MN HOUSE RESEARCH

Bill Summary

H.F. 2184

As introduced

Subject	Governor's HHS Omnibus Finance Bill
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Overview

This bill provides the governor's budget recommendations for the Department of Human Services, Department of Health, and a variety of other entities.

Article 1: Children and Family Services

This article makes various changes to the child care assistance program, DHS licensing and background study provisions, and child welfare provisions.

Section	Description
1	**Homeless.** Amends § 119B.011, by adding subd. 13b. Defines "homeless" under the statute governing the child care assistance program. Provides a September 21, 2020, effective date.
2	**Provider.** Amends § 119B.011, subd. 19. Modifies the definition of "provider" under the statute governing the child care assistance program. Provides a July 1, 2019, effective date.
3	**Transition year families.** Amends § 119B.011, subd. 20. Modifies the definition of "transition year families" under the statute governing the child care assistance program. Provides a March 23, 2020, effective date.
4	**Child care market rate survey.** Amends § 119B.02, subd. 7. Changes the frequency of the child care market rate survey from once every two years to once every three years beginning in state fiscal year 2021. Provides an immediate effective date.

Section	Description
5	**Applications.** Amends § 119B.025, subd. 1. Specifies the process counties must follow when handling applications of families who meet the definition of homeless. Provides a September 21, 2020, effective date.
6	**Portability pool.** Amends § 119B.03, subd. 9. Modifies the portability pool by requiring families who are receiving basic sliding fee child care assistance and move from one county to another to notify the family's previous county of residence of the move (under current law, families must notify the new county of residence within 60 days of moving and submit information to the new county of residence to verify eligibility for the basic sliding fee program). Removes the six-month time limit on receipt of portability pool assistance. Provides a December 2, 2019, effective date.
7	**General eligibility requirements.** Amends § 119B.09, subd. 1. Specifies a family remains eligible for child care assistance until the redetermination if the family has a child that reaches 13 years of age or the child has a disability and reaches 15 years of age. Provides a June 29, 2020, effective date.
8	**Date of eligibility for assistance.** Amends § 119B.09, subd. 7. Limits retroactive payments to three months from the date of application for CCAP (the current limit is six months). Provides a July 1, 2019, effective date.
9	**Maintain steady child care authorizations.** Amends § 119B.095, subd. 2. Requires the amount of child care authorized to continue at the same number of hours or more hours until redetermination when a child reaches 13 years of age or a child with a disability reaches 15 years of age. Provides a June 29, 2020, effective date.
10	**Assistance for persons who are homeless.** Amends § 119B.095, by adding subd. 3. Makes homeless applicants for child care assistance eligible for 60 hours of child care assistance per service period for three months from the date the county receives the application. Allows additional hours to be authorized as needed based on the applicant's participation in employment, education, or Minnesota family investment program (MFIP) or diversionary work program (DWP) employment plan. Requires the parent to verify that the parent meets eligibility and activity requirements for child care assistance to continue receiving assistance after the initial three months. Provides a September 21, 2020, effective date.

Section	Description
11	**Record-keeping requirement.** Amends § 119B.125, subd. 6. Modifies record-keeping requirements child care assistance program (CCAP) providers must meet. Provides a July 1, 2019, effective date.
12	**Subsidy restrictions.** Amends § 119B.13, subd. 1. Paragraph (a) modifies the CCAP maximum rates to be based on the most recent child care provider survey and to be automatically updated to the most recent survey in September after the most recent rate survey. Paragraph (i) modifies the maximum registration fee paid under child care assistance and automatically updates maximum registration fees based on the market rate surveys. Provides a September 20, 2019, effective date for paragraph (a) and a September 23, 2019, effective date for paragraph (i).
13	**Provider payments.** Amends § 119B.13, subd. 6. Requires providers to bill only for services that meet specified documentation requirements. Expands the list of conditions under which the commissioner or a county may refuse to issue a child care authorization to a provider, revoke an existing child care authorization, stop payment issued to a provider, or refuse to pay a bill submitted by a provider. Provides a July 1, 2019, effective date.
14	**Absent days.** Amends § 119B.13, subd. 7. Defines “absent day” and “holidays limit.” Requires providers to properly bill for absent days and holidays. Specifies that a provider’s failure to properly bill for these days results in an overpayment. Provides a July 1, 2019, effective date.
15	**Fair hearing allowed for applicants and recipients.** Amends § 119B.16, subd. 1. Modifies the fair hearings process under the CCAP. Provides a February 26, 2021, effective date.
16	**Fair hearing allowed for providers.** Amends § 119B.16, subd. 1a. Modifies the fair hearings process for providers under the CCAP. Provides a February 26, 2021, effective date.
17	**Joint fair hearings.** Amends § 119B.16, subd. 1b. Modifies the joint fair hearings process for providers and families under the CCAP. Provides a February 26, 2021, effective date.
18	**Notice to providers.** Amends § 119B.16, by adding subd. 1c. Requires the county or commissioner to mail written notice to the provider against whom the action is being taken prior to taking an

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appealable action. Specifies timelines for mailing the notice and the information that must be included in the notice. Provides a February 26, 2021, effective date.

19 **Fair hearing stayed.**

Amends § 119B.16, by adding subd. 3. Specifies circumstances under which a provider's fair hearing must be stayed. Provides a February 26, 2021, effective date.

