INSTRUCTION.**

940.19 The revisor of statutes shall change the phrases "Board of Examiners for Nursing Home
 940.20 Administrators" to "Board of Executives for Long Term Services and Supports" and "Board
 940.21 of Examiners" to "Board of Executives" wherever the phrases appear in Minnesota Statutes
 940.22 and apply to the board established in Minnesota Statutes, section 144A.19.

940.23 Sec. 26. **REPEALER.**

940.24 (a) Minnesota Statutes 2018, section 144A.472, subdivision 4, is repealed July 1, 2019.

940.25 (b) Minnesota Statutes 2018, sections 144A.441; and 144A.442, are repealed August 1,
 940.26 2021.

941.1

ARTICLE 19

941.2

MISCELLANEOUS

941.3 Section 1. Minnesota Statutes 2018, section 124D.142, is amended to read:

941.4

124D.142 QUALITY RATING AND IMPROVEMENT SYSTEM.

941.5 (a) There is established a quality rating and improvement system (QRIS) framework to
 941.6 ensure that Minnesota's children have access to high-quality early learning and care programs
 941.7 in a range of settings so that they are fully ready for kindergarten by 2020. ~~Creation of a~~
 941.8 The standards-based voluntary quality rating and improvement system includes:

941.9 (1) quality opportunities in order to improve the educational outcomes of children so
 941.10 that they are ready for school. The framework shall be based on the Minnesota quality rating
 941.11 system rating tool and a common set of child outcome and program standards and informed
 941.12 by evaluation results;

941.13 (2) a tool to increase the number of publicly funded and regulated early learning and
 941.14 care services in both public and private market programs that are high quality. If a program
 941.15 or provider chooses to participate, the program or provider will be rated and may receive
 941.16 public funding associated with the rating. The state shall develop a plan to link future early
 941.17 learning and care state funding to the framework in a manner that complies with federal
 941.18 requirements; and

941.19 (3) tracking progress toward statewide access to high-quality early learning and care
 941.20 programs, progress toward the number of low-income children whose parents can access
 941.21 quality programs, and progress toward increasing the number of children who are fully
 941.22 prepared to enter kindergarten.

941.23 ~~(b) In planning a statewide quality rating and improvement system framework in~~
 941.24 ~~paragraph (a), the state shall use evaluation results of the Minnesota quality rating system~~
 941.25 ~~rating tool in use in fiscal year 2008 to recommend:~~

941.26 ~~(1) a framework of a common set of child outcome and program standards for a voluntary~~
 941.27 ~~statewide quality rating and improvement system;~~

941.28 ~~(2) a plan to link future funding to the framework described in paragraph (a), clause (2);~~
 941.29 ~~and~~

941.30 ~~(3) a plan for how the state will realign existing state and federal administrative resources~~
 941.31 ~~to implement the voluntary quality rating and improvement system framework. The state~~
 941.32 ~~shall provide the recommendation in this paragraph to the early childhood education finance~~
 941.33 ~~committees of the legislature by March 15, 2011.~~

942.1 ~~(e) Prior to the creation of a statewide quality rating and improvement system in paragraph~~
942.2 ~~(a), the state shall employ the Minnesota quality rating system rating tool in use in fiscal~~
942.3 ~~year 2008 in the original Minnesota Early Learning Foundation pilot areas and additional~~
942.4 ~~pilot areas supported by private or public funds with its modification as a result of the~~
942.5 ~~evaluation results of the pilot project.~~

942.6 (b) A child care provider who has a quality rating under this section and is disqualified
942.7 from receiving child care assistance program reimbursement under chapter 119B, as provided
942.8 under section 256.98, subdivision 8, paragraph (c), must also have the quality rating
942.9 rescinded.

942.10 Sec. 2. Minnesota Statutes 2018, section 124D.165, subdivision 4, is amended to read:

942.11 Subd. 4. **Early childhood program eligibility.** (a) In order to be eligible to accept an
942.12 for early learning scholarship funds, a program must:

942.13 (1) participate in the quality rating and improvement system under section 124D.142;
942.14 and

942.15 (2) beginning July 1, 2020, have a three- or four-star rating in the quality rating and
942.16 improvement system.

942.17 (b) Any program accepting scholarships must use the revenue to supplement and not
942.18 supplant federal funding.

942.19 (c) Notwithstanding paragraph (a), all Minnesota early learning foundation scholarship
942.20 program pilot sites are eligible to accept an early learning scholarship under this section.

942.21 (d) A program is not eligible for early learning scholarship funds if:

942.22 (1) it is disqualified from receiving payment for child care services from the child care
942.23 assistance program under chapter 119B, as provided under section 256.98, subdivision 8,
942.24 paragraph (c); or

942.25 (2) the commissioner of human services refuses to issue a child care authorization,
942.26 revokes an existing child care authorization, stops payment issued to a program, or refuses
942.27 to pay a bill under section 119B.13, subdivision 6, paragraph (d), clause (2).

942.28 **EFFECTIVE DATE.** This section is effective July 1, 2019.

942.29 Sec. 3. Minnesota Statutes 2018, section 125A.515, subdivision 1, is amended to read:

942.30 Subdivision 1. **Approval of on-site education programs.** The commissioner shall
942.31 approve on-site education programs for placement of children and youth in residential

943.1 facilities including detention centers, before being licensed by the Department of Human
943.2 Services or the Department of Corrections. Education programs in these facilities shall
943.3 conform to state and federal education laws including the Individuals with Disabilities
943.4 Education Act (IDEA). This section applies only to placements in children's residential
943.5 facilities and psychiatric residential treatment facilities, as defined in section 256B.0625,
943.6 subdivision 45a, licensed by the Department of Human Services or the Department of
943.7 Corrections. For purposes of this section, "on-site education program" means the educational
943.8 services provided directly on the grounds of the children's residential facility or psychiatric
943.9 residential treatment facility to children and youth placed for care and treatment.

943.10 Sec. 4. Minnesota Statutes 2018, section 125A.515, subdivision 3, is amended to read:

943.11 Subd. 3. **Responsibilities for providing education.** (a) The district in which the children's
943.12 residential facility or psychiatric residential treatment facility is located must provide
943.13 education services, including special education if eligible, to all students placed in a facility.

943.14 (b) For education programs operated by the Department of Corrections, the providing
943.15 district shall be the Department of Corrections. For students remanded to the commissioner
943.16 of corrections, the providing and resident district shall be the Department of Corrections.

943.17 Sec. 5. Minnesota Statutes 2018, section 125A.515, subdivision 4, is amended to read:

943.18 Subd. 4. **Education services required.** (a) Education services must be provided to a
943.19 student beginning within three business days after the student enters the children's residential
943.20 facility or psychiatric residential treatment facility. The first four days of the student's
943.21 placement may be used to screen the student for educational and safety issues.

943.22 (b) If the student does not meet the eligibility criteria for special education, regular
943.23 education services must be provided to that student.

943.24 Sec. 6. Minnesota Statutes 2018, section 125A.515, subdivision 5, is amended to read:

943.25 Subd. 5. **Education programs for students placed in children's residential**
943.26 **facilities.** (a) When a student is placed in a children's residential facility or psychiatric
943.27 residential treatment facility under this section that has an on-site education program, the
943.28 providing district, upon notice from the children's residential facility, must contact the
943.29 resident district within one business day to determine if a student has been identified as
943.30 having a disability, and to request at least the student's transcript, and for students with
943.31 disabilities, the most recent individualized education program (IEP) and evaluation report.

944.1 The resident district must send a facsimile copy to the providing district within two business
944.2 days of receiving the request.

944.3 (b) If a student placed under this section has been identified as having a disability and
944.4 has an individualized education program in the resident district:

944.5 (1) the providing agency must conduct an individualized education program meeting to
944.6 reach an agreement about continuing or modifying special education services in accordance
944.7 with the current individualized education program goals and objectives and to determine if
944.8 additional evaluations are necessary; and

944.9 (2) at least the following people shall receive written notice or documented phone call
944.10 to be followed with written notice to attend the individualized education program meeting:

944.11 (i) the person or agency placing the student;

944.12 (ii) the resident district;

944.13 (iii) the appropriate teachers and related services staff from the providing district;

944.14 (iv) appropriate staff from the children's residential facility or psychiatric residential
944.15 treatment facility;

944.16 (v) the parents or legal guardians of the student; and

944.17 (vi) when appropriate, the student.

944.18 (c) For a student who has not been identified as a student with a disability, a screening
944.19 must be conducted by the providing districts as soon as possible to determine the student's
944.20 educational and behavioral needs and must include a review of the student's educational
944.21 records.

944.22 Sec. 7. Minnesota Statutes 2018, section 125A.515, subdivision 7, is amended to read:

944.23 Subd. 7. **Minimum educational services required.** When a student is placed in a
944.24 children's residential facility or psychiatric residential treatment facility under this section,
944.25 at a minimum, the providing district is responsible for:

944.26 (1) the education necessary, including summer school services, for a student who is not
944.27 performing at grade level as indicated in the education record or IEP; and

944.28 (2) a school day, of the same length as the school day of the providing district, unless
944.29 the unique needs of the student, as documented through the IEP or education record in
944.30 consultation with treatment providers, requires an alteration in the length of the school day.

945.1 Sec. 8. Minnesota Statutes 2018, section 125A.515, subdivision 8, is amended to read:

945.2 Subd. 8. **Placement, services, and due process.** When a student's treatment and
945.3 educational needs allow, education shall be provided in a regular educational setting. The
945.4 determination of the amount and site of integrated services must be a joint decision between
945.5 the student's parents or legal guardians and the treatment and education staff. When
945.6 applicable, educational placement decisions must be made by the IEP team of the providing
945.7 district. Educational services shall be provided in conformance with the least restrictive
945.8 environment principle of the Individuals with Disabilities Education Act. The providing
945.9 district and children's residential facility or psychiatric residential treatment facility shall
945.10 cooperatively develop discipline and behavior management procedures to be used in
945.11 emergency situations that comply with the Minnesota Pupil Fair Dismissal Act and other
945.12 relevant state and federal laws and regulations.

945.13 Sec. 9. **[137.68] ADVISORY COUNCIL ON RARE DISEASES.**

945.14 Subdivision 1. Establishment. The University of Minnesota is requested to establish
945.15 an advisory council on rare diseases to provide advice on research, diagnosis, treatment,
945.16 and education related to rare diseases. For purposes of this section, "rare disease" has the
945.17 meaning given in United States Code, title 21, section 360bb. The council shall be called
945.18 the Chloe Barnes Advisory Council on Rare Diseases.

945.19 Subd. 2. Membership. (a) The advisory council may consist of public members appointed
945.20 by the Board of Regents or a designee according to paragraph (b) and four members of the
945.21 legislature appointed according to paragraph (c).

945.22 (b) The Board of Regents or a designee is requested to appoint the following public
945.23 members:

945.24 (1) three physicians licensed and practicing in the state with experience researching,
945.25 diagnosing, or treating rare diseases. At least one physician appointed under this clause
945.26 must be a pediatrician;

945.27 (2) one registered nurse or advanced practice registered nurse licensed and practicing
945.28 in the state with experience treating rare diseases;

945.29 (3) at least two hospital administrators, or their designees, from hospitals in the state
945.30 that provide care to persons diagnosed with a rare disease. One administrator or designee
945.31 appointed under this clause must represent a hospital in which the scope of service focuses
945.32 on rare diseases of pediatric patients;

946.1 (4) three persons age 18 or older who either have a rare disease or are a caregiver of a
946.2 person with a rare disease;

946.3 (5) a representative of a rare disease patient organization that operates in the state;

946.4 (6) a social worker with experience providing services to persons diagnosed with a rare
946.5 disease;

946.6 (7) a pharmacist with experience with drugs used to treat rare diseases;

946.7 (8) a dentist licensed and practicing in the state with experience treating rare diseases;

946.8 (9) a representative of the biotechnology industry;

946.9 (10) a representative of health plan companies;

946.10 (11) a medical researcher with experience conducting research on rare diseases; and

946.11 (12) a genetic counselor with experience providing services to persons diagnosed with
946.12 a rare disease or caregivers of those persons.

946.13 (c) The advisory council shall include two members of the senate, one appointed by the
946.14 majority leader and one appointed by the minority leader; and two members of the house
946.15 of representatives, one appointed by the speaker of the house and one appointed by the
946.16 minority leader.

946.17 (d) The commissioner of health or a designee, a representative of Mayo Medical School,
946.18 and a representative of the University of Minnesota Medical School, shall serve as ex officio,
946.19 nonvoting members of the advisory council.

946.20 (e) Initial appointments to the advisory council shall be made no later than September
946.21 1, 2019. Members appointed according to paragraph (b) shall serve for a term of three years,
946.22 except that the initial members appointed according to paragraph (b) shall have an initial
946.23 term of two, three, or four years determined by lot by the chairperson. Members appointed
946.24 according to paragraph (b) shall serve until their successors have been appointed.

946.25 Subd. 3. **Meetings.** The Board of Regents or a designee is requested to convene the first
946.26 meeting of the advisory council no later than October 1, 2019. The advisory council shall
946.27 meet at the call of the chairperson or at the request of a majority of advisory council members.

946.28 Subd. 4. **Duties.** (a) The advisory council's duties may include, but are not limited to:

946.29 (1) in conjunction with the state's medical schools, the state's schools of public health,
946.30 and hospitals in the state that provide care to persons diagnosed with a rare disease,

947.1 developing resources or recommendations relating to quality of and access to treatment and
947.2 services in the state for persons with a rare disease, including but not limited to:

947.3 (i) a list of existing, publicly accessible resources on research, diagnosis, treatment, and
947.4 education relating to rare diseases;

947.5 (ii) identifying best practices for rare disease care implemented in other states, at the
947.6 national level, and at the international level, that will improve rare disease care in the state
947.7 and seeking opportunities to partner with similar organizations in other states and countries;

947.8 (iii) identifying problems faced by patients with a rare disease when changing health
947.9 plans, including recommendations on how to remove obstacles faced by these patients to
947.10 finding a new health plan and how to improve the ease and speed of finding a new health
947.11 plan that meets the needs of patients with a rare disease; and

947.12 (iv) identifying best practices to ensure health care providers are adequately informed
947.13 of the most effective strategies for recognizing and treating rare diseases; and

947.14 (2) advising, consulting, and cooperating with the Department of Health, the Advisory
947.15 Committee on Heritable and Congenital Disorders, and other agencies of state government
947.16 in developing information and programs for the public and the health care community
947.17 relating to diagnosis, treatment, and awareness of rare diseases.

947.18 (b) The advisory council shall collect additional topic areas for study and evaluation
947.19 from the general public. In order for the advisory council to study and evaluate a topic, the
947.20 topic must be approved for study and evaluation by the advisory council.

947.21 Subd. 5. **Conflict of interest.** Advisory council members are subject to the Board of
947.22 Regents policy on conflicts of interest.