20 **Final department action.**

Amends § 119B.16, by adding subd. 4. Specifies the county agency's or the commissioner's action is considered final unless the commissioner receives a timely and proper request for an appeal. Provides a February 26, 2021, effective date.

21 **Administrative review.**

Creates § 119B.161.

Subd. 1. Applicability. Specifies conditions under which a provider has the right to administrative review.

Subd. 2. Notice. Specifies the timeline a county agency or the commissioner has for mailing a written notice to a provider when suspending payment or denying or revoking the provider's authorization. Lists the information that must be included in the notice. Requires the county agency or commissioner to send notice to each affected family if payment to a provider is suspended or the provider's authorization is denied or revoked.

Subd. 3. Duration. Specifies the duration of a payment suspension or the denial or revocation of a provider's authorization.

Subd. 4. Good cause exception. Lists the conditions under which the commissioner may find that good cause exists not to deny, revoke, or suspend a provider's authorization, or not to continue a denial, revocation, or suspension of a provider's authorization.

Provides a February 26, 2021, effective date.

22 **Child foster home variances for capacity.**

Amends § 245A.04, by adding subd. 9a. Allows the commissioner to grant a variance for a licensed family foster parent to have additional foster children under specified circumstances. Specifies that a variance granted prior to October 1, 2019, remains in effect until January 1, 2020.

Section	Description
23	**Children's residential facility.** Amends § 245C.02, by adding subd. 6b. Defines "children's residential facility" in background study chapter. Makes this section effective for background studies initiated on or after July 1, 2019.
24	**Fingerprints and photograph.** Amends § 245C.05, subd. 5. Adds children's residential facilities to requirement for fingerprints for a national criminal history record check. Makes this section effective for background studies initiated on or after July 1, 2019.
25	**Background studies conducted by Department of Human Services.** Amends § 245C.08, subd. 1. Adds children's residential facilities to list for review of additional background study information. Makes this section effective for background studies initiated on or after July 1, 2019.
26	**Children's residential facilities.** Amends § 245C.10, by adding subd. 14. Establishes maximum fee of $51 for children's residential services background studies. Makes this section effective for background studies initiated on or after July 1, 2019.
27	**Five-year bar to set aside disqualification; children's residential facilities.** Amends § 245C.24, by adding subd. 5. Prohibits the commissioner from setting aside a disqualification for an individual in connection with a children's residential facility license who was convicted of felony physical assault or drug-related offense in the past five years. Makes this section effective for background studies initiated on or after July 1, 2019.
28	**Appeal of department action.** Amends § 245E.06, subd. 3. Specifies a provider's rights related to the department's action taken under the child care assistance program fraud investigation statute against a provider are established in sections 119B.16 and 119B.161. Provides a February 26, 2021, effective date.
29	**Decertification.** Amends § 245H.07. **Subd. 1. Generally.** Modifies the list of conditions under which the commissioner may decertify a center. **Subd. 2. Reconsideration.** Specifies the process for a certification holder to request reconsideration of a decertification. Provides a February 26, 2021, effective date.

Section	Description
30	**American Indian child welfare projects.** Amends § 256.01, subd. 14b. Adds clarifying language to subdivision allowing for projects to initiate tribal delivery of child welfare services.
31	**Foster care.** Amends § 260C.007, subd. 18. Clarifies definition of "foster care." Adds placement colocated with a parent or guardian in a licensed residential family-based substance use disorder treatment program, and adds a child returned for a trial home visit to the foster care definition.
32	**Licensed residential family-based substance use disorder treatment program.** Amends § 260C.007, by adding subd. 22a. Defines "licensed residential family-based substance use disorder treatment program."
33	**Hearing and release requirements.** Amends § 260C.178, subd. 1. Adds cross-reference.
34	**Family-focused residential placement.** Proposes coding for § 260C.190. **Subd. 1. Placement.** Allows for a child to be placed colocated with a parent in a licensed residential family-based substance use disorder treatment program for up to 12 months. **Subd. 2. Case plans.** Requires a written case plan indicating that placement with a parent in a residential family-based substance use disorder treatment program is in the child's best interest; specifies case plan requirements and timelines. **Subd. 3. Required reviews and permanency proceedings.** Specifies required court procedures and timelines for case review and permanency, in different circumstances, for a child colocated with a parent in a residential family-based substance use disorder treatment program.
35	**Dispositions.** Amends § 260C.201, subd. 1. Adds language to include a child colocated with a parent in a residential family-based substance use disorder treatment program; clarifies permanency proceeding language.
36	**Written findings.** Amends § 260C.201, subd. 2. Adds language to include a child colocated with a parent in a residential family-based substance use disorder treatment program, to the requirement

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	for written findings regarding the appropriateness of a placement when legal custody of the child is transferred.
37	**Case plan.** Amends § 260C.201, subd. 6. Requires a case plan for a child colocated with a parent in a residential family-based substance use disorder treatment program to specify the recommendation for colocation before the placement.
38	**Placement decisions based on the best interests of the child.** Amends § 260C.212, subd. 2. Requires the agency to determine and document whether colocation with a parent in a residential family-based substance use disorder treatment program is in the child's best interests.
39	**Voluntary foster care; child is colocated with parent in treatment program.** Proposes coding for § 260C.228. **Subd. 1. Generally.** Allows for a written voluntary placement agreement after a child's case plan recommends a colocated placement in a residential family-based substance use disorder treatment program. **Subd. 2. Judicial review.** Establishes requirements for judicial review and agency reporting for a voluntary placement under this section. **Subd. 3. Termination.** Specifies that the voluntary placement agreement terminates when the parent is discharged for the treatment program, or upon written and dated request from the parent.
40	**Administrative or court review of placements.** Amends § 260C.452, subd. 4. Adds requirement for official documentation that a youth was formerly in foster care, for a local social services agency transition plan at age 18 or older.
41	**Required permanency proceedings.** Amends § 260C. 503, subd. 1. Adds reference to new section relating to residential family-based substance use disorder treatment program placement.
42	**Parent not considered voluntarily unemployed, underemployed, or employed on a less than full-time basis.** Amends § 518A.32, subd. 3. Makes this subdivision applicable to all incarcerated parents by removing the exception for parents incarcerated due to nonpayment of child support. Makes the section effective the day following final enactment.

Section	Description
43	**Instruction to commissioner.** Requires the commissioner of human services to establish a schedule for individuals in connection with a licensed children's residential facility to receive federal funding to complete a new required background study by March 1, 2020, or by March 1, 2021, for individuals connected with facilities that are not eligible for federal funding.
44	**Child welfare training academy.** **Subd. 1. Establishment; purpose.** Requires the commissioner to modify the Child Welfare Training System, to be known as the Child Welfare Training Academy. **Subd. 2. Administration.** Requires the Child Welfare Training Academy to operate through five regional hubs, using training methods best suited to the content and in line with national best practices. Requires each child welfare worker and supervisor to complete a certification when training is completed, and biennially thereafter. Requires each regional hub to have a regional organizational effectiveness specialist. Requires training to include training and resources on worker well-being and secondary traumatic stress. **Subd. 3. Partnerships.** Requires the commissioner to partner with the University of Minnesota to administer the workforce training, and with one or more agencies to focus on workforce well-being and organizational resilience. **Subd. 4. Rulemaking.** Allows the commissioner to adopt rules in accordance with this section.
45	**Child welfare caseload study.** Requires the commissioner to conduct a child welfare caseload study by July 1, 2020, and report the results to the legislature by December 1, 2020. Requires continued monitoring of child welfare caseloads.
46	**Repealer.** Repeals the following statutes and rules: • section 119B.16, subd. 2 (informal conference) • section 245E.06, subds. 2 (written notice of department sanction), 4 (consolidated hearing with licensing sanction), and 5 (effect of department's administrative determination or sanction) • part 3400.0185, subp. 5 (notice to providers of actions adverse to the provider)

Section	Description

- part 2960.3030, subp. 3 (exceptions to capacity limits)

Article 2: Operations

This article makes various changes to: (1) the False Claims Act; (2) Department of Human Services child care licensing provisions, including modifying child care training requirements and adding new requirements related to family child care physical space; (3) child care and human services background study requirements; and (4) provisions related to certified license-exempt child care centers.

Article 3: Direct Care and Treatment

This article modifies the required county share of the cost of care for individuals in the Minnesota Sex Offender Program (MSOP), including the cost of care for individuals provisionally discharged to the community, and repeals sections relating to state-operated services funding.

Section	Description
1	**Liability of county; reimbursement.** Amends § 246B.10. Specifies that the county share for the cost of care for a civilly committed sex offender is ten percent per day, for individuals admitted to the MSOP before August 1, 2011. Specifies that the county share for the cost of care is 25 percent per day for individuals admitted to the MSOP on or after August 1, 2011, for days at the facility or services received while the individual is on provisional discharge. Modifies conditions requiring the county to pay the state the remaining amount for the MSOP cost of care. Makes this section effective July 1, 2019.
2	**Repealer.** (a) Repeals § 246.18, subds. 8 and 9 (related to the state-operated services account). (b) Repeals Laws 2010, 1st Spec. Sess. ch. 1, art. 25, § 3, subd. 10 (state-operated services appropriations).

Article 4: Continuing Care for Older Adults

This article makes various changes to the nursing facility payment rate system, called value-based reimbursement (VBR), including reforming the property payment rates.

Section	Description
1	**Resident assessment schedule.** Amends § 144.0724, subd. 4. In a subdivision requiring nursing facilities to conduct certain resident assessments to determine case mix classifications for reimbursement, provides that for rehabilitation therapy a facility must perform a significant change in status assessment if all speech, occupational, and physical therapies have ended, and specifies timing for this assessment. Also specifies that any modifications to the most recent assessments must be included in the case mix classification analysis.
2	**Short stays.** Amends § 144.0724, subd. 5. Provides that a nursing facility is not required to conduct an admission assessment of a resident if the resident is admitted to and discharged from the facility on the same day.
3	**Request for reconsideration of resident classifications.** Amends § 144.0724, subd. 8. Allows a reconsideration of a resident's case mix classification by the commissioner of health to include consideration of any items changed during the audit process, and removes language requiring a reconsideration request to include a copy of the minimum data set (MDS) used to determine the case mix classification.
4	**Definitions.** Amends § 144.071, subd. 1a. In a subdivision defining terms for the nursing home bed moratorium section, modifies the definitions of building, capital assets, and depreciation guidelines by adding cross-references to the definitions of those terms in section 256R.261 (definitions for nursing facility property rates). Also strikes definitions of project construction costs and technology.
5	**Moratorium.** Amends § 144A.071, subd. 2. In current law the commissioner of health may approve a nursing facility construction project whose costs are at or below $1,000,000; construction projects with costs above that amount must meet one of the criteria in paragraph (a) or (b) in order to be approved by the commissioner. This section raises the cost threshold for construction projects the commissioner may approve without requiring the project to satisfy additional criteria, from $1,000,000 to $1,500,000. Also requires the commissioner of human services, in addition to the commissioner of health as in current law, to be provided with an itemized cost estimate for project construction costs before final plan approval of a construction project.