947.23 Subd. 6. **Annual report.** By January 1 of each year, beginning January 1, 2020, the
947.24 advisory council shall report to the chairs and ranking minority members of the legislative
947.25 committees with jurisdiction over higher education and health care policy on the advisory
947.26 council's activities under subdivision 4 and other issues on which the advisory council may
947.27 choose to report.

947.28 Sec. 10. Minnesota Statutes 2018, section 256I.05, subdivision 1c, is amended to read:

947.29 Subd. 1c. **Rate increases.** An agency may not increase the rates negotiated for housing
947.30 support above those in effect on June 30, 1993, except as provided in paragraphs (a) to (f).

947.31 (a) An agency may increase the rates for room and board to the MSA equivalent rate
947.32 for those settings whose current rate is below the MSA equivalent rate.

948.1 (b) An agency may increase the rates for residents in adult foster care whose difficulty
948.2 of care has increased. The total housing support rate for these residents must not exceed the
948.3 maximum rate specified in subdivisions 1 and 1a. Agencies must not include nor increase
948.4 difficulty of care rates for adults in foster care whose difficulty of care is eligible for funding
948.5 by home and community-based waiver programs under title XIX of the Social Security Act.

948.6 (c) The room and board rates will be increased each year when the MSA equivalent rate
948.7 is adjusted for SSI cost-of-living increases by the amount of the annual SSI increase, less
948.8 the amount of the increase in the medical assistance personal needs allowance under section
948.9 256B.35.

948.10 (d) When housing support pays for an individual's room and board, or other costs
948.11 necessary to provide room and board, the rate payable to the residence must continue for
948.12 up to 18 calendar days per incident that the person is temporarily absent from the residence,
948.13 not to exceed 60 days in a calendar year, if the absence or absences have received the prior
948.14 approval of the county agency's social service staff. Prior approval is not required for
948.15 emergency absences due to crisis, illness, or injury.

948.16 (e) For facilities meeting substantial change criteria within the prior year. Substantial
948.17 change criteria exists if the establishment experiences a 25 percent increase or decrease in
948.18 the total number of its beds, if the net cost of capital additions or improvements is in excess
948.19 of 15 percent of the current market value of the residence, or if the residence physically
948.20 moves, or changes its licensure, and incurs a resulting increase in operation and property
948.21 costs.

948.22 (f) Until June 30, 1994, an agency may increase by up to five percent the total rate paid
948.23 for recipients of assistance under sections 256D.01 to 256D.21 or 256D.33 to 256D.54 who
948.24 reside in residences that are licensed by the commissioner of health as a boarding care home,
948.25 but are not certified for the purposes of the medical assistance program. However, an increase
948.26 under this clause must not exceed an amount equivalent to 65 percent of the 1991 medical
948.27 assistance reimbursement rate for nursing home resident class A, in the geographic grouping
948.28 in which the facility is located, as established under Minnesota Rules, parts 9549.0051 to
948.29 9549.0058.

948.30 (g) An agency may increase the rates by \$100 per month for residents in settings under
948.31 sections 144D.025 and 256I.04, subdivision 2a, paragraph (b), clause (2).

948.32 **ARTICLE 20**

948.33 **HUMAN SERVICES FORECAST ADJUSTMENTS**

948.34 Section 1. **DEPARTMENT OF HUMAN SERVICES FORECAST ADJUSTMENT.**

950.1 **(h) Medical Assistance**

950.2 Appropriations by Fund

950.3 General (222,176,000)

950.4 Health Care Access -0-

950.5 **(i) Alternative Care** -0-

950.6 **(j) Consolidated Chemical Dependency**
950.7 **Treatment Fund (CCDTF) Entitlement** (17,872,000)

950.8 Subd. 3. Technical Activities (402,000)

950.9 This appropriation is from the federal TANF
950.10 fund.

950.11 **Sec. 3. EFFECTIVE DATE.**

950.12 Sections 1 and 2 are effective the day following final enactment.

950.13 **ARTICLE 21**
950.14 **APPROPRIATIONS**

950.15 **Section 1. HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

950.16 The sums shown in the columns marked "Appropriations" are appropriated to the agencies
950.17 and for the purposes specified in this article. The appropriations are from the general fund,
950.18 or another named fund, and are available for the fiscal years indicated for each purpose.
950.19 The figures "2020" and "2021" used in this article mean that the appropriations listed under
950.20 them are available for the fiscal year ending June 30, 2020, or June 30, 2021, respectively.
950.21 "The first year" is fiscal year 2020. "The second year" is fiscal year 2021. "The biennium"
950.22 is fiscal years 2020 and 2021.

950.23	<u>APPROPRIATIONS</u>	
950.24	<u>Available for the Year</u>	
950.25	<u>Ending June 30</u>	
950.26	<u>2020</u>	<u>2021</u>

950.27 **Sec. 2. COMMISSIONER OF HUMAN**
950.28 **SERVICES**

950.29 Subdivision 1. Total Appropriation \$ 8,244,091,000 \$ 8,389,748,000

951.1	<u>Appropriations by Fund</u>	
951.2	<u>2020</u>	<u>2021</u>
951.3	<u>General</u>	<u>7,408,365,000</u> <u>7,543,903,000</u>
951.4	<u>State Government</u>	
951.5	<u>Special Revenue</u>	<u>16,193,000</u> <u>16,148,000</u>
951.6	<u>Health Care Access</u>	<u>531,017,000</u> <u>555,809,000</u>
951.7	<u>Federal TANF</u>	<u>273,620,000</u> <u>271,992,000</u>
951.8	<u>Lottery Prize</u>	<u>1,896,000</u> <u>1,896,000</u>

951.9 The amounts that may be spent for each
 951.10 purpose are specified in the following
 951.11 subdivisions.

951.12 **Subd. 2. TANF Maintenance of Effort**

951.13 **(a) Nonfederal Expenditures. The**
 951.14 commissioner shall ensure that sufficient
 951.15 qualified nonfederal expenditures are made
 951.16 each year to meet the state's maintenance of
 951.17 effort (MOE) requirements of the TANF block
 951.18 grant specified under Code of Federal
 951.19 Regulations, title 45, section 263.1. In order
 951.20 to meet these basic TANF/MOE requirements,
 951.21 the commissioner may report as TANF/MOE
 951.22 expenditures only nonfederal money expended
 951.23 for allowable activities listed in the following
 951.24 clauses:

951.25 (1) MFIP cash, diversionary work program,
 951.26 and food assistance benefits under Minnesota
 951.27 Statutes, chapter 256J;

951.28 (2) the child care assistance programs under
 951.29 Minnesota Statutes, sections 119B.03 and
 951.30 119B.05, and county child care administrative
 951.31 costs under Minnesota Statutes, section
 951.32 119B.15;

951.33 (3) state and county MFIP administrative costs
 951.34 under Minnesota Statutes, chapters 256J and
 951.35 256K;

- 952.1 (4) state, county, and tribal MFIP employment
952.2 services under Minnesota Statutes, chapters
952.3 256J and 256K;
- 952.4 (5) expenditures made on behalf of legal
952.5 noncitizen MFIP recipients who qualify for
952.6 the MinnesotaCare program under Minnesota
952.7 Statutes, chapter 256L;
- 952.8 (6) qualifying working family credit
952.9 expenditures under Minnesota Statutes, section
952.10 290.0671;
- 952.11 (7) qualifying Minnesota education credit
952.12 expenditures under Minnesota Statutes, section
952.13 290.0674; and
- 952.14 (8) qualifying Head Start expenditures under
952.15 Minnesota Statutes, section 119A.50.
- 952.16 **(b) Nonfederal Expenditures; Reporting.**
952.17 For the activities listed in paragraph (a),
952.18 clauses (2) to (8), the commissioner may
952.19 report only expenditures that are excluded
952.20 from the definition of assistance under Code
952.21 of Federal Regulations, title 45, section
952.22 260.31.
- 952.23 **(c) Certain Expenditures Required. The**
952.24 commissioner shall ensure that the MOE used
952.25 by the commissioner of management and
952.26 budget for the February and November
952.27 forecasts required under Minnesota Statutes,
952.28 section 16A.103, contains expenditures under
952.29 paragraph (a), clause (1), equal to at least 16
952.30 percent of the total required under Code of
952.31 Federal Regulations, title 45, section 263.1.
- 952.32 **(d) Limitation; Exceptions. The**
952.33 commissioner must not claim an amount of
952.34 TANF/MOE in excess of the 75 percent

953.1 standard in Code of Federal Regulations, title
 953.2 45, section 263.1(a)(2), except:
 953.3 (1) to the extent necessary to meet the 80
 953.4 percent standard under Code of Federal
 953.5 Regulations, title 45, section 263.1(a)(1), if it
 953.6 is determined by the commissioner that the
 953.7 state will not meet the TANF work
 953.8 participation target rate for the current year;
 953.9 (2) to provide any additional amounts under
 953.10 Code of Federal Regulations, title 45, section
 953.11 264.5, that relate to replacement of TANF
 953.12 funds due to the operation of TANF penalties;
 953.13 and
 953.14 (3) to provide any additional amounts that may
 953.15 contribute to avoiding or reducing TANF work
 953.16 participation penalties through the operation
 953.17 of the excess MOE provisions of Code of
 953.18 Federal Regulations, title 45, section 261.43
 953.19 (a)(2).
 953.20 **(e) Supplemental Expenditures.** For the
 953.21 purposes of paragraph (d), the commissioner
 953.22 may supplement the MOE claim with working
 953.23 family credit expenditures or other qualified
 953.24 expenditures to the extent such expenditures
 953.25 are otherwise available after considering the
 953.26 expenditures allowed in this subdivision.
 953.27 **(f) Reduction of Appropriations; Exception.**
 953.28 The requirement in Minnesota Statutes, section
 953.29 256.011, subdivision 3, that federal grants or
 953.30 aids secured or obtained under that subdivision
 953.31 be used to reduce any direct appropriations
 953.32 provided by law, does not apply if the grants
 953.33 or aids are federal TANF funds.

954.1 **(g) IT Appropriations Generally.** This
954.2 appropriation includes funds for information
954.3 technology projects, services, and support.
954.4 Notwithstanding Minnesota Statutes, section
954.5 16E.0466, funding for information technology
954.6 project costs shall be incorporated into the
954.7 service level agreement and paid to the Office
954.8 of MN.IT Services by the Department of
954.9 Human Services under the rates and
954.10 mechanism specified in that agreement.

954.11 **(h) Receipts for Systems Project.**
954.12 Appropriations and federal receipts for
954.13 information systems projects for MAXIS,
954.14 PRISM, MMIS, ISDS, METS, and SSIS must
954.15 be deposited in the state systems account
954.16 authorized in Minnesota Statutes, section
954.17 256.014. Money appropriated for computer
954.18 projects approved by the commissioner of the
954.19 Office of MN.IT Services, funded by the
954.20 legislature, and approved by the commissioner
954.21 of management and budget may be transferred
954.22 from one project to another and from
954.23 development to operations as the
954.24 commissioner of human services considers
954.25 necessary. Any unexpended balance in the
954.26 appropriation for these projects does not
954.27 cancel and is available for ongoing
954.28 development and operations.

954.29 **(i) Federal SNAP Education and Training**
954.30 **Grants.** Federal funds available during fiscal
954.31 years 2020 and 2021 for Supplemental
954.32 Nutrition Assistance Program Education and
954.33 Training and SNAP Quality Control
954.34 Performance Bonus grants are appropriated
954.35 to the commissioner of human services for the

955.1 purposes allowable under the terms of the
 955.2 federal award. This paragraph is effective the
 955.3 day following final enactment.

955.4 **Subd. 3. Working Family Credit as TANF/MOE**

955.5 The commissioner may claim as TANF/MOE
 955.6 up to \$6,707,000 per year of working family
 955.7 credit expenditures in each fiscal year.

955.8 **Subd. 4. Central Office; Operations**

955.9 Appropriations by Fund

955.10	<u>General</u>	<u>151,887,000</u>	<u>149,178,000</u>
955.11	<u>State Government</u>		
955.12	<u>Special Revenue</u>	<u>5,451,000</u>	<u>5,441,000</u>
955.13	<u>Health Care Access</u>	<u>21,620,000</u>	<u>22,656,000</u>
955.14	<u>Federal TANF</u>	<u>100,000</u>	<u>100,000</u>

955.15 **(a) Administrative Recovery; Set-Aside.** The
 955.16 commissioner may invoice local entities
 955.17 through the SWIFT accounting system as an
 955.18 alternative means to recover the actual cost of
 955.19 administering the following provisions:

955.20 (1) Minnesota Statutes, section 125A.744,
 955.21 subdivision 3;

955.22 (2) Minnesota Statutes, section 245.495,
 955.23 paragraph (b);

955.24 (3) Minnesota Statutes, section 256B.0625,
 955.25 subdivision 20, paragraph (k);

955.26 (4) Minnesota Statutes, section 256B.0924,
 955.27 subdivision 6, paragraph (g);

955.28 (5) Minnesota Statutes, section 256B.0945,
 955.29 subdivision 4, paragraph (d); and

955.30 (6) Minnesota Statutes, section 256F.10,
 955.31 subdivision 6, paragraph (b).

955.32 **(b) Minnesota Pathways to Prosperity and**
 955.33 **Well-Being Pilot Project. \$1,000,000 in fiscal**

956.1 year 2020 and \$1,000,000 in fiscal year 2021
956.2 are from the general fund for grants to Dakota
956.3 and Olmsted Counties to implement the
956.4 Minnesota Pathways to Prosperity and
956.5 Well-Being pilot project described in Laws
956.6 2017, First Special Session chapter 6, article
956.7 7, section 34. The commissioner shall release
956.8 the grant funds only upon verifying that
956.9 sufficient funds have been raised to fully fund
956.10 a unified benefit set for the 100 clients in the
956.11 pilot project. The commissioner shall provide
956.12 authorization to Dakota and Olmsted Counties
956.13 to operate the pilot project. The base for this
956.14 appropriation is \$1,000,000 in fiscal year 2022
956.15 and \$0 in fiscal year 2023. These
956.16 appropriations are available until June 30,
956.17 2022.

956.18 **(c) Child Care Licensing Inspections.**
956.19 \$673,000 in fiscal year 2020 and \$722,000 in
956.20 fiscal year 2021 are from the general fund to
956.21 add eight child care licensing staff for the
956.22 purpose of increasing the frequency of
956.23 inspections of child care centers to ensure the
956.24 health and safety of children in care, provide
956.25 technical assistance to newly licensed
956.26 programs, and monitor struggling programs
956.27 more closely to evaluate whether the program
956.28 should be referred to the Office of Inspector
956.29 General for a potential fraud investigation.

956.30 **(d) Child Care Assistance Programs - Fraud**
956.31 **and Abuse Data Analysts.** \$317,000 in fiscal
956.32 year 2020 and \$339,000 in fiscal year 2021
956.33 are from the general fund to add two data
956.34 analysts to strengthen the commissioner's
956.35 ability to identify, detect, and prevent fraud

957.1 and abuse in the child care assistance programs
957.2 under Minnesota Statutes, chapter 119B.

957.3 **(e) Office of Inspector General**
957.4 **Investigators.** \$418,000 in fiscal year 2020
957.5 and \$483,000 in fiscal year 2021 are from the
957.6 general fund to add four investigators to the
957.7 Office of Inspector General to detect, prevent,
957.8 and make recoveries from fraudulent activities
957.9 among providers in the medical assistance
957.10 program under Minnesota Statutes, chapter
957.11 256B.

957.12 **(f) Office of Inspector General Tracking**
957.13 **System.** \$355,000 in fiscal year 2020 and
957.14 \$105,000 in fiscal year 2021 are from the
957.15 general fund to purchase a system to record,
957.16 track, and report on investigative activity for
957.17 the Office of Inspector General to strengthen
957.18 fraud prevention and investigation activities
957.19 for child care assistance programs under
957.20 Minnesota Statutes, chapter 119B.

957.21 **(g) Fraud Prevention Investigation Grant**
957.22 **Program.** \$529,000 in fiscal year 2020 and
957.23 \$546,000 in fiscal year 2021 are from the
957.24 general fund for the fraud prevention
957.25 investigation grant program under Minnesota
957.26 Statutes, section 256.983. Of these amounts,
957.27 the commissioner may use up to \$104,000 in
957.28 fiscal year 2020 and up to \$121,000 in fiscal
957.29 year 2021 to add one permanent full-time
957.30 equivalent employee to support the grant
957.31 program.

957.32 **(h) Child Care Assistance Programs - Law**
957.33 **Enforcement.** \$350,000 in fiscal year 2020
957.34 and \$350,000 in fiscal year 2021 are from the
957.35 general fund to add two additional law

958.1 enforcement officers under contract with the
 958.2 Bureau of Criminal Apprehension to conduct
 958.3 criminal investigations in child care assistance
 958.4 program cases.

958.5 (i) **Base Level Adjustment.** The general fund
 958.6 base is \$145,788,000 in fiscal year 2022 and
 958.7 \$148,270,000 in fiscal year 2023. The health
 958.8 care access fund base is \$22,644,000 in fiscal
 958.9 year 2022 and \$20,894,000 in fiscal year 2023.

958.10 The state government special revenue fund
 958.11 base is \$5,441,000 in fiscal year 2022 and
 958.12 \$5,442,000 in fiscal year 2023.

958.13 Subd. 5. **Central Office; Children and Families**

958.14	<u>Appropriations by Fund</u>		
958.15	<u>General</u>	<u>13,598,000</u>	<u>14,424,000</u>
958.16	<u>Federal TANF</u>	<u>2,582,000</u>	<u>2,582,000</u>

958.17 (a) **Financial Institution Data Match and**
 958.18 **Payment of Fees.** The commissioner is
 958.19 authorized to allocate up to \$310,000 each
 958.20 year in fiscal year 2020 and fiscal year 2021
 958.21 from the systems special revenue account to
 958.22 make payments to financial institutions in
 958.23 exchange for performing data matches
 958.24 between account information held by financial
 958.25 institutions and the public authority's database
 958.26 of child support obligors as authorized by
 958.27 Minnesota Statutes, section 13B.06,
 958.28 subdivision 7.

958.29 (b) **Child Welfare Training Academy.**
 958.30 \$1,371,000 in fiscal year 2020 and \$2,517,000
 958.31 in fiscal year 2021 are from the general fund
 958.32 for the Child Welfare Training Academy for
 958.33 the provision of child protection worker
 958.34 training under Minnesota Statutes, section
 958.35 626.5591, subdivision 2.

959.1 **(c) Child Care Assistance Programs -**
 959.2 **Improvements.** \$71,000 in fiscal year 2020
 959.3 and \$82,000 in fiscal year 2021 are from the
 959.4 general fund to add one temporary staff person
 959.5 to plan for improvements to provider
 959.6 registration and oversight for the child care
 959.7 assistance programs under Minnesota Statutes,
 959.8 chapter 119B. This is a onetime appropriation.

959.9 **(d) Base Level Adjustment.** The general fund
 959.10 base is \$14,540,000 in fiscal year 2022 and
 959.11 \$14,793,000 in fiscal year 2023.

959.12 **Subd. 6. Central Office; Health Care**

	<u>Appropriations by Fund</u>	
959.14 <u>General</u>	<u>24,024,000</u>	<u>24,507,000</u>
959.15 <u>State Government</u>		
959.16 <u>Special Revenue</u>	<u>277,000</u>	<u>242,000</u>
959.17 <u>Health Care Access</u>	<u>25,456,000</u>	<u>25,344,000</u>

959.18 **(a) Nonemergency Medical Transportation**
 959.19 **Program Audits.** \$557,000 in fiscal year 2020
 959.20 and \$1,119,000 in fiscal year 2021 are from
 959.21 the general fund to conduct audits of the
 959.22 nonemergency medical transportation
 959.23 program.

959.24 **(b) Outpatient Pharmacy.** \$113,000 in fiscal
 959.25 year 2020 and \$50,000 in fiscal year 2021 are
 959.26 from the general fund to contract for 340B
 959.27 pharmacy data in order to perform the new
 959.28 pricing calculations and conduct a cost of
 959.29 dispensing survey.

959.30 **(c) Health Care Financing System Analysis.**
 959.31 \$500,000 in fiscal year 2020 is from the
 959.32 general fund for the commissioner to contract
 959.33 with the University of Minnesota to conduct
 959.34 an analysis of a unified health care financing
 959.35 system.

960.1 **(d) Advisory Council on Rare Diseases.**
 960.2 \$150,000 in fiscal year 2020 and \$150,000 in
 960.3 fiscal year 2021 are from the general fund for
 960.4 transfer to the Board of Regents of the
 960.5 University of Minnesota for the advisory
 960.6 council on rare diseases under Minnesota
 960.7 Statutes, section 137.68.

960.8 **(e) Base Level Adjustment.** The general fund
 960.9 base is \$27,551,000 in fiscal year 2022 and
 960.10 \$29,867,000 in fiscal year 2023. The state
 960.11 government special revenue fund base is
 960.12 \$242,000 in fiscal year 2022 and \$242,000 in
 960.13 fiscal year 2023. The health care access fund
 960.14 base is \$26,449,000 in fiscal year 2022 and
 960.15 \$27,197,000 in fiscal year 2023.

960.16 **Subd. 7. Central Office; Continuing Care for**
 960.17 **Older Adults**

960.18	<u>Appropriations by Fund</u>	
960.19	<u>General</u>	<u>20,330,000</u> <u>17,991,000</u>
960.20	<u>State Government</u>	
960.21	<u>Special Revenue</u>	<u>125,000</u> <u>125,000</u>

960.22 **(a) Assisted Living Survey.** Beginning in
 960.23 fiscal year 2020, \$2,500,000 is appropriated
 960.24 in the even numbered year of each biennium
 960.25 to fund a resident experience survey and
 960.26 family survey for all housing with services
 960.27 sites. This paragraph does not expire.

960.28 **(b) Information and Assistance Grant**
 960.29 **Transfer.** \$1,000,000 in fiscal year 2020 and
 960.30 \$1,000,000 in fiscal year 2021 are transferred
 960.31 to the continuing care for older adults
 960.32 administration from the aging and adult
 960.33 services grants for developing the Home and
 960.34 Community-Based Report Card for assisted
 960.35 living. This transfer is ongoing.

961.1 (c) Base Level Adjustment. The general fund
 961.2 base is \$20,486,000 in fiscal year 2022 and
 961.3 \$18,006,000 in fiscal year 2023. The state
 961.4 government special revenue fund base is
 961.5 \$125,000 in fiscal year 2022 and \$125,000 in
 961.6 fiscal year 2023.

961.7 Subd. 8. Central Office; Community Supports

961.8	<u>Appropriations by Fund</u>		
961.9	<u>General</u>	<u>35,828,000</u>	<u>36,063,000</u>
961.10	<u>Lottery Prize</u>	<u>163,000</u>	<u>163,000</u>

961.11 (a) Certified Community Behavioral Health
 961.12 Center (CCBHC) Expansion. \$310,000 in
 961.13 fiscal year 2020 and \$285,000 in fiscal year
 961.14 2021 are from the general fund to support
 961.15 CCBHC expansion.

961.16 (b) Base Level Adjustment. The general fund
 961.17 base is \$35,683,000 in fiscal year 2022 and
 961.18 \$35,383,000 in fiscal year 2023.

961.19 Subd. 9. Forecasted Programs; MFIP/DWP

961.20	<u>Appropriations by Fund</u>		
961.21	<u>General</u>	<u>89,448,000</u>	<u>111,069,000</u>
961.22	<u>Federal TANF</u>	<u>78,705,000</u>	<u>76,851,000</u>

961.23	<u>Subd. 10. Forecasted Programs; MFIP Child</u>		
961.24	<u>Care Assistance</u>	<u>107,038,000</u>	<u>124,304,000</u>

961.25	<u>Subd. 11. Forecasted Programs; General</u>		
961.26	<u>Assistance</u>	<u>49,959,000</u>	<u>50,586,000</u>

961.27 (a) General Assistance Standard. The
 961.28 commissioner shall set the monthly standard
 961.29 of assistance for general assistance units
 961.30 consisting of an adult recipient who is
 961.31 childless and unmarried or living apart from
 961.32 parents or a legal guardian at \$203. The
 961.33 commissioner may reduce this amount

962.1 according to Laws 1997, chapter 85, article 3,
962.2 section 54.

962.3 **(b) Emergency General Assistance Limit.**

962.4 The amount appropriated for emergency
962.5 general assistance is limited to no more than
962.6 \$6,729,812 in fiscal year 2020 and \$6,729,812
962.7 in fiscal year 2021. Funds to counties shall be
962.8 allocated by the commissioner using the
962.9 allocation method under Minnesota Statutes,
962.10 section 256D.06.

962.11 **Subd. 12. Forecasted Programs; Minnesota**
962.12 **Supplemental Aid**

42,348,000 46,420,000

962.13 **Subd. 13. Forecasted Programs; Housing**
962.14 **Support**

167,645,000 170,218,000

962.15 **Subd. 14. Forecasted Programs; Northstar Care**
962.16 **for Children**

86,497,000 94,095,000

962.17 **Subd. 15. Forecasted Programs; MinnesotaCare**

25,100,000 31,274,000

962.18 **(a) Generally.** This appropriation is from the
962.19 health care access fund.

962.20 **(b) OneCare Buy-In Option.** The fiscal year
962.21 2023 base for MinnesotaCare is increased by
962.22 \$112,000,000 to serve as a reserve for the
962.23 Department of Human Services to
962.24 operationalize the OneCare Buy-In Option
962.25 under Minnesota Statutes, chapter 256T. This
962.26 is a onetime increase.

962.27 **Subd. 16. Forecasted Programs; Medical**
962.28 **Assistance**

962.29 Appropriations by Fund

962.30 General 5,654,780,000 5,714,893,000

962.31 Health Care Access 454,626,000 472,320,000

962.32 **(a) Behavioral Health Services.** \$1,000,000
962.33 in fiscal year 2020 and \$1,000,000 in fiscal
962.34 year 2021 are for behavioral health services
962.35 provided by hospitals identified under

- 963.1 Minnesota Statutes, section 256.969,
 963.2 subdivision 2b, paragraph (a), clause (4). The
 963.3 increase in payments shall be made by
 963.4 increasing the adjustment under Minnesota
 963.5 Statutes, section 256.969, subdivision 2b,
 963.6 paragraph (e), clause (2).
- 963.7 **(b) Base Level Adjustment.** The health care
 963.8 access fund base is \$512,550,000 in fiscal year
 963.9 2022 and \$520,447,000 in fiscal year 2023.
- | | | | |
|--------|--|-------------------|-------------------|
| 963.10 | <u>Subd. 17. Forecasted Programs; Alternative</u> | | |
| 963.11 | <u>Care</u> | <u>45,243,000</u> | <u>45,245,000</u> |
- 963.12 **Alternative Care Transfer.** Any money
 963.13 allocated to the alternative care program that
 963.14 is not spent for the purposes indicated does
 963.15 not cancel but must be transferred to the
 963.16 medical assistance account.
- | | | | |
|--------|---|--------------------|--------------------|
| 963.17 | <u>Subd. 18. Forecasted Programs; Chemical</u> | | |
| 963.18 | <u>Dependency Treatment Fund</u> | <u>131,372,000</u> | <u>135,609,000</u> |
- 963.19 **Subd. 19. Grant Programs; Support Services**
 963.20 **Grants**
- | | | | |
|--------|-------------------------------|-------------------|-------------------|
| 963.21 | <u>Appropriations by Fund</u> | | |
| 963.22 | <u>General</u> | <u>8,715,000</u> | <u>8,715,000</u> |
| 963.23 | <u>Federal TANF</u> | <u>96,312,000</u> | <u>96,311,000</u> |
- | | | | |
|--------|---|-------------------|-------------------|
| 963.24 | <u>Subd. 20. Grant Programs; Basic Sliding Fee</u> | | |
| 963.25 | <u>Child Care Assistance Grants</u> | <u>63,935,000</u> | <u>75,046,000</u> |
- 963.26 **(a) Basic Sliding Fee Waiting List**
 963.27 **Allocation.** Notwithstanding Minnesota
 963.28 Statutes, section 119B.03, \$7,821,000 in fiscal
 963.29 year 2020 and \$17,901,000 in fiscal year 2021
 963.30 are to reduce the basic sliding fee program
 963.31 waiting list as follows:
- 963.32 (1) the calendar year 2020 allocation shall be
 963.33 increased to serve families on the waiting list.
 963.34 To receive funds appropriated for this purpose,

964.1 a county must have a waiting list in the most
 964.2 recent published waiting list month;
 964.3 (2) funds shall be distributed proportionately
 964.4 based on the average of the most recent six
 964.5 months of published waiting lists to counties
 964.6 that meet the criteria in clause (1);
 964.7 (3) allocations in calendar years 2021 and
 964.8 beyond shall be calculated using the allocation
 964.9 formula in Minnesota Statutes, section
 964.10 119B.03; and
 964.11 (4) the guaranteed floor for calendar year 2021
 964.12 shall be based on the revised calendar year
 964.13 2020 allocation.

964.14 **(b) Increase for Maximum Rates.**
 964.15 Notwithstanding Minnesota Statutes, section
 964.16 119B.03, subdivisions 6, 6a, and 6b, the
 964.17 commissioner must allocate the additional
 964.18 basic sliding fee child care funds for calendar
 964.19 year 2020 to counties for updated maximum
 964.20 rates based on relative need to cover maximum
 964.21 rate increases. In distributing the additional
 964.22 funds, the commissioner shall consider the
 964.23 following factors by county:

964.24 (1) number of children;
 964.25 (2) provider type;
 964.26 (3) age of children; and
 964.27 (4) amount of the increase in maximum rates.