Section	Description
6	**Exceptions authorizing increase in beds; hardship areas.** Amends § 144A.071, subd. 3. The amendments to paragraph (d) provide that if a nursing facility in a hardship area adds beds and after these beds are added 50 percent or more of the facility's beds are newly licensed, the facility's operating payment rate and external fixed payment rate shall be determined according to a new subdivision governing total payment rates for new facilities (§ 256R.21, subd. 5), and the facility's property payment rate shall be determined under a new section governing property payment rates (§ 256R.26).
7	**Exceptions for replacement beds.** Amends § 144A.071, subd. 4a. In a paragraph authorizing a nursing facility moratorium exception to replace a facility in Wilkin County damaged by a flood, changes a reference governing the interim and settle-up payment provisions for that facility from a rule being repealed in this article to a new section in chapter 256R governing interim operating and external fixed cost payment rates and settle-up (§ 256R.27).
8	**Exceptions for replacement beds after June 30, 2003.** Amends § 144A.071, subd. 4c. In a paragraph authorizing a nursing facility moratorium exception to licensed beds transferred to a new facility on the grounds of the Ah-Gwah-Ching campus, changes a reference governing the interim and settle-up payment provisions for that facility from a rule being repealed in this article to a new section in chapter 256R governing interim operating and external fixed cost payment rates and settle-up (§ 256R.27).
9	**Cost estimate of a moratorium exception project.** Amends § 144A.071, subd. 5a. In a subdivision establishing requirements for cost estimates of nursing facility moratorium exception projects, requires the commissioner of human services to prepare an estimate of the property-related payment rate to be established when the project is complete, and specifies what governs the final property rate. Strikes paragraphs governing the interest rate used to estimate the cost of a proposal.
10	**Relocation projects.** Amends § 144A.073, subd. 3c. Allows the commissioner to accept relocation proposals at any time (current law allows the commissioner to accept at any time relocation proposals that are cost-neutral with respect to state costs). Also strikes a paragraph describing how cost neutrality is measured.
11	**Capital assets.** Amends § 256R.02, subd. 8. Modifies the definition of "capital assets" under the nursing facility VBR.

Section	Description
12	**External fixed costs.** Amends § 256R.02, subd. 19. Modifies the definition of "external fixed costs" under the nursing facility VBR. Provides a January 1, 2020, effective date.
13	**Calculation of a quality score.** Amends § 256R.16, subd. 1. Removes the July 1 effective date for adjustments to the methodology for computing the total quality score.
14	**Total payment rate for new facilities.** Amends § 256R.21, by adding subd. 5. Specifies the manner in which the total payment rate must be determined for a new facility created under a cost-neutral relocation moratorium exception project. Provides a January 1, 2020, effective date.
15	**Determination of total care-related payment rate limits.** Amends § 256R.23, subd. 5. Modifies the calculation for determining each facility's total care-related payment rate limit. Provides a January 1, 2020, effective date.
16	**Determination of the other operating payment rate.** Amends § 256R.24, subd. 3. Modifies the calculation for determining a facility's other operating payment rate.
17	**External fixed costs payment rate.** Amends § 256R.25. Removes planned closure rate adjustments, consolidation rate adjustments, and single-bed room incentives from the external fixed costs payment rate (these adjustments are repealed as part of this proposal). Provides a January 1, 2020, effective date.
18	**Property payment rate.** Amends § 256R.26. **Subd. 1. Generally.** Paragraph (a) requires the commissioner to reimburse nursing facilities participating in MA for the rental use of real estate and depreciable assets. Paragraph (b) requires the commercial valuation system selected by the commissioner to be utilized in all appraisals. Prohibits adjustments or substitutions from being permitted for any alternative analysis of properties. Paragraph (c) requires the property appraisal firm selected by the commissioner to produce a report detailing both the depreciated replacement cost (DRC) and undepreciated replacement cost (URC) of the nursing facility. Excludes the valuation of movable equipment, land, or land improvements from the valuation. Requires the valuation to be adjusted for any shared area included in the DRC

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and URC not used for nursing facility purposes. Excludes the physical plant for central operations from the appraisal.

Paragraph (d) allows the initial appraisal to include the full value of all shared areas. Requires the DRC, URC, and square footage to be adjusted to reflect only the nursing facility usage of shared areas in the final nursing facility values. Specifies the basis for the adjustment.

Subd. 2. Appraised value. Bases the DRC and URC on the appraisals of a building and attached fixtures as determined by the contracted property appraisal firm using a commercial valuation system selected by the commissioner.

Subd. 3. Initial rate year. Specifies the property payment rate for the initial rate year effective January 1, 2020.

Subd. 4. Subsequent rate years. Paragraph (a) requires the commissioner, beginning in calendar year 2020, to contract with a property appraisal firm to appraise the building and attached fixtures for nursing facilities using the commercial valuation system. Requires approximately one-third of nursing facilities to be appraised each year.

Paragraph (b) specifies the timing for a nursing facility to appeal findings of fact in an appraisal report.

Paragraphs (c) and (d) specify the manner in which property payment rates are determined for rate years 2021 to 2023.

Paragraph (e) specifies requirements for appraisals completed after 2016.

Subd. 5. Special reappraisals. Paragraph (a) allows a nursing facility that completes an addition to or replacement of a building or attached fixtures to request a property rate adjustment. Specifies the process for requesting and determining a property rate adjustment.

Paragraph (b) allows a nursing facility that completes a threshold construction project to request a project rate adjustment if the building improvement or addition costs exceed $300,000 and the project is not reflected in an appraisal used for rate setting. Specifies additional eligibility requirements for a property rate adjustment under this paragraph and the manner in which the rate adjustment is determined.

Paragraph (c) specifies appraisal requirements for nursing facilities new to the medical assistance (MA) program effective January 1, 2020.

Subd. 6. Limitation on appraisal valuations. Limits the increase in the URC to $500,000 per year since the last completed appraisal plus any completed

Section	Description
	moratorium exception project costs. Requires any limitation to the URC to be applied in the same proportion to the DRC. **Subd. 7. Total hold harmless rate.** Paragraph (a) lists the items included in the total hold harmless rate. Paragraph (b) adds certain moratorium rate adjustments to the total hold harmless rate. Paragraph (c) includes the following in the total hold harmless rate: (1) planned closure rate adjustments; (2) consolidation rate adjustments; and (3) single-bed room incentives from previous years. **Subd. 8. Phase out of hold harmless rate.** For a facility that has a higher total hold harmless rate than the new property payment rate, specifies a phase out schedule of the hold harmless rate over six years.
19	**Nursing facility property rate definitions.** Creates § 256R.261. **Subd. 1. Definitions.** Specifies the following terms have the meaning given them for purposes of the nursing facility property payment rates under VBR. **Subd. 2. Addition.** Defines “addition.” **Subd. 3. Appraisal.** Defines “appraisal.” **Subd. 4. Building.** Defines “building.” **Subd. 5. Commercial valuation system.** Defines “commercial valuation system.” **Subd. 6. Depreciable movable equipment.** Defines “depreciable movable equipment.” **Subd. 7. Depreciated replacement cost or DRC.** Defines “depreciated replacement cost” or “DRC.” **Subd. 8. Depreciation expense.** Defines “depreciation expense.” **Subd. 9. Depreciation guidelines.** Defines “depreciation guidelines.” **Subd. 10. Equipment allowance.** Defines “equipment allowance.” **Subd. 11. Fair rental value system.** Defines “fair rental value system.” **Subd. 12. Fixed equipment.** Defines “fixed equipment.”

Section	Description
	Subd. 13. Land improvement. Defines "land improvement."
	Subd. 14. Rental rate. Defines "rental rate."
	Subd. 15. Shared area. Defines "shared area."
	Subd. 16. Threshold project. Defines "threshold project."
	Subd. 17. Undepreciated replacement cost or URC. Defines "undepreciated replacement cost" or "URC."
	Subd. 18. Undepreciated replacement cost (URC) per bed limit. Defines "undepreciated replacement cost (URC) per bed limit."
20	**Property rate calculation under fair rental value system.** Creates § 256R.265.
	Subd. 1. Square feet per bed limit. Specifies the calculation for the square feet per bed limit.
	Subd. 2. Total URC limit. Specifies the calculation for the total URC limit.
	Subd. 3. Calculation of total property rate. Specifies the calculation for the total property rate.
21	**Interim and settle up total operating and external fixed cost payment rates.** Creates § 256R.27.
	Subd. 1. Generally. Paragraph (a) requires a newly constructed nursing facility or a nursing facility with a capacity increase of 50 percent or more to receive an interim total operating rate payment and settle up total operating cost payment. Paragraph (b) requires a nursing facility to submit a written application to the commissioner to receive an interim total operating payment rate. Paragraph (c) specifies the effective date of the interim total operating payment rate and prohibits an interim total operating payment rate from being in effect for more than 17 months. Paragraph (d) specifies the time period during which the nursing facility must receive the interim total operating payment rate. Paragraph (e) specifies the time period during which the settle up total operating cost payment rate is in effect.

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Paragraph (f) specifies the manner in which the total operating payment rate and the external fixed costs payment rate must be determined during the 15-month period following the settle up reporting period.

Paragraph (g) specifies the manner in which the total operating payment rate and the external fixed costs payment rate must be determined following the time period under paragraph (f).

Paragraph (h) requires the commissioner to determine interim total operating cost payment rates and settle up total operating cost payment rates for a newly constructed nursing facility or a nursing facility with a capacity increase of 50 percent or more.

Subd. 2. Determination of interim operating and external fixed cost payment rate. Paragraph (a) requires a nursing facility to submit an interim cost report for the reporting year in which the nursing facility plans to begin operation. Specifies the information that must be included in the interim cost report. Specifies the calculation to determine the anticipated interim standardized days and resident days for the reporting period.