964.28 **(c) Base Level Adjustment.** The general fund
 964.29 base is \$79,556,000 in fiscal year 2022 and
 964.30 \$86,527,000 in fiscal year 2023.

964.31 **Subd. 21. Grant Programs; Child Care**
 964.32 **Development Grants**

2,337,000

2,337,000

965.1 (a) First Children's Finance Child Care Site
 965.2 Assistance Grant. \$500,000 in fiscal year
 965.3 2020 and \$500,000 in fiscal year 2021 are for
 965.4 a grant to First Children's Finance for loans to
 965.5 improve or increase availability of child care
 965.6 or early childhood education sites. This is a
 965.7 onetime appropriation.

965.8 (b) REETAIN Grant. \$100,000 in fiscal year
 965.9 2020 and \$100,000 in fiscal year 2021 are for
 965.10 the REETAIN grant program under Minnesota
 965.11 Statutes, section 119B.195. The unencumbered
 965.12 balance in the first year does not cancel but is
 965.13 available for the second year.

965.14 (c) Base Level Adjustment. The general fund
 965.15 base is \$1,837,000 in fiscal year 2022 and
 965.16 \$1,837,000 in fiscal year 2023.

965.17 Subd. 22. Grant Programs; Child Support
 965.18 Enforcement Grants 50,000 50,000

965.19 Subd. 23. Grant Programs; Children's Services
 965.20 Grants

965.21	<u>Appropriations by Fund</u>		
965.22	<u>General</u>	<u>44,282,000</u>	<u>48,785,000</u>
965.23	<u>Federal TANF</u>	<u>140,000</u>	<u>140,000</u>

965.24 (a) Title IV-E Adoption Assistance. (1) The
 965.25 commissioner shall allocate funds from the
 965.26 Title IV-E reimbursement to the state from
 965.27 the Fostering Connections to Success and
 965.28 Increasing Adoptions Act for adoptive, foster,
 965.29 and kinship families as required in Minnesota
 965.30 Statutes, section 256N.261.

965.31 (2) Additional federal reimbursement to the
 965.32 state as a result of the Fostering Connections
 965.33 to Success and Increasing Adoptions Act's
 965.34 expanded eligibility for title IV-E adoption
 965.35 assistance is for postadoption, foster care,

966.1 adoption, and kinship services, including a
966.2 parent-to-parent support network.

966.3 **(b) Parent Support for Better Outcomes**
966.4 **Grants.** \$150,000 in fiscal year 2020 and
966.5 \$150,000 in fiscal year 2021 are from the
966.6 general fund for grants to Minnesota One-Stop
966.7 for Communities to provide mentoring,
966.8 guidance, and support services to parents
966.9 navigating the child welfare system in
966.10 Minnesota in order to promote the
966.11 development of safe, stable, and healthy
966.12 families. Grant funds may be used for parent
966.13 mentoring, peer-to-peer support groups,
966.14 housing support services, training, staffing,
966.15 and administrative costs. This is a onetime
966.16 appropriation.

966.17 **(c) Sexually Exploited Youth and Youth At**
966.18 **Risk of Sexual Exploitation.** \$250,000 in
966.19 fiscal year 2020 and \$250,000 in fiscal year
966.20 2021 are from the general fund for activities
966.21 under the safe harbor program.

966.22 **(d) Family Foster Care Improvement**
966.23 **Models.** \$75,000 in fiscal year 2020 is from
966.24 the general fund for a grant to Hennepin
966.25 County to establish and promote family foster
966.26 care recruitment models. The county shall use
966.27 the grant funds to increase foster care
966.28 providers through administrative
966.29 simplification, nontraditional recruitment
966.30 models, and family incentive options, and
966.31 develop a strategic planning model to recruit
966.32 family foster care providers. This is a onetime
966.33 appropriation.

967.1 (e) Base Level Adjustment. The general fund
 967.2 base is \$51,483,000 in fiscal year 2022 and
 967.3 \$51,198,000 in fiscal year 2023.

967.4 Subd. 24. Grant Programs; Children and
 967.5 Community Service Grants

59,201,000

59,701,000

967.6 (a) Adult Protection Grants. \$1,000,000 in
 967.7 fiscal year 2020 and \$1,500,000 in fiscal year
 967.8 2021 are for grant funding for adult abuse
 967.9 maltreatment investigations and adult
 967.10 protective services to counties and tribes as
 967.11 allocated and specified under Minnesota
 967.12 Statutes, section 256M.42.

967.13 (b) Base Level Adjustment. The general fund
 967.14 base is \$60,251,000 in fiscal year 2022 and
 967.15 \$60,856,000 in fiscal year 2023.

967.16 Subd. 25. Grant Programs; Children and
 967.17 Economic Support Grants

25,575,000

24,315,000

967.18 (a) Minnesota Food Assistance Program.
 967.19 Unexpended funds for the Minnesota food
 967.20 assistance program for fiscal year 2020 do not
 967.21 cancel but are available for this purpose in
 967.22 fiscal year 2021.

967.23 (b) Homeless Youth Act. \$750,000 in fiscal
 967.24 year 2020 and \$750,000 in fiscal year 2021
 967.25 are to provide grants under Minnesota Statutes,
 967.26 section 256K.45. This appropriation is added
 967.27 to the base.

967.28 (c) Emergency Services Grants. \$500,000
 967.29 in fiscal year 2020 and \$500,000 in fiscal year
 967.30 2021 are to provide emergency services grants
 967.31 under Minnesota Statutes, section 256E.36.
 967.32 This appropriation is added to the base.

967.33 (d) Long-Term Homeless Supportive
 967.34 Services. \$250,000 in fiscal year 2020 and

968.1 \$250,000 in fiscal year 2021 are to provide
 968.2 integrated services needed to stabilize
 968.3 individuals, families, and youth living in
 968.4 supportive housing under Minnesota Statutes,
 968.5 section 256K.26. This appropriation is added
 968.6 to the base.

968.7 (e) **Community Action Grants.** \$500,000 in
 968.8 fiscal year 2020 and \$500,000 in fiscal year
 968.9 2021 are for community action grants under
 968.10 Minnesota Statutes, sections 256E.30 to
 968.11 256E.32. This is a onetime appropriation.

968.12 (f) **Food Shelf Programs.** \$260,000 in fiscal
 968.13 year 2020 is for food shelf programs under
 968.14 Minnesota Statutes, section 256E.34, to
 968.15 purchase diapers. Hunger Solutions must
 968.16 establish an application process for food
 968.17 shelves and determine the allocation of money
 968.18 to food shelves. This appropriation is in
 968.19 addition to any other appropriation for food
 968.20 shelf programs under Minnesota Statutes,
 968.21 section 256E.34. This is a onetime
 968.22 appropriation.

968.23 (g) **Base Level Adjustment.** The general fund
 968.24 base is \$23,565,000 in fiscal year 2022 and
 968.25 \$23,565,000 in fiscal year 2023.

968.26 Subd. 26. **Grant Programs; Health Care Grants**

968.27	<u>Appropriations by Fund</u>		
968.28	<u>General</u>	<u>3,711,000</u>	<u>3,711,000</u>
968.29	<u>State Government</u>		
968.30	<u>Special Revenue</u>	<u>10,340,000</u>	<u>10,340,000</u>
968.31	<u>Health Care Access</u>	<u>3,465,000</u>	<u>3,465,000</u>

968.32 Subd. 27. **Grant Programs; Other Long-Term**
 968.33 **Care Grants** 1,925,000 1,925,000

968.34 Subd. 28. **Grant Programs; Aging and Adult**
 968.35 **Services Grants** 31,811,000 31,995,000

969.1	<u>Subd. 29. Grant Programs; Deaf and</u>		
969.2	<u>Hard-of-Hearing Grants</u>	<u>2,886,000</u>	<u>2,886,000</u>
969.3	<u>Subd. 30. Grant Programs; Disabilities Grants</u>	<u>22,231,000</u>	<u>22,944,000</u>
969.4	<u>(a) Training of Direct Support Services</u>		
969.5	<u>Providers. \$375,000 in fiscal year 2020 and</u>		
969.6	<u>\$375,000 in fiscal year 2021 are for stipends</u>		
969.7	<u>to pay for training of individual providers of</u>		
969.8	<u>direct support services as defined in Minnesota</u>		
969.9	<u>Statutes, section 256B.0711, subdivision 1.</u>		
969.10	<u>This training is available to individual</u>		
969.11	<u>providers who have completed designated</u>		
969.12	<u>voluntary trainings made available through</u>		
969.13	<u>the State Service Employees International</u>		
969.14	<u>Union Healthcare Minnesota Committee. This</u>		
969.15	<u>is a onetime appropriation. This appropriation</u>		
969.16	<u>is available only if the labor agreement</u>		
969.17	<u>between the state of Minnesota and the Service</u>		
969.18	<u>Employees International Union Healthcare</u>		
969.19	<u>Minnesota under Minnesota Statutes, section</u>		
969.20	<u>179A.54, is approved under Minnesota</u>		
969.21	<u>Statutes, section 3.855.</u>		
969.22	<u>(b) Training for New Worker Orientation.</u>		
969.23	<u>\$125,000 in fiscal year 2020 and \$125,000 in</u>		
969.24	<u>fiscal year 2021 are for new worker orientation</u>		
969.25	<u>training and is allocated to the Minnesota State</u>		
969.26	<u>Service Employees International Union</u>		
969.27	<u>Healthcare Minnesota Committee. This is a</u>		
969.28	<u>onetime appropriation. This appropriation is</u>		
969.29	<u>available only if the labor agreement between</u>		
969.30	<u>the state of Minnesota and the Service</u>		
969.31	<u>Employees International Union Healthcare</u>		
969.32	<u>Minnesota under Minnesota Statutes, section</u>		
969.33	<u>179A.54, is approved under Minnesota</u>		
969.34	<u>Statutes, section 3.855.</u>		

970.1 (c) **Benefits Planning Grants.** \$600,000 in
 970.2 fiscal year 2020 and \$600,000 in fiscal year
 970.3 2021 are to provide grant funding to the
 970.4 Disability Hub for benefits planning to people
 970.5 with disabilities.

970.6 (d) **Regional Support for Person-Centered**
 970.7 **Practices Grants.** \$374,000 in fiscal year
 970.8 2020 and \$486,000 in fiscal year 2021 are to
 970.9 extend and expand regional capacity for
 970.10 person-centered planning. This grant funding
 970.11 must be allocated to regional cohorts for
 970.12 training, coaching, and mentoring for
 970.13 person-centered and collaborative safety
 970.14 practices benefiting people with disabilities,
 970.15 and employees, organizations, and
 970.16 communities serving people with disabilities.

970.17 (e) **Disability Hub for Families Grants.**
 970.18 \$100,000 in fiscal year 2020 and \$200,000 in
 970.19 fiscal year 2021 are for grants to connect
 970.20 families through innovation grants, life
 970.21 planning tools, and website information as
 970.22 they support a child or family member with
 970.23 disabilities.

970.24 (f) **Electronic Visit Verification.** \$500,000
 970.25 in fiscal year 2021 is for grants to providers
 970.26 who use a different vendor than the contract
 970.27 with the State of Minnesota for electronic visit
 970.28 verification.

970.29 (g) **Base Level Adjustment.** The general fund
 970.30 base is \$22,556,000 in fiscal year 2022 and
 970.31 \$22,168,000 in fiscal year 2023.

970.32 Subd. 31. **Grant Programs; Housing Support**
 970.33 **Grants**

10,264,000

11,364,000

970.34 Subd. 32. **Grant Programs; Adult Mental Health**
 970.35 **Grants**

971.1	<u>Appropriations by Fund</u>		
971.2	<u>General</u>	<u>80,723,000</u>	<u>80,292,000</u>
971.3	<u>Health Care Access</u>	<u>750,000</u>	<u>750,000</u>

971.4 **(a) Certified Community Behavioral Health**

971.5 **Center (CCBHC) Expansion. \$200,000 in**
 971.6 **fiscal year 2021 is from the general fund for**
 971.7 **grants for planning, staff training, and other**
 971.8 **quality improvements that are required to**
 971.9 **comply with federal CCBHC criteria for three**
 971.10 **expansion sites.**

971.11 **(b) Center for Victims of Torture. \$500,000**

971.12 **in fiscal year 2020 and \$500,000 in fiscal year**
 971.13 **2021 are from the general fund for a grant to**
 971.14 **the Center for Victims of Torture. This grant**
 971.15 **may be used to fund start-up and additional**
 971.16 **operating costs for three sites to employ the**
 971.17 **integrated care model for mental health**
 971.18 **targeted case management.**

971.19 **(c) Mental Health Consultation. \$500,000**

971.20 **in fiscal year 2020 and \$500,000 in fiscal year**
 971.21 **2021 are from the general fund for grants to**
 971.22 **organizations to provide culturally specific**
 971.23 **mental health and substance use disorder**
 971.24 **consultation, to foster connections between**
 971.25 **the mental health and substance use disorder**
 971.26 **communities and cultural and ethnic**
 971.27 **communities. Culturally specific provider**
 971.28 **consultation includes:**

971.29 **(1) having available as a resource to other**
 971.30 **providers, a provider who understands the**
 971.31 **client's culture and can utilize that**
 971.32 **understanding to a client's benefit;**

971.33 **(2) providing regular consultation to mental**
 971.34 **health and substance use disorder treatment**

972.1 providers serving families from cultural and
 972.2 ethnic communities; and
 972.3 (3) providing culturally appropriate referrals
 972.4 for services for parents and children with
 972.5 mental health conditions and substance use
 972.6 disorders.

972.7 **(d) Mobile Crisis Program.** \$415,000 in
 972.8 fiscal year 2020 and \$415,000 in fiscal year
 972.9 2021 are from the general fund for a grant to
 972.10 Olmsted County under Minnesota Statutes,
 972.11 section 245.4661, to fund the administration
 972.12 of mobile mental health crisis services
 972.13 provided by the Southeast Mobile Crisis Team.

972.14 **(e) Recovery Community Organizations**
 972.15 **Grants.** \$500,000 in fiscal year 2020 and
 972.16 \$500,000 in fiscal year 2021 are from the
 972.17 general fund for grants to recovery community
 972.18 organizations to provide community-based
 972.19 peer recovery support services that are not
 972.20 otherwise eligible for reimbursement under
 972.21 Minnesota Statutes, section 254B.05, including
 972.22 but not limited to training, hiring, and
 972.23 supervising recovery peers and peer specialists
 972.24 as part of the continuum of care for substance
 972.25 use disorders. This is a onetime appropriation.

972.26 **(f) Base Level Adjustment.** The general fund
 972.27 base is \$78,592,000 in fiscal year 2022 and
 972.28 \$78,592,000 in fiscal year 2023.

972.29 **Subd. 33. Grant Programs; Child Mental Health**
 972.30 **Grants**

26,026,000

26,026,000

972.31 **(a) Children's Intensive Services Reform.**
 972.32 \$400,000 in fiscal year 2020 and \$400,000 in
 972.33 fiscal year 2021 are for start-up grants to
 972.34 prospective psychiatric residential treatment

973.1 facility sites for administrative expenses,
 973.2 consulting services, Health Insurance
 973.3 Portability and Accountability Act of 1996
 973.4 (HIPAA) compliance, therapeutic resources
 973.5 including evidence-based, culturally
 973.6 appropriate curriculums, and training programs
 973.7 for staff and clients as well as allowable
 973.8 physical renovations to the property.

973.9 **(b) Replicable Homeless Youth Drop-In**
 973.10 **Program Model.** \$100,000 in fiscal year 2020
 973.11 and \$100,000 in fiscal year 2021 are for a
 973.12 grant to an organization in Anoka County
 973.13 providing services and programming through
 973.14 a drop-in program to meet the basic needs,
 973.15 including mental health needs, of homeless
 973.16 youth in the northern metropolitan suburbs,
 973.17 to develop a model of its homeless youth
 973.18 drop-in program that can be shared and
 973.19 replicated in other communities throughout
 973.20 Minnesota. This is a onetime appropriation.

973.21 **(c) Child Care Assistance for Certain**
 973.22 **Caregivers.** \$200,000 in fiscal year 2020 and
 973.23 \$200,000 in fiscal year 2021 are for child care
 973.24 assistance under Minnesota Statutes, section
 973.25 119B.05, subdivision 1, clause (11).

973.26 **(d) Base Level Adjustment.** The general fund
 973.27 base is \$26,426,000 in fiscal year 2022 and
 973.28 \$26,426,000 in fiscal year 2023.

973.29 **Subd. 34. Grant Programs; Chemical**
 973.30 **Dependency Treatment Support Grants**

973.31	<u>Appropriations by Fund</u>		
973.32	<u>General</u>	<u>2,136,000</u>	<u>2,136,000</u>
973.33	<u>Lottery Prize</u>	<u>1,733,000</u>	<u>1,733,000</u>

973.34 **Problem Gambling.** \$225,000 in fiscal year
 973.35 2020 and \$225,000 in fiscal year 2021 are

974.1 from the lottery prize fund for a grant to the
 974.2 state affiliate recognized by the National
 974.3 Council on Problem Gambling. The affiliate
 974.4 must provide services to increase public
 974.5 awareness of problem gambling, education,
 974.6 and training for individuals and organizations
 974.7 providing effective treatment services to
 974.8 problem gamblers and their families, and
 974.9 research related to problem gambling.

974.10 Subd. 35. **Direct Care and Treatment -**
 974.11 **Generally**

974.12 (a) **Transfer Authority.** Money appropriated
 974.13 to budget activities under this subdivision and
 974.14 subdivisions 36, 37, 38, and 39 may be
 974.15 transferred between budget activities and
 974.16 between years of the biennium with the
 974.17 approval of the commissioner of management
 974.18 and budget.

974.19 (b) **State Operated Services Account.** Any
 974.20 balance remaining in the state operated
 974.21 services account at the end of fiscal year 2019
 974.22 shall be transferred to the general fund.

974.23 Subd. 36. **Direct Care and Treatment - Mental**
 974.24 **Health and Substance Abuse**

129,209,000

129,201,000

974.25 (a) **Transfer Authority.** Money previously
 974.26 appropriated to support the continued
 974.27 operations of the Community Addiction
 974.28 Enterprise (C.A.R.E.) program may be
 974.29 transferred to the enterprise fund for C.A.R.E.

974.30 (b) **Base Level Adjustment.** The general fund
 974.31 base is \$129,197,000 in fiscal year 2022 and
 974.32 \$129,197,000 in fiscal year 2023.

974.33 Subd. 37. **Direct Care and Treatment -**
 974.34 **Community-Based Services**

16,630,000

17,177,000

975.1 (a) Transfer Authority. Money previously
 975.2 appropriated to support the continued
 975.3 operations of the Minnesota State Operated
 975.4 Community Services (MSOCS) program may
 975.5 be transferred to the enterprise fund for
 975.6 MSOCS.

975.7 (b) MSOCS Operating Adjustment.
 975.8 \$1,594,000 in fiscal year 2020 and \$3,729,000
 975.9 in fiscal year 2021 are from the general fund
 975.10 for the Minnesota State Operated Community
 975.11 Services program. The commissioner shall
 975.12 transfer \$1,594,000 in fiscal year 2020 and
 975.13 \$3,729,000 in fiscal year 2021 to the enterprise
 975.14 fund for MSOCS.

975.15 (c) Base Level Adjustment. The general fund
 975.16 base is \$17,176,000 in fiscal year 2022 and
 975.17 \$17,176,000 in fiscal year 2023.

975.18 Subd. 38. Direct Care and Treatment - Forensic
 975.19 Services

112,126,000

115,342,000

975.20 Base Level Adjustment. The general fund
 975.21 base is \$115,944,000 in fiscal year 2022 and
 975.22 \$115,944,000 in fiscal year 2023.

975.23 Subd. 39. Direct Care and Treatment - Sex
 975.24 Offender Program

97,072,000

97,621,000

975.25 (a) Transfer Authority. Money appropriated
 975.26 for the Minnesota sex offender program may
 975.27 be transferred between fiscal years of the
 975.28 biennium with the approval of the
 975.29 commissioner of management and budget.

975.30 (b) Base Level Adjustment. The general fund
 975.31 base is \$98,166,000 in fiscal year 2022 and
 975.32 \$98,166,000 in fiscal year 2023.

975.33 Subd. 40. Direct Care and Treatment -
 975.34 Operations

47,523,000

47,732,000

976.1 **Base Level Adjustment.** The general fund
 976.2 base is \$47,656,000 in fiscal year 2022 and
 976.3 \$47,656,000 in fiscal year 2023.

976.4 **Subd. 41. Technical Activities** 95,781,000 96,008,000

976.5 **(a) Generally.** This appropriation is from the
 976.6 federal TANF fund.

976.7 **(b) Base Level Adjustment.** The TANF fund
 976.8 base is \$96,360,000 in fiscal year 2022 and
 976.9 \$96,620,000 in fiscal year 2023.

976.10 **Sec. 3. COMMISSIONER OF HEALTH**

976.11 **Subdivision 1. Total Appropriation** **\$ 247,887,000 \$ 252,238,000**

976.12 Appropriations by Fund

	<u>2020</u>	<u>2021</u>
976.13		
976.14 <u>General</u>	<u>141,794,000</u>	<u>144,511,000</u>
976.15 <u>State Government</u>		
976.16 <u>Special Revenue</u>	<u>57,662,000</u>	<u>60,186,000</u>
976.17 <u>Health Care Access</u>	<u>36,718,000</u>	<u>35,828,000</u>
976.18 <u>Federal TANF</u>	<u>11,713,000</u>	<u>11,713,000</u>

976.19 The amounts that may be spent for each
 976.20 purpose are specified in the following
 976.21 subdivisions.

976.22 **Subd. 2. Health Improvement**

976.23 Appropriations by Fund

976.24 <u>General</u>	<u>102,078,000</u>	<u>101,178,000</u>
976.25 <u>State Government</u>		
976.26 <u>Special Revenue</u>	<u>7,183,000</u>	<u>7,030,000</u>
976.27 <u>Health Care Access</u>	<u>36,718,000</u>	<u>35,828,000</u>
976.28 <u>Federal TANF</u>	<u>11,713,000</u>	<u>11,713,000</u>

976.29 **(a) TANF Appropriations.** (1) \$3,579,000
 976.30 of the TANF fund each year is for home
 976.31 visiting and nutritional services listed under
 976.32 Minnesota Statutes, section 145.882,
 976.33 subdivision 7, clauses (6) and (7). Funds must
 976.34 be distributed to community health boards

977.1 according to Minnesota Statutes, section
977.2 145A.131, subdivision 1;

977.3 (2) \$2,000,000 of the TANF fund each year
977.4 is for decreasing racial and ethnic disparities
977.5 in infant mortality rates under Minnesota
977.6 Statutes, section 145.928, subdivision 7;

977.7 (3) \$4,978,000 of the TANF fund each year
977.8 is for the family home visiting grant program
977.9 according to Minnesota Statutes, section
977.10 145A.17. \$4,000,000 of the funding must be
977.11 distributed to community health boards
977.12 according to Minnesota Statutes, section
977.13 145A.131, subdivision 1. \$978,000 of the
977.14 funding must be distributed to tribal
977.15 governments according to Minnesota Statutes,
977.16 section 145A.14, subdivision 2a;

977.17 (4) \$1,156,000 of the TANF fund each year
977.18 is for family planning grants under Minnesota
977.19 Statutes, section 145.925; and

977.20 (5) The commissioner may use up to 6.23
977.21 percent of the funds appropriated each year to
977.22 conduct the ongoing evaluations required
977.23 under Minnesota Statutes, section 145A.17,
977.24 subdivision 7, and training and technical
977.25 assistance as required under Minnesota
977.26 Statutes, section 145A.17, subdivisions 4 and
977.27 5.

977.28 (b) **TANF Carryforward.** Any unexpended
977.29 balance of the TANF appropriation in the first
977.30 year of the biennium does not cancel but is
977.31 available for the second year.

977.32 (c) **Comprehensive Suicide Prevention.**
977.33 \$3,730,000 each fiscal year from the general
977.34 fund is to support a comprehensive,

978.1 community-based suicide prevention strategy.
978.2 The funds are allocated as follows:
978.3 (1) \$1,291,000 each fiscal year is for
978.4 community-based suicide prevention grants
978.5 authorized in Minnesota Statutes, section
978.6 145.56, subdivision 2. Specific emphasis must
978.7 be placed on those communities with the
978.8 greatest disparities;
978.9 (2) \$913,000 each fiscal year is to support
978.10 evidence-based training for educators and
978.11 school staff and purchase suicide prevention
978.12 curriculum for student use statewide, as
978.13 authorized in Minnesota Statutes, section
978.14 145.56, subdivision 2;
978.15 (3) \$205,000 each fiscal year is to implement
978.16 the Zero Suicide framework with up to 20
978.17 behavioral and health care organizations each
978.18 year to treat individuals at risk for suicide and
978.19 support those individuals across systems of
978.20 care upon discharge;
978.21 (4) \$1,321,000 each fiscal year is to develop
978.22 and fund a Minnesota-based network of
978.23 National Suicide Prevention Lifeline,
978.24 providing statewide coverage; and
978.25 (5) the commissioner may retain up to 18.23
978.26 percent of the appropriation under this
978.27 subdivision to administer the comprehensive
978.28 suicide prevention strategy.
978.29 **(d) Statewide Tobacco Cessation. \$1,598,000**
978.30 **in fiscal year 2020 and \$2,748,000 in fiscal**
978.31 **year 2021 are from the general fund to the**
978.32 **commissioner of health for statewide tobacco**
978.33 **cessation services under Minnesota Statutes,**
978.34 **section 144.397. The general fund base for**

979.1 this activity is \$2,878,000 in fiscal year 2022
979.2 and \$2,878,000 in fiscal year 2023.

979.3 **(e) Health Care Access Survey.** \$450,000 in
979.4 fiscal year 2020 is from the health care access
979.5 fund for the commissioner to continue and
979.6 improve the Minnesota Health Care Access
979.7 Survey. This appropriation is added to the
979.8 department's base budget for even-numbered
979.9 fiscal years.

979.10 **(f) Community Solutions for Healthy Child**
979.11 **Development Grant Program.** \$2,000,000
979.12 in fiscal year 2020 is for the community
979.13 solutions for healthy child development grant
979.14 program to promote health and racial equity
979.15 for young children and their families under
979.16 Minnesota Statutes, section 145.9285. The
979.17 commissioner may use up to 23.5 percent of
979.18 the total appropriation for administration. This
979.19 is a onetime appropriation and is available
979.20 until June 30, 2023.

979.21 **(g) Grant to Proof Alliance.** (1) \$500,000 in
979.22 fiscal year 2020 and \$500,000 in fiscal year
979.23 2021 are from the general fund for a grant to
979.24 Proof Alliance. These appropriations are in
979.25 addition to base level funding for this purpose.
979.26 Of this appropriation, Proof Alliance shall
979.27 make grants to eligible regional collaboratives
979.28 for the purposes specified in clause (3).

979.29 **(2) "Eligible regional collaboratives" means**
979.30 a partnership between at least one local
979.31 government and at least one community-based
979.32 organization and, where available, a family
979.33 home visiting program. For purposes of this
979.34 clause, a local government includes a county
979.35 or multicounty organization, a tribal

980.1 government, a county-based purchasing entity,
980.2 or a community health board.

980.3 (3) Eligible regional collaboratives must use
980.4 grant funds to reduce the incidence of fetal
980.5 alcohol spectrum disorders and other prenatal
980.6 drug-related effects in children in Minnesota
980.7 by identifying and serving pregnant women
980.8 suspected of or known to use or abuse alcohol
980.9 or other drugs. Eligible regional collaboratives
980.10 must provide intensive services to chemically
980.11 dependent women to increase positive birth
980.12 outcomes.

980.13 (4) Proof Alliance must make grants to eligible
980.14 regional collaboratives from both rural and
980.15 urban areas of the state.

980.16 (5) An eligible regional collaborative that
980.17 receives a grant under this paragraph must
980.18 report to Proof Alliance by January 15 of each
980.19 year on the services and programs funded by
980.20 the grant. The report must include measurable
980.21 outcomes for the previous year, including the
980.22 number of pregnant women served and the
980.23 number of toxic-free babies born. Proof
980.24 Alliance must compile the information in these
980.25 reports and report that information to the
980.26 commissioner of human services by February
980.27 15 of each year.

980.28 **(h) Palliative Care Advisory Council.**
980.29 \$44,000 in fiscal year 2020 and \$44,000 in
980.30 fiscal year 2021 are from the general fund for
980.31 the Palliative Care Advisory Council under
980.32 Minnesota Statutes, section 144.059. This is
980.33 a onetime appropriation.