Paragraph (b) specifies the calculation for the interim total operating cost payment rate.

Subd. 3. Determination of settle up operating and external fixed cost payment rate. Paragraphs (a) and (b) specify the time period for which a facility must file settle up cost reports.

Paragraph (c) specifies the calculation for the settle up total operating cost payment rate.

22 **Rate adjustment for private rooms for medical necessity.**

Amends § 256R.44. Reduces the amount paid for a private room for medical necessity and removes a cross-reference that is proposed to be repealed. Provides a January 1, 2020, effective date.

23 **Rate adjustment for critical access nursing facilities.**

Amends § 256R.47. Extends the suspension of this provision to December 31, 2023.

24 **Determination of rate adjustment.**

Amends § 256R.50, subd. 6. Limits bed relocation rate adjustments to three full years following the effective date of the rate adjustment. Sunsets this subdivision when the final rate adjustment determined under this subdivision expires.

Section	Description
25	**Direction to commissioner; moratorium exception funding.** In fiscal year 2019, allows the commissioner of human services to approve moratorium exception projects for which the full annualized share of MA costs does not exceed $1,500,000 plus any carryover of previous appropriations for this purpose. Provides an immediate effective date.
26	**Repealer.** Paragraph (a) repeals Minn. Stat. §§ 144A.071, subd. 4d (consolidation of nursing facilities); 256R.40 (nursing facility voluntary closure); and 256R.41 (single-bed room incentive) effective July 1, 2019. Paragraph (b) repeals Minn. Stat. §§ 256B.431, subds. 3a (property-related costs after July 1, 1985), 3f (property costs after July 1, 1988), 3g (property costs after July 1, 1990, for certain facilities), 3i (property costs for the rate year beginning July 1, 1990), 13 (hold harmless property-related rates), 15 (capital repair and replacement cost reporting and rate determination), 17 (special provisions for moratorium exceptions), 17a (allowable interest expense), 17c (replacement-costs-new per bed limit), 17d (determination of rental per diem for total replacement projects), 17e (replacement-costs-new per bed limit effective October 1, 2007), 18 (updating appraisals, additions, and replacements), 21 (indexing thresholds), 22 (changes to nursing facility reimbursement), 30 (bed layaway and delicensure), and 45 (rate adjustments for some moratorium exception projects); 256B.434, subds. 4 (alternate rates for nursing facilities), 4f (construction project rate adjustments effective October 1, 2006), 4i (construction project rate adjustments for certain nursing facilities), and 4j (construction project rate increase for certain nursing facilities); and 256R.36 (hold harmless), and Minn. Rules, parts 9549.0057 (determination of interim and settle up operating cost payment rates); and 9549.0060, subps. 4, 5, 6, 7, 10, 11, and 14 (determination of the property-related payment rate) effective January 1, 2020.

Article 5: Disability Services

This article modernizes the Telecommunications Access Minnesota Program, requires early intensive developmental and behavioral intervention providers to receive background studies, modifies home and community-based services standards, modifies day services, modernizes the purchase of health care coverage for people living with HIV and aligns the program with the federal Affordable Care Act, modifies the Disability Waiver Rate System, modifies electronic visit verification, and makes various other changes.

Section	Description
1	**Deaf.** Amends § 237.50, subd. 4a. Modifies terminology in the definition of "deaf" under the telecommunications chapter of statutes. Provides a July 1, 2019, effective date and requires implementation by October 1, 2019.
2	**Discounted telecommunications services.** Amends § 237.50, by adding subd. 4c. Defines "discounted telecommunications services." Provides a July 1, 2019, effective date and requires implementation by October 1, 2019.
3	**Hard-of-hearing.** Amends § 237.50, subd. 6a. Modifies the definition of "hard-of-hearing." Provides a July 1, 2019, effective date and requires implementation by October 1, 2019.
4	**Interconnectivity product.** Amends § 237.50, by adding subd. 6b. Defines "interconnectivity product." Provides a July 1, 2019, effective date and requires implementation by October 1, 2019.
5	**Multifunctional safety device.** Amends § 237.50, by adding subd. 6c. Defines "multifunctional safety device." Provides a July 1, 2019, effective date and requires implementation by October 1, 2019.
6	**Telecommunications device.** Amends § 237.50, subd. 10a. Modifies terminology in the definition of "telecommunications device." Provides a July 1, 2019, effective date and requires implementation by October 1, 2019.
7	**Telecommunications relay services.** Amends § 237.50, subd. 11. Modifies terminology in the definition of "telecommunications relay services." Provides a July 1, 2019, effective date and requires implementation by October 1, 2019.

Section	Description
8	**Creation.** Amends § 237.51, subd. 1. Expands the devices distributed through the Telecommunications Access Minnesota Program to include interconnectivity products and multifunctional safety devices. Provides a July 1, 2019, effective date and requires implementation by October 1, 2019.
9	**Commissioner of human services duties.** Amends § 237.51, subd. 5a. Modifies the commissioner's duties under the Telecommunications Access Minnesota Program by making conforming changes and requiring the commissioner to assist a person with completing an application for discounted telecommunications services. Provides a July 1, 2019, effective date and requires implementation by October 1, 2019.
10	**Expenditures.** Amends § 237.52, subd. 5. Makes conforming changes. Provides a July 1, 2019, effective date and requires implementation by October 1, 2019.
11	**Telecommunications device, interconnectivity products, and multifunctional safety devices.** Amends § 237.53. Makes conforming changes related to expanding the types of devices distributed by the program and requires the commissioner of human services to assess the person's telecommunications needs and provide information about assistive communications devices and products and where a person might obtain or purchase such devices. Lists assistive communications devices and products. Requires the commissioner of human services to assist a person who is applying for telecommunications devices and products in applying for discounted telecommunications services. Provides a July 1, 2019, effective date and requires implementation by October 1, 2019.
12	**Early intensive developmental and behavioral intervention providers.** Amends § 245C.03, by adding subd. 13. Requires the commissioner to conduct background studies when initiated by an early intensive developmental and behavioral intervention provider.
13	**Early intensive developmental and behavioral intervention providers.** Amends § 245C.10, by adding subd. 14. Requires the commissioner to recover the cost of background studies for early intensive developmental and behavioral intervention providers through a fee of no more than $32 per study charged to the enrolled agency. Appropriates fees collected to the commissioner for the purposes of conducting background studies.
14	**Applicability.** Amends § 245D.03, subd. 1. Modifies the lists of basic support services and intensive support services under the statutory chapter governing Home and Community-Based

Section	Description
	Services Standards to include additional services. Provides a January 1, 2021, effective date, or upon federal approval, whichever is later. Requires the commissioner of human services to notify the revisor when federal approval is obtained.
15	**Requirements for intensive support services.** Amends § 245D.071, subd. 1. Modifies the list of intensive support services exempt from certain requirements. Provides an immediate effective date.
16	**Integrated community supports; setting capacity report.** Creates § 245D.12. Paragraph (a) requires integrated community support license holders to submit a setting capacity report to the commissioner to ensure the service delivery location meets home and community-based services setting requirements. Paragraph (b) lists the information the report must include. Paragraph (c) allows only one license holder to deliver integrated community supports at a multifamily housing building. Makes this section effective upon the date of federal approval. Requires the commissioner of human services to notify the revisor when federal approval is obtained.
17	**Reimbursement.** Amends § 252.275, subd. 3. Reduces the county share for semi-independent living services from 30 percent to 15 percent. Provides a July 1, 2019, effective date.
18	**Day services for adults with disabilities.** Amends § 252.41, subd. 3. Modifies the definition of "day services for adults with disabilities." Provides a January 1, 2021, effective date, or upon federal approval, whichever is later. Requires the commissioner of human services to notify the revisor when federal approval is obtained.
19	**Independence.** Amends § 252.41, subd. 4. Modifies the definition of "independence" under the statute governing day services. Provides a January 1, 2021, effective date.
20	**Integration.** Amends § 252.41, subd. 5. Modifies the definition of "integration." Provides a January 1, 2021, effective date.
21	**Productivity.** Amends § 252.41, subd. 6. Modifies the definition of "productivity." Provides a January 1, 2021, effective date.

Section	Description
22	**Regional center.** Amends § 252.41, subd. 7. Modifies the definition of "regional center." Provides a January 1, 2021, effective date.
23	**Vendor.** Amends § 252.41, subd. 9. Modifies the definition of "vendor." Provides a January 1, 2021, effective date.
24	**Services principles.** Amends § 252.42. Updates terminology, expands services to all persons with disabilities (currently services are limited to persons with developmental disabilities). Provides a January 1, 2021, effective date.
25	**Commissioner's duties.** Amends § 252.43. Updates terminology, makes technical changes. Provides a January 1, 2021, effective date.
26	**Lead agency board responsibilities.** Amends § 252.44. Updates terminology, specifies the authority under which case management services are provided, removes obsolete language. Provides a January 1, 2021, effective date.
27	**Vendor's duties.** Amends § 252.45. Updates terminology and cross-references. Provides a January 1, 2021, effective date.
28	**Purchase of health care coverage for people living with HIV.** Amends § 256.9365. **Subd. 1. Program established.** Expands the program to include cost sharing for prescriptions, including co-payments, deductibles, and coinsurance. Prohibits the commissioner from paying for the portion of a premium that is paid by the individual's employer. **Subd. 2. Eligibility requirements.** Modifies eligibility requirements for the program. **Subd. 3. Cost-effective coverage.** Removes obsolete language.
29	**Elderly waiver cost limits.** Amends § 256B.0915, subd. 3a. Adds paragraph (f), which requires the commissioner to approve exceptions to the monthly case mix budget cap to pay for an enhanced rate for