- 981.1 **(i) Domestic Violence and Sexual Assault**
981.2 **Prevention Program. \$750,000 in fiscal year**
981.3 **2020 and \$750,000 in fiscal year 2021 are**
981.4 **from the general fund for purposes of the**
981.5 **domestic violence and sexual assault**
981.6 **prevention program under Minnesota Statutes,**
981.7 **section 145.987. This is a onetime**
981.8 **appropriation.**
- 981.9 **(j) Comprehensive Advanced Life Support**
981.10 **Educational Program. \$100,000 in fiscal**
981.11 **year 2020 and \$100,000 in fiscal year 2021**
981.12 **are from the general fund for the**
981.13 **comprehensive advanced life support**
981.14 **educational program under Minnesota Statutes,**
981.15 **section 144.6062. These appropriations are in**
981.16 **addition to base funding for the program in**
981.17 **fiscal years 2020 and 2021.**
- 981.18 **(k) HIV Prevention Grants. \$500,000 in**
981.19 **fiscal year 2020 and \$500,000 in fiscal year**
981.20 **2021 are from the general fund for grants to**
981.21 **Minnesota nonprofit organizations for projects**
981.22 **aimed at preventing the spread of HIV/AIDS,**
981.23 **targeting communities in Minnesota at high**
981.24 **risk for HIV infection, and for individuals in**
981.25 **Minnesota living with HIV/AIDS. Grants shall**
981.26 **be awarded on a request for proposal basis and**
981.27 **priority shall be given to organizations that**
981.28 **have experience in dealing with issues relating**
981.29 **to HIV/AIDS. This is a onetime appropriation.**
- 981.30 **(l) Sexually Exploited Youth and Youth At**
981.31 **Risk of Sexual Exploitation. \$250,000 in**
981.32 **fiscal year 2020 and \$250,000 in fiscal year**
981.33 **2021 are from the general fund for**
981.34 **trauma-informed, culturally specific services**
981.35 **for sexually exploited youth under the safe**

982.1 harbor program. Youth 24 years of age or
 982.2 younger are eligible for services under this
 982.3 paragraph.

982.4 (m) **Home Visiting.** \$250,000 in fiscal year
 982.5 2020 and \$250,000 in fiscal year 2021 are
 982.6 from the general fund for home visiting
 982.7 programs under Minnesota Statutes, section
 982.8 145.87. This is a onetime appropriation.

982.9 (n) **The TAP Program.** \$5,000 in fiscal year
 982.10 2020 and \$5,000 in fiscal year 2021 are for
 982.11 transfers to The TAP in St. Paul to support
 982.12 mental health in disability communities
 982.13 through spoken art forms, community support,
 982.14 and community engagement. This is a onetime
 982.15 appropriation.

982.16 (o) **Base Level Adjustments.** The general
 982.17 fund base is \$99,434,000 in fiscal year 2022
 982.18 and \$99,434,000 in fiscal year 2023. The
 982.19 health care access fund base is \$36,878,000
 982.20 in fiscal year 2022 and \$35,828,000 in fiscal
 982.21 year 2023.

982.22 Subd. 3. **Health Protection**

982.23	<u>Appropriations by Fund</u>	
982.24	<u>General</u>	<u>28,904,000</u> <u>32,421,000</u>
982.25	<u>State Government</u>	
982.26	<u>Special Revenue</u>	<u>50,479,000</u> <u>53,156,000</u>

982.27 (a) **Vulnerable Adults Program**
 982.28 **Improvements.** \$7,438,000 in fiscal year 2020
 982.29 and \$4,302,000 in fiscal year 2021 are from
 982.30 the general fund for the commissioner to
 982.31 continue necessary current operations
 982.32 improvements to the regulatory activities,
 982.33 systems, analysis, reporting, and
 982.34 communications that contribute to the health,
 982.35 safety, care quality, and abuse prevention for

983.1 vulnerable adults in Minnesota. \$1,103,000 in
983.2 fiscal year 2020 and \$1,103,000 in fiscal year
983.3 2021 are from the state government special
983.4 revenue fund to improve the frequency of
983.5 home care provider inspections. The state
983.6 government special revenue appropriations
983.7 under this paragraph are onetime
983.8 appropriations.

983.9 **(b) Vulnerable Adults Regulatory Reform.**
983.10 \$2,432,000 in fiscal year 2020 and \$8,114,000
983.11 in fiscal year 2021 are from the general fund
983.12 for the commissioner to establish the assisted
983.13 living licensure under Minnesota Statutes,
983.14 section 144I.01. This is a onetime
983.15 appropriation. The commissioner shall transfer
983.16 fine revenue previously deposited to the state
983.17 government special revenue fund under
983.18 Minnesota Statutes, section 144A.474,
983.19 subdivision 11, which is estimated to be
983.20 \$632,000, to a dedicated account in the state
983.21 treasury.

983.22 **(c) Laboratory Equipment. \$840,000 in**
983.23 fiscal year 2020 and \$655,000 in fiscal year
983.24 2021 are from the general fund for the
983.25 commissioner to purchase equipment for the
983.26 public health laboratory. These appropriations
983.27 are onetime appropriations and available until
983.28 June 30, 2023.

983.29 **(d) Provider Network Adequacy Reviews.**
983.30 \$231,000 in fiscal year 2020 and \$231,000 in
983.31 fiscal year 2021 are from the general fund for
983.32 health plan product reviews and licensing of
983.33 health maintenance organizations. The
983.34 \$77,000 annual transfer from the state
983.35 government special revenue fund to the

984.1 general fund required by Laws 2008, chapter
 984.2 364, section 17, paragraph (b), shall end in
 984.3 fiscal year 2019.

984.4 **(e) Network Adequacy Waiver Application**
 984.5 **Review Process.** \$235,000 in fiscal year 2020
 984.6 and \$153,000 in fiscal year 2021 are from the
 984.7 general fund for review of network adequacy
 984.8 waiver applications and review of provider
 984.9 networks for health maintenance organizations
 984.10 and for health carriers offering individual and
 984.11 small group health plans.

984.12 **(f) Regulation of Low-Dose X-Ray Security**
 984.13 **Screening Systems.** \$86,000 in fiscal year
 984.14 2020 and \$58,000 in fiscal year 2021 are from
 984.15 the state government special revenue fund for
 984.16 rulemaking under Minnesota Statutes, section
 984.17 144.121. The base for this appropriation is
 984.18 \$31,000 in fiscal year 2022 and \$31,000 in
 984.19 fiscal year 2023.

984.20 **(g) Base Level Adjustment.** The general fund
 984.21 base is \$25,150,000 in fiscal year 2022 and
 984.22 \$24,719,000 in fiscal year 2023. The state
 984.23 government special revenue fund base is
 984.24 \$65,484,000 in fiscal year 2022 and
 984.25 \$65,444,000 in fiscal year 2023.

984.26 **Subd. 4. Health Operations** 10,812,000 10,912,000

984.27 **Sec. 4. HEALTH-RELATED BOARDS**

984.28 **Subdivision 1. Total Appropriation** **\$ 27,185,000** **\$ 26,576,000**

984.29 This appropriation is from the state
 984.30 government special revenue fund unless
 984.31 specified otherwise. The amounts that may be
 984.32 spent for each purpose are specified in the
 984.33 following subdivisions.

984.34 **Subd. 2. Board of Chiropractic Examiners** 629,000 641,000

985.1	<u>Subd. 3. Board of Dentistry</u>	<u>1,503,000</u>	<u>1,450,000</u>
985.2	<u>Subd. 4. Board of Dietetics and Nutrition</u>		
985.3	<u>Practice</u>	<u>147,000</u>	<u>149,000</u>
985.4	<u>Subd. 5. Board of Marriage and Family Therapy</u>	<u>384,000</u>	<u>389,000</u>
985.5	<u>Base Level Adjustment. The base is \$384,000</u>		
985.6	<u>in fiscal year 2022 and \$384,000 in fiscal year</u>		
985.7	<u>2023.</u>		
985.8	<u>Subd. 6. Board of Medical Practice</u>	<u>6,013,000</u>	<u>5,996,000</u>
985.9	<u>(a) Health Professional Services Program.</u>		
985.10	<u>This appropriation includes \$1,023,000 in</u>		
985.11	<u>fiscal year 2020 and \$1,002,000 in fiscal year</u>		
985.12	<u>2021 for the health professional services</u>		
985.13	<u>program.</u>		
985.14	<u>(b) Base Level Adjustment. The base is</u>		
985.15	<u>\$5,912,000 in fiscal year 2022 and \$5,868,000</u>		
985.16	<u>in fiscal year 2023.</u>		
985.17	<u>Subd. 7. Board of Nursing</u>	<u>4,993,000</u>	<u>4,993,000</u>
985.18	<u>Subd. 8. Board of Nursing Home Administrators</u>	<u>3,733,000</u>	<u>3,201,000</u>
985.19	<u>(a) Administrative Services Unit - Operating</u>		
985.20	<u>Costs. Of this appropriation, \$3,445,000 in</u>		
985.21	<u>fiscal year 2020 and \$2,910,000 in fiscal year</u>		
985.22	<u>2021 are for operating costs of the</u>		
985.23	<u>administrative services unit. The</u>		
985.24	<u>administrative services unit may receive and</u>		
985.25	<u>expend reimbursements for services it</u>		
985.26	<u>performs for other agencies.</u>		
985.27	<u>(b) Administrative Services Unit - Volunteer</u>		
985.28	<u>Health Care Provider Program. Of this</u>		
985.29	<u>appropriation, \$150,000 in fiscal year 2020</u>		
985.30	<u>and \$150,000 in fiscal year 2021 are to pay</u>		
985.31	<u>for medical professional liability coverage</u>		
985.32	<u>required under Minnesota Statutes, section</u>		
985.33	<u>214.40.</u>		

986.1 **(c) Administrative Services Unit -**
986.2 **Retirement Costs.** Of this appropriation,
986.3 \$558,000 in fiscal year 2020 is a onetime
986.4 appropriation to the administrative services
986.5 unit to pay for the retirement costs of
986.6 health-related board employees. This funding
986.7 may be transferred to the health board
986.8 incurring retirement costs. Any board that has
986.9 an unexpended balance for an amount
986.10 transferred under this paragraph shall transfer
986.11 the unexpended amount to the administrative
986.12 services unit. These funds are available either
986.13 year of the biennium.

986.14 **(d) Administrative Services Unit - Contested**
986.15 **Cases and Other Legal Proceedings.** Of this
986.16 appropriation, \$200,000 in fiscal year 2020
986.17 and \$200,000 in fiscal year 2021 are for costs
986.18 of contested case hearings and other
986.19 unanticipated costs of legal proceedings
986.20 involving health-related boards funded under
986.21 this section. Upon certification by a
986.22 health-related board to the administrative
986.23 services unit that costs will be incurred and
986.24 that there is insufficient money available to
986.25 pay for the costs out of money currently
986.26 available to that board, the administrative
986.27 services unit is authorized to transfer money
986.28 from this appropriation to the board for
986.29 payment of those costs with the approval of
986.30 the commissioner of management and budget.
986.31 The commissioner of management and budget
986.32 must require any board that has an unexpended
986.33 balance for an amount transferred under this
986.34 paragraph to transfer the unexpended amount
986.35 to the administrative services unit to be

987.1	<u>deposited in the state government special</u>		
987.2	<u>revenue fund.</u>		
987.3	<u>Subd. 9. Board of Optometry</u>	<u>200,000</u>	<u>201,000</u>
987.4	<u>Subd. 10. Board of Pharmacy</u>	<u>4,311,000</u>	<u>4,342,000</u>
987.5	<u>Subd. 11. Board of Physical Therapy</u>	<u>547,000</u>	<u>549,000</u>
987.6	<u>Subd. 12. Board of Podiatric Medicine</u>	<u>199,000</u>	<u>199,000</u>
987.7	<u>Subd. 13. Board of Psychology</u>	<u>1,357,000</u>	<u>1,395,000</u>
987.8	<u>Base Level Adjustment. The base is</u>		
987.9	<u>\$1,355,000 in fiscal year 2022 and \$1,355,000</u>		
987.10	<u>in fiscal year 2023.</u>		
987.11	<u>Subd. 14. Board of Social Work</u>	<u>1,437,000</u>	<u>1,404,000</u>
987.12	<u>Subd. 15. Board of Veterinary Medicine</u>	<u>345,000</u>	<u>353,000</u>
987.13	<u>Subd. 16. Board of Behavioral Health and</u>		
987.14	<u>Therapy</u>	<u>937,000</u>	<u>858,000</u>
987.15	<u>Base Level Adjustment. The base is \$833,000</u>		
987.16	<u>in fiscal year 2022 and \$833,000 in fiscal year</u>		
987.17	<u>2023.</u>		
987.18	<u>Subd. 17. Board of Occupational Therapy</u>		
987.19	<u>Practice</u>	<u>450,000</u>	<u>456,000</u>
987.20	<u>Sec. 5. EMERGENCY MEDICAL SERVICES</u>		
987.21	<u>REGULATORY BOARD</u>	<u>\$ 3,747,000</u>	<u>\$ 3,809,000</u>
987.22	<u>(a) Cooper/Sams Volunteer Ambulance</u>		
987.23	<u>Program. \$950,000 in fiscal year 2020 and</u>		
987.24	<u>\$950,000 in fiscal year 2021 are for the</u>		
987.25	<u>Cooper/Sams volunteer ambulance program</u>		
987.26	<u>under Minnesota Statutes, section 144E.40.</u>		
987.27	<u>(1) Of this amount, \$861,000 in fiscal year</u>		
987.28	<u>2020 and \$861,000 in fiscal year 2021 are for</u>		
987.29	<u>the ambulance service personnel longevity</u>		
987.30	<u>award and incentive program under Minnesota</u>		
987.31	<u>Statutes, section 144E.40.</u>		
987.32	<u>(2) Of this amount, \$89,000 in fiscal year 2020</u>		
987.33	<u>and \$89,000 in fiscal year 2021 are for the</u>		

988.1 operations of the ambulance service personnel
 988.2 longevity award and incentive program under
 988.3 Minnesota Statutes, section 144E.40.

988.4 (b) EMSRB Operations. \$1,851,000 in fiscal
 988.5 year 2020 and \$1,913,000 in fiscal year 2021
 988.6 are for board operations. The base for this
 988.7 program is \$1,880,000 in fiscal year 2022 and
 988.8 \$1,880,000 in fiscal year 2023.

988.9 (c) Regional Grants. \$585,000 in fiscal year
 988.10 2020 and \$585,000 in fiscal year 2021 are for
 988.11 regional emergency medical services
 988.12 programs, to be distributed equally to the eight
 988.13 emergency medical service regions under
 988.14 Minnesota Statutes, section 144E.52.

988.15 (d) Ambulance Training Grant. \$585,000
 988.16 in fiscal year 2020 and \$585,000 in fiscal year
 988.17 2021 are for training grants under Minnesota
 988.18 Statutes, section 144E.35.

988.19 (e) Base Level Adjustment. The base is
 988.20 \$3,776,000 in fiscal year 2022 and \$3,776,000
 988.21 in fiscal year 2023.

988.22 Sec. 6. COUNCIL ON DISABILITY \$ 1,014,000 \$ 1,006,000

988.23 Sec. 7. OMBUDSMAN FOR MENTAL
 988.24 HEALTH AND DEVELOPMENTAL
 988.25 DISABILITIES \$ 2,438,000 \$ 2,438,000

988.26 Department of Psychiatry Monitoring.
 988.27 \$100,000 in fiscal year 2020 and \$100,000 in
 988.28 fiscal year 2021 are for monitoring the
 988.29 Department of Psychiatry at the University of
 988.30 Minnesota.

988.31 Sec. 8. OMBUDSPERSONS FOR FAMILIES \$ 714,000 \$ 723,000

988.32 Sec. 9. COMMISSIONER OF COMMERCE \$ 764,000 \$ 786,000

988.33 (a) Pharmacy Benefit Manager Licensing.
 988.34 \$277,000 in fiscal year 2020 and \$274,000 in

989.1 fiscal year 2021 are from the general fund for
 989.2 licensing activities under Minnesota Statutes,
 989.3 chapter 62W. The base for this appropriation
 989.4 is \$274,000 in fiscal year 2022 and \$274,000
 989.5 in fiscal year 2023. \$246,000 each year shall
 989.6 be used solely for staff costs for two
 989.7 enforcement investigators solely for
 989.8 enforcement activities under Minnesota
 989.9 Statutes, chapter 62W.

989.10 (b) **Base Level Adjustment.** The base is
 989.11 \$815,000 in fiscal year 2022 and \$843,000 in
 989.12 fiscal year 2023.

989.13 **Sec. 10. MNSURE BOARD** **\$ 9,293,000 \$ 4,539,000**

989.14 (a) **Generally.** These appropriations are from
 989.15 the health care access fund.

989.16 (b) **State-Based Premium Tax Credit.**
 989.17 \$1,241,000 in fiscal year 2020 and \$4,539,000
 989.18 in fiscal year 2021 are for technology and
 989.19 program development and administration
 989.20 related to management and implementation of
 989.21 the advanced state-based health insurance
 989.22 premium tax credit. This is a onetime
 989.23 appropriation.

989.24 (c) **Premium Subsidy Program.** \$8,052,000
 989.25 in fiscal year 2020 is for administration of the
 989.26 premium subsidy program in Minnesota
 989.27 Statutes, chapter 62V. This is a onetime
 989.28 appropriation.

989.29 Sec. 11. Laws 2017, First Special Session chapter 6, article 18, section 2, subdivision 1,
 989.30 is amended to read:

989.31 **7,654,331,000**
 989.32 **Subdivision 1. Total Appropriation** **\$ 7,548,395,000 \$ 7,654,595,000**

990.1 Appropriations by Fund			
990.2		2018	2019
990.3			6,880,153,000
990.4	General	6,819,523,000	<u>6,880,253,000</u>
990.5	State Government		
990.6	Special Revenue	4,274,000	4,274,000
990.7			501,104,000
990.8	Health Care Access	446,453,000	<u>501,268,000</u>
990.9	Federal TANF	276,249,000	266,904,000
990.10	Lottery Prize	1,896,000	1,896,000

990.11 The amounts that may be spent for each
 990.12 purpose are specified in the following
 990.13 subdivisions.

990.14 **EFFECTIVE DATE.** This section is effective retroactively from April 1, 2019.

990.15 Sec. 12. Laws 2017, First Special Session chapter 6, article 18, section 2, subdivision 3,
 990.16 is amended to read:

990.17 Subd. 3. **Central Office; Operations**

990.18 Appropriations by Fund			
990.19			121,009,000
990.20	General	136,778,000	<u>121,024,000</u>
990.21	State Government		
990.22	Special Revenue	4,149,000	4,149,000
990.23	Health Care Access	21,019,000	21,019,000
990.24	Federal TANF	100,000	100,000

990.25 (a) **Administrative Recovery; Set-Aside.** The
 990.26 commissioner may invoice local entities
 990.27 through the SWIFT accounting system as an
 990.28 alternative means to recover the actual cost of
 990.29 administering the following provisions:

990.30 (1) Minnesota Statutes, section 125A.744,
 990.31 subdivision 3;

990.32 (2) Minnesota Statutes, section 245.495,
 990.33 paragraph (b);

990.34 (3) Minnesota Statutes, section 256B.0625,
 990.35 subdivision 20, paragraph (k);

991.1 (4) Minnesota Statutes, section 256B.0924,
991.2 subdivision 6, paragraph (g);

991.3 (5) Minnesota Statutes, section 256B.0945,
991.4 subdivision 4, paragraph (d); and

991.5 (6) Minnesota Statutes, section 256F.10,
991.6 subdivision 6, paragraph (b).

991.7 **(b) Transfer to Office of Legislative**

991.8 **Auditor.** \$600,000 in fiscal year 2018 and
991.9 \$600,000 in fiscal year 2019 are for transfer
991.10 to the Office of the Legislative Auditor for
991.11 audit activities under Minnesota Statutes,
991.12 section 3.972, subdivision 2b.

991.13 **(c) Base Level Adjustment.** The general fund
991.14 base is \$133,378,000 in fiscal year 2020 and
991.15 \$133,418,000 in fiscal year 2021.

991.16 **EFFECTIVE DATE.** This section is effective retroactively from April 1, 2019.

991.17 Sec. 13. Laws 2017, First Special Session chapter 6, article 18, section 2, subdivision 5,
991.18 is amended to read:

991.19 **Subd. 5. Central Office; Health Care**

991.20 Appropriations by Fund

991.21		21,249,000
991.22	General	<u>21,336,000</u>
991.23	Health Care Access	23,804,000

991.24 **(a) Integrated Health Partnership Health**

991.25 **Information Exchange.** \$125,000 in fiscal

991.26 year 2018 and \$250,000 in fiscal year 2019

991.27 are from the general fund to contract with

991.28 state-certified health information exchange

991.29 vendors to support providers participating in

991.30 an integrated health partnership under

991.31 Minnesota Statutes, section 256B.0755, to

991.32 connect enrollees with community supports

992.1 and social services and improve collaboration
992.2 among participating and authorized providers.

992.3 **(b) Transfer to Legislative Auditor.** 153,000
992.4 in fiscal year 2018 and \$153,000 in fiscal year
992.5 2019 are from the general fund for transfer to
992.6 the Office of the Legislative Auditor for the
992.7 auditor to establish and maintain a team of
992.8 auditors with the training and experience
992.9 necessary to fulfill the requirements in
992.10 Minnesota Statutes, section 3.972, subdivision
992.11 2a.

992.12 **(c) Outpatient Pharmacy.** \$87,000 in fiscal
992.13 year 2019 is from the general fund to contract
992.14 for 340B pharmacy data in order to perform
992.15 the new pricing calculations and conduct a
992.16 cost of dispensing survey.

992.17 ~~(e)~~ **(d) Base Level Adjustment.** The general
992.18 fund base is \$21,257,000 in fiscal year 2020
992.19 and \$21,302,000 in fiscal year 2021.

992.20 **EFFECTIVE DATE.** This section is effective retroactively from April 1, 2019.

992.21 Sec. 14. Laws 2017, First Special Session chapter 6, article 18, section 2, subdivision 15,
992.22 is amended to read:

992.23 Subd. 15. **Forecasted Programs; Medical**
992.24 **Assistance**

992.25	Appropriations by Fund		
992.26			5,172,292,000
992.27	General	5,174,139,000	<u>5,172,290,000</u>
992.28			438,848,000
992.29	Health Care Access	385,159,000	<u>439,012,000</u>

992.30 **(a) Behavioral Health Services.** \$1,000,000
992.31 in fiscal year 2018 and \$1,000,000 in fiscal
992.32 year 2019 are for behavioral health services
992.33 provided by hospitals identified under
992.34 Minnesota Statutes, section 256.969,

993.1 subdivision 2b, paragraph (a), clause (4). The
993.2 increase in payments shall be made by
993.3 increasing the adjustment under Minnesota
993.4 Statutes, section 256.969, subdivision 2b,
993.5 paragraph (e), clause (2).

993.6 **(b) Self-Directed Workforce Collective**

993.7 **Bargaining Agreement.** (1) This
993.8 appropriation includes money to implement a
993.9 collective bargaining agreement between the
993.10 state and the Service Employees International
993.11 Union Healthcare Minnesota (SEIU). This
993.12 appropriation is not available until the
993.13 collective bargaining agreement between the
993.14 state of Minnesota and the Service Employees
993.15 International Union Healthcare Minnesota
993.16 under Minnesota Statutes, section 179A.54,
993.17 is approved as provided in clause (3).

993.18 (2) The commissioner of management and
993.19 budget is authorized to negotiate and enter
993.20 into a collective bargaining agreement with
993.21 SEIU under Minnesota Statutes, section
993.22 179A.54, subject to clause (1), and subdivision
993.23 7, paragraph (f). The economic terms of the
993.24 collective bargaining agreement may include
993.25 wage floor increases for direct support
993.26 workers, paid time off, holiday pay, wage
993.27 increases for workers serving people with
993.28 complex needs, training stipends, and training
993.29 for direct support workers and for
993.30 implementation of the registry as outlined in
993.31 the collective bargaining agreement.

993.32 (3) Notwithstanding Minnesota Statutes,
993.33 sections 3.855, 179A.22, subdivision 4, and
993.34 179A.54, subdivision 5, upon approval of a
993.35 negotiated collective bargaining agreement by

994.1 the SEIU and the commissioner of
 994.2 management and budget, the commissioner
 994.3 of human services is authorized to implement
 994.4 the negotiated collective bargaining
 994.5 agreement.

994.6 **EFFECTIVE DATE.** This section is effective retroactively from April 1, 2019.

994.7 Sec. 15. **TRANSFERS; PREMIUM SECURITY ACCOUNT.**

994.8 (a) By August 30, 2020, the commissioner of commerce shall transfer \$142,000,000
 994.9 from the premium security account to the general fund. This is a onetime transfer.

994.10 (b) By August 30, 2020, the commissioner of commerce shall transfer \$281,483,000
 994.11 from the premium security account to the health care access fund. This is a onetime transfer.

994.12 Sec. 16. **RETURN OF PAYMENTS FOR JENSEN SETTLEMENT COSTS.**

994.13 Any money not used for payment of court-ordered costs or money returned by the court
 994.14 in United States District Court, case 0:09-cv-01775-DWF-BRT, Jensen et al. v. Minnesota
 994.15 Department of Human Services et al., is appropriated to the commissioner of human services
 994.16 for expenses related to direct care and treatment programs and notwithstanding any other
 994.17 provision is available until June 30, 2020.

994.18 Sec. 17. **TRANSFERS; HUMAN SERVICES.**

994.19 Subdivision 1. **Grants.** The commissioner of human services, with the approval of the
 994.20 commissioner of management and budget, may transfer unencumbered appropriation balances
 994.21 for the biennium ending June 30, 2021, within fiscal years among the MFIP, general
 994.22 assistance, medical assistance, MinnesotaCare, MFIP child care assistance under Minnesota
 994.23 Statutes, section 119B.05, Minnesota supplemental aid program, group residential housing
 994.24 program, the entitlement portion of Northstar Care for Children under Minnesota Statutes,
 994.25 chapter 256N, and the entitlement portion of the chemical dependency consolidated treatment
 994.26 fund, and between fiscal years of the biennium. The commissioner shall inform the chairs
 994.27 and ranking minority members of the senate Health and Human Services Finance Division
 994.28 and the house of representatives Health and Human Services Finance Committee quarterly
 994.29 about transfers made under this subdivision.

994.30 Subd. 2. **Administration.** Positions, salary money, and nonsalary administrative money
 994.31 may be transferred within the Departments of Health and Human Services as the
 994.32 commissioners consider necessary, with the advance approval of the commissioner of

995.1 management and budget. The commissioner shall inform the chairs and ranking minority
 995.2 members of the senate Health and Human Services Finance Division and the house of
 995.3 representatives Health and Human Services Finance Committee quarterly about transfers
 995.4 made under this subdivision.

995.5 Sec. 18. **INDIRECT COSTS NOT TO FUND PROGRAMS.**

995.6 The commissioners of health and human services shall not use indirect cost allocations
 995.7 to pay for the operational costs of any program for which they are responsible.

995.8 Sec. 19. **EXPIRATION OF UNCODIFIED LANGUAGE.**

995.9 All uncodified language contained in this article expires on June 30, 2021, unless a
 995.10 different expiration date is explicit.

995.11 Sec. 20. **EFFECTIVE DATE.**

995.12 This article is effective July 1, 2019, unless a different effective date is specified."

995.13 Delete the title and insert:

995.14 "A bill for an act
 995.15 relating to state government; establishing the health and human services budget;
 995.16 modifying provisions governing children and families, operations, direct care and
 995.17 treatment, continuing care for older adults, disability services, chemical and mental
 995.18 health, mental health uniform service standards, health care, prescription drugs,
 995.19 health-related licensing boards, Department of Health programs, health coverage,
 995.20 resident rights and consumer protections, independent senior living facilities,
 995.21 dementia care services for assisted living facilities with dementia care, assisted
 995.22 living licensure conforming changes, third-party logistics providers and wholesale
 995.23 distributors, and prescription drug pricing; establishing OneCare Buy-In;
 995.24 establishing pharmacy benefit manager licensure; establishing prescription drug
 995.25 repository program; establishing insulin assistance program; establishing OneCare
 995.26 Buy-In reserve account; establishing assisted living licensure; requiring reports;
 995.27 making technical changes; modifying penalties; providing for rulemaking;
 995.28 modifying fees; making forecast adjustments; appropriating money; amending
 995.29 Minnesota Statutes 2018, sections 8.31, subdivision 1; 13.46, subdivision 3; 13.69,
 995.30 subdivision 1; 15C.02; 16A.151, subdivision 2; 16A.724, subdivision 2; 18K.02,
 995.31 subdivision 3; 18K.03; 62A.021, by adding subdivisions; 62A.152, subdivision
 995.32 3; 62A.25, subdivision 2; 62A.28, subdivision 2; 62A.30, by adding a subdivision;
 995.33 62A.3094, subdivision 1; 62D.02, subdivision 4; 62D.03, subdivision 1; 62D.05,
 995.34 subdivision 1; 62D.06, subdivision 1; 62D.12, by adding a subdivision; 62D.124,
 995.35 subdivisions 1, 2, 3, by adding subdivisions; 62D.17, subdivision 1; 62D.19;
 995.36 62D.30, subdivision 8; 62E.02, subdivision 3; 62J.497, subdivision 1; 62K.075;
 995.37 62K.10, subdivisions 2, 3, 4, 5; 62Q.01, by adding a subdivision; 62Q.184,
 995.38 subdivisions 1, 3; 62Q.47; 119B.011, subdivisions 19, 20, by adding a subdivision;
 995.39 119B.02, subdivisions 3, 6, 7; 119B.025, subdivision 1, by adding a subdivision;
 995.40 119B.03, subdivision 9; 119B.05, subdivision 1; 119B.09, subdivisions 1, 7;
 995.41 119B.095, subdivision 2, by adding a subdivision; 119B.125, subdivision 6;
 995.42 119B.13, subdivisions 1, 6, 7; 119B.16, subdivisions 1, 1a, 1b, by adding
 995.43 subdivisions; 124D.142; 124D.165, subdivision 4; 125A.515, subdivisions 1, 3,

996.1 4, 5, 7, 8; 144.051, subdivisions 4, 5, 6; 144.057, subdivisions 1, 3; 144.0724,
 996.2 subdivisions 4, 5, 8; 144.121, subdivision 1a, by adding a subdivision; 144.122;
 996.3 144.3831, subdivision 1; 144.4165; 144.4167, subdivision 4; 144.562, subdivision
 996.4 2; 144.966, subdivision 2; 144.99, subdivision 1; 144A.04, subdivision 5; 144A.071,
 996.5 subdivisions 1a, 2, 3, 4a, 4c, 5a; 144A.073, subdivision 3c; 144A.20, subdivision
 996.6 1; 144A.24; 144A.26; 144A.43, subdivisions 11, 30, by adding a subdivision;
 996.7 144A.44, subdivision 1; 144A.471, subdivisions 7, 9; 144A.472, subdivisions 5,
 996.8 7; 144A.473; 144A.474, subdivisions 2, 9, 11; 144A.475, subdivisions 1, 2, 3b,
 996.9 5; 144A.476, subdivision 1; 144A.479, subdivision 7; 144A.4791, subdivisions
 996.10 1, 3, 6, 7, 8, 9, 10; 144A.4792, subdivisions 1, 2, 5, 10; 144A.4793, subdivision
 996.11 6; 144A.4796, subdivision 2; 144A.4797, subdivision 3; 144A.4798; 144A.4799;
 996.12 144A.484, subdivision 1; 145.4235, subdivisions 2, 3, 4, by adding a subdivision;
 996.13 147.37; 147D.27, by adding a subdivision; 147E.40, subdivision 1; 147F.17,
 996.14 subdivision 1; 148.59; 148.6445, subdivisions 1, 2, 2a, 3, 4, 5, 6, 10; 148.7815,
 996.15 subdivision 1; 148B.5301, subdivision 2; 148E.0555, subdivision 6; 148E.120,
 996.16 subdivision 2; 148E.180; 148F.11, subdivision 1; 150A.06, by adding subdivisions;
 996.17 150A.091, by adding subdivisions; 151.01, subdivisions 23, 31, 35, by adding a
 996.18 subdivision; 151.06, by adding a subdivision; 151.065, subdivisions 1, 2, 3, 6;
 996.19 151.071, subdivisions 1, 2; 151.15, subdivision 1, by adding subdivisions; 151.19,
 996.20 subdivisions 1, 3; 151.21, subdivision 7, by adding a subdivision; 151.211,
 996.21 subdivision 2, by adding a subdivision; 151.252, subdivisions 1, 1a, 3; 151.253,
 996.22 by adding a subdivision; 151.32; 151.40, subdivisions 1, 2; 151.43; 151.46; 151.47,
 996.23 subdivision 1, by adding a subdivision; 152.126, subdivision 6; 152.22, subdivisions
 996.24 11, 13, by adding subdivisions; 152.25, subdivisions 1, 1a, 1c, 4; 152.27,
 996.25 subdivisions 2, 3, 4, 5, 6; 152.28, subdivision 1; 152.29, subdivisions 1, 2, 3, 3a;
 996.26 152.31; 152.32, subdivision 2; 152.33, subdivisions 1, 2; 152.34; 152.36,
 996.27 subdivision 2; 171.171; 214.25, subdivision 2; 237.50, subdivisions 4a, 6a, 10a,
 996.28 11, by adding subdivisions; 237.51, subdivisions 1, 5a; 237.52, subdivision 5;
 996.29 237.53; 245.095; 245.462, subdivisions 6, 8, 9, 14, 17, 18, 21, 23, by adding a
 996.30 subdivision; 245.4661, subdivision 9; 245.467, subdivisions 2, 3; 245.469,
 996.31 subdivisions 1, 2; 245.470, subdivision 1; 245.4712, subdivision 2; 245.472,
 996.32 subdivision 2; 245.4863; 245.4871, subdivisions 9a, 10, 11a, 17, 21, 26, 27, 29,
 996.33 32, 34; 245.4876, subdivisions 2, 3; 245.4879, subdivisions 1, 2; 245.488,
 996.34 subdivision 1; 245.4889, subdivision 1; 245.696, by adding a subdivision; 245.735,
 996.35 subdivision 3; 245A.02, subdivisions 3, 5a, 8, 9, 12, 14, 18, by adding subdivisions;
 996.36 245A.03, subdivisions 1, 3; 245A.04, subdivisions 1, 2, 4, 6, 7, 10, by adding
 996.37 subdivisions; 245A.05; 245A.07, subdivisions 1, 2, 2a, 3; 245A.10, subdivision
 996.38 4; 245A.14, subdivisions 4, 8, by adding subdivisions; 245A.145, subdivisions 1,
 996.39 2; 245A.151; 245A.16, subdivision 1, by adding a subdivision; 245A.18,
 996.40 subdivision 2; 245A.40; 245A.41; 245A.50; 245A.51, subdivision 3, by adding
 996.41 subdivisions; 245A.66, subdivisions 2, 3; 245C.02, subdivision 6a, by adding
 996.42 subdivisions; 245C.03, subdivision 1, by adding a subdivision; 245C.05,
 996.43 subdivisions 2c, 2d, 4, 5, 5a; 245C.08, subdivisions 1, 3; 245C.10, by adding a
 996.44 subdivision; 245C.13, subdivision 2, by adding a subdivision; 245C.14, subdivision
 996.45 1; 245C.15, by adding a subdivision; 245C.22, subdivisions 4, 5; 245C.24; 245C.30,
 996.46 subdivisions 1, 2, 3; 245C.32, subdivision 2; 245D.03, subdivision 1; 245D.071,
 996.47 subdivision 1; 245D.081, subdivision 3; 245E.01, subdivision 8; 245E.02, by
 996.48 adding subdivisions; 245F.05, subdivision 2; 245H.01, by adding subdivisions;
 996.49 245H.03, by adding a subdivision; 245H.07; 245H.10, subdivision 1; 245H.11;
 996.50 245H.12; 245H.13, subdivision 5, by adding subdivisions; 245H.14, subdivisions
 996.51 1, 3, 4, 5, 6; 245H.15, subdivision 1; 246.54, by adding a subdivision; 246B.10;
 996.52 252.27, subdivision 2a; 252.275, subdivision 3; 252.41, subdivisions 3, 4, 5, 6, 7,
 996.53 9; 252.42; 252.43; 252.44; 252.45; 254B.02, subdivision 1; 254B.03, subdivisions
 996.54 2, 4; 254B.04, subdivision 1; 254B.05, subdivisions 1a, 5; 254B.06, subdivisions
 996.55 1, 2; 256.01, subdivision 14b; 256.046, subdivision 1; 256.478; 256.9365; 256.962,
 996.56 subdivision 5; 256.969, subdivisions 2b, 3a, 9, 17, 19; 256B.02, subdivision 7;
 996.57 256B.04, subdivisions 14, 21, 22; 256B.055, subdivision 2; 256B.056, subdivision
 996.58 3; 256B.0615, subdivision 1; 256B.0616, subdivisions 1, 3; 256B.0622,

997.1 subdivisions 1, 2, 3a, 4, 5a, 7, 7a, 7b, 7d; 256B.0623, subdivisions 1, 2, 3, 4, 5, 6,
 997.2 7, 8, 10, 11, 12; 256B.0624, subdivisions 2, 4, 5, 6, 7, 8, 9, 11; 256B.0625,
 997.3 subdivisions 3b, 5, 5l, 9, 13, 13d, 13e, 13f, 17, 19c, 23, 24, 30, 31, 42, 45a, 48,
 997.4 49, 56a, 57, 61, 62, 65, by adding subdivisions; 256B.064, subdivisions 1a, 1b, 2,
 997.5 by adding subdivisions; 256B.0644; 256B.0651, subdivision 17; 256B.0658;
 997.6 256B.0659, subdivisions 12, 21; 256B.0757, subdivisions 1, 2, 4, 5, 8, by adding
 997.7 subdivisions; 256B.0915, subdivisions 3a, 3b; 256B.092, subdivision 13;
 997.8 256B.0941, subdivisions 1, 3; 256B.0943, subdivisions 1, 2, 3, 4, 5, 6, 7, 8, 9, 11;
 997.9 256B.0944, subdivisions 1, 3, 4, 5, 6, 7, 8, 9; 256B.0946, subdivisions 1, 1a, 2, 3,
 997.10 4, 6; 256B.0947, subdivisions 1, 2, 3, 3a, 5, 6, 7a; 256B.0949, subdivisions 2, 4,
 997.11 5a, by adding a subdivision; 256B.27, subdivision 3; 256B.434, subdivisions 1,
 997.12 3; 256B.49, subdivision 24; 256B.4912, by adding subdivisions; 256B.4913,
 997.13 subdivisions 4a, 5; 256B.4914, subdivisions 2, 4, 5, 6, 7, 8, 9, 10, 10a, 14, 15, by
 997.14 adding a subdivision; 256B.69, subdivisions 6, 6d, 35, by adding a subdivision;
 997.15 256B.76, subdivisions 2, 4; 256B.766; 256B.85, subdivisions 3, 11, 12; 256I.03,
 997.16 subdivision 15; 256I.04, subdivisions 1, 2a, 2f; 256I.05, subdivision 1c; 256I.06,
 997.17 subdivision 8; 256J.24, subdivision 5; 256L.03, by adding a subdivision; 256L.07,
 997.18 subdivision 2, by adding a subdivision; 256L.11, subdivisions 2, 7; 256L.121,
 997.19 subdivision 3; 256M.41, subdivision 3, by adding a subdivision; 256R.02,
 997.20 subdivisions 8, 19, by adding subdivisions; 256R.08, subdivision 1; 256R.10, by
 997.21 adding a subdivision; 256R.16, subdivision 1; 256R.21, by adding a subdivision;
 997.22 256R.23, subdivision 5; 256R.24; 256R.25; 256R.26; 256R.44; 256R.47; 256R.50,
 997.23 subdivision 6; 260C.007, subdivision 18, by adding a subdivision; 260C.178,
 997.24 subdivision 1; 260C.201, subdivisions 1, 2, 6; 260C.212, subdivision 2; 260C.452,
 997.25 subdivision 4; 260C.503, subdivision 1; 270B.12, by adding a subdivision;
 997.26 290.0131, by adding a subdivision; 295.51, subdivision 1a; 295.52, subdivision
 997.27 8; 295.57, subdivision 3; 295.582, subdivision 1; 317A.811, by adding a
 997.28 subdivision; 325F.72, subdivisions 1, 2, 4; 461.12, subdivisions 2, 3, 4, 5, 6, 8;
 997.29 461.18; 518A.32, subdivision 3; 609.685; 609.6855; 626.556, subdivision 10;
 997.30 626.5572, subdivision 6; Laws 2003, First Special Session chapter 14, article 13C,
 997.31 section 2, subdivision 6, as amended; Laws 2017, First Special Session chapter 6,
 997.32 article 1, section 45; article 3, section 49; article 5, section 11; article 8, sections
 997.33 71; 72; article 18, section 2, subdivisions 1, 3, 5, 15; proposing coding for new
 997.34 law in Minnesota Statutes, chapters 62A; 62C; 62D; 62K; 62Q; 62V; 119B; 137;
 997.35 144; 144A; 144G; 145; 148; 151; 245; 245A; 245D; 256; 256B; 256L; 256M;
 997.36 256R; 260C; 290; 461; 609; proposing coding for new law as Minnesota Statutes,
 997.37 chapters 62W; 144I; 144J; 144K; 245I; 256T; 317B; repealing Minnesota Statutes
 997.38 2018, sections 62A.021, subdivisions 1, 3; 119B.16, subdivision 2; 144A.071,
 997.39 subdivision 4d; 144A.441; 144A.442; 144A.45, subdivision 6; 144A.472,
 997.40 subdivision 4; 144A.481; 144D.01; 144D.015; 144D.02; 144D.025; 144D.03;
 997.41 144D.04; 144D.045; 144D.05; 144D.06; 144D.065; 144D.066; 144D.07; 144D.08;
 997.42 144D.09; 144D.10; 144D.11; 144G.01; 144G.02; 144G.03; 144G.04; 144G.05;
 997.43 144G.06; 151.214, subdivision 2; 151.42; 151.44; 151.49; 151.50; 151.51; 151.55;
 997.44 151.60; 151.61; 151.62; 151.63; 151.64; 151.65; 151.66; 151.67; 151.68; 151.69;
 997.45 151.70; 151.71; 214.17; 214.18; 214.19; 214.20; 214.21; 214.22; 214.23; 214.24;
 997.46 245.462, subdivision 4a; 245E.06, subdivisions 2, 4, 5; 245H.10, subdivision 2;
 997.47 246.18, subdivisions 8, 9; 252.41, subdivision 8; 252.431; 252.451; 254B.03,
 997.48 subdivision 4a; 256B.0615, subdivisions 2, 4, 5; 256B.0616, subdivisions 2, 4, 5;
 997.49 256B.0624, subdivision 10; 256B.0625, subdivision 63; 256B.0659, subdivision
 997.50 22; 256B.0705; 256B.0943, subdivision 10; 256B.0944, subdivision 10; 256B.0946,
 997.51 subdivision 5; 256B.0947, subdivision 9; 256B.431, subdivisions 3a, 3f, 3g, 3i,
 997.52 10, 13, 15, 16, 17, 17a, 17c, 17d, 17e, 18, 21, 22, 30, 45; 256B.434, subdivisions
 997.53 4, 4f, 4i, 4j, 6, 10; 256B.4913, subdivisions 4a, 6, 7; 256L.11, subdivisions 2a, 6a;
 997.54 256R.36; 256R.40; 256R.41; Laws 2010, First Special Session chapter 1, article
 997.55 25, section 3, subdivision 10; Laws 2011, First Special Session chapter 9, article
 997.56 6, section 97, subdivision 6; Minnesota Rules, parts 2960.3030, subpart 3;
 997.57 3400.0185, subpart 5; 6400.6970; 7200.6100; 7200.6105; 9502.0425, subparts 4,
 997.58 16, 17; 9503.0155, subpart 8; 9505.0370; 9505.0371; 9505.0372; 9520.0010;

998.1 9520.0020; 9520.0030; 9520.0040; 9520.0050; 9520.0060; 9520.0070; 9520.0080;
998.2 9520.0090; 9520.0100; 9520.0110; 9520.0120; 9520.0130; 9520.0140; 9520.0150;
998.3 9520.0160; 9520.0170; 9520.0180; 9520.0190; 9520.0200; 9520.0210; 9520.0230;
998.4 9549.0057; 9549.0060, subparts 4, 5, 6, 7, 10, 11, 14."