Section	Description
	PCA services. Limits the amount of the exception and requires the exception to be reapproved on an annual basis at the time of a participant's annual reassessment. Provides a July 1, 2019, effective date, or upon federal approval, whichever is later. Requires the commissioner of human services to notify the revisor when federal approval is obtained.
30	**Background studies.** Amends § 256B.0949, by adding subd. 16a. Specifies background study requirements are met by an early intensive developmental and behavioral intervention services agency through the commissioner's NETStudy system.
31	**Definitions.** Amends § 256B.4914, subd. 2. Defines "direct care staff" and modifies the definition of "unit of service" under the disability waiver rates system (DWRS).
32	**Applicable services.** Amends § 256B.4914, subd. 3. Updates terminology and alphabetizes the list of applicable services under the DWRS. Provides a January 1, 2021, effective date, or upon federal approval, whichever is later. Requires the commissioner of human services to notify the revisor when federal approval is obtained.
33	**Base wage index and standard component value.** Amends § 256B.4914, subd. 5. Paragraph (a) modifies the base wage index by adding adult day services, updating terminology, and removing independent living skills specialist staff and supported employment staff. Paragraphs (b) and (c) add a competitive workforce factor of 4.7 percent to provide increased compensation to direct care staff, require the commissioner to report to the legislature with an analysis of the competitive workforce factor, and list the information that must be included in the report. Limits recommended changes to the competitive workforce factor. Paragraphs (d) and (f) modify certain component values. Paragraph (g) establishes component values for adult day services. Paragraphs (k) and (l) remove obsolete language, require the commissioner to use lagged wage data and Consumer Price Index data, and change the frequency of automatic adjustments to the base wage index and certain component values from once every five years to once every two years. Paragraph (m) removes the 2014 and 2015 out-of-framework adjustments from service rates calculated under the DWRS.

Section	Description
	Paragraph (n) removes any rate adjustments applied to the service rates calculated outside of the DWRS rate methodology from rate calculations upon implementation of automatic inflation adjustments under this section. Paragraph (p) requires the commissioner to use the most recently available data prior to a scheduled update if the Bureau of Labor Statistics occupational codes used to calculate the base wage index are revised. Provides a January 1, 2021, effective date, or upon federal approval, whichever is later, except paragraph (b) is effective January 1, 2020, or upon federal approval, whichever is later, and the removal of supported employment staff is effective September 1, 2019. Requires the commissioner of human services to notify the revisor when federal approval is obtained.
34	**Payments for residential support services.** Amends § 256B.4914, subd. 6. Paragraphs (a) and (b) specify the services included under residential support services and specify the payment calculation for corporate residential support services. Paragraph (d) specifies the calculation for integrated community support services. Paragraph (e) specifies the total rate calculation. Paragraph (f) updates terminology and specifies that customized living is adjusted for regional differences in the cost of providing services. Removes obsolete language. Provides a January 1, 2021, effective date, or upon federal approval, whichever is later. Requires the commissioner of human services to notify the revisor when federal approval is obtained.
35	**Payments for day programs.** Amends § 256B.4914, subd. 7. Updates terminology and services. Provides a January 1, 2021, effective date, or upon federal approval, whichever is later. Requires the commissioner of human services to notify the revisor when federal approval is obtained.
36	**Payments for unit-based services with programming.** Amends § 256B.4914, subd. 8. Updates terminology and makes technical changes. Specifies the calculation for employment exploration services provided in a shared manner. Removes obsolete language. Provides a January 1, 2021, effective date, or upon federal approval, whichever is later. Requires the commissioner of human services to notify the revisor when federal approval is obtained.

Section	Description
37	**Payments for unit-based services without programming.** Amends § 256B.4914, subd. 9. Adds individualized home supports to unit-based services without programming and specifies the calculation for individualized home supports provided in a shared manner. Provides a January 1, 2021, effective date, or upon federal approval, whichever is later. Requires the commissioner of human services to notify the revisor when federal approval is obtained.
38	**Updating payment values and additional information.** Amends § 256B.4914, subd. 10. Removes obsolete language, requires the commissioner to review direct care workforce labor market measures and different competitive workforce factors by service. Modifies the frequency of adjustments to the regional adjustment factors. Requires the commissioner to develop a new rate methodology for certain residential services and submit recommendations to the legislature by January 1, 2020. Requires the commissioner to study value-based payment strategies for fee-for-service home and community-based services and submit a report to the legislature by October 1, 2020, with recommended strategies to improve the quality, efficiency, and effectiveness of services. Provides an immediate effective date.
39	**Reporting and analysis of cost data.** Amends § 256B.4914, subd. 10a. Paragraph (f) requires providers who receive the competitive workforce factor to prepare a written distribution plan for the additional revenue received through the competitive workforce factor, make the plan available and accessible to all direct care staff, and upon request, submit the plan to the commissioner. Paragraph (g) requires providers enrolled to provide services with rates determined under the DWRS to submit specified labor market data to the commissioner annually on or before November 1. Paragraph (h) requires the commissioner to publish annual reports on provider and state-level labor market data. Paragraph (i) requires the commissioner to temporarily suspend payments to a provider if the data requested is not received 90 days after the required submission date. Requires withheld payments to be made once data is received by the commissioner. Provides an immediate effective date, except paragraph (g) is effective November 1, 2019, and paragraph (h) is effective February 1, 2020.
40	**Eligibility.** Amends § 256B.85, subd. 3. Specifies a pregnant woman eligible under MA is eligible for community first services and supports (CFSS) without federal financial participation if the woman meets certain criteria. Provides an immediate effective date.

Section	Description
41	**Electronic visit verification.** Amends Laws 2017, 1st Spec. Sess. ch. 6, art. 3, § 49. **Subd. 1. Documentation; establishment.** Modifies terminology. **Subd. 2. Definitions.** Modifies terminology and expands the definition of "service." **Subd. 3. Requirements.** Modifies terminology and removes obsolete language. Requires the commissioner to make a state-selected electronic visit verification system available to service providers. **Subd. 3a. Provider requirements.** Specifies provider requirements related to selecting an electronic visit verification system and complying with requirements and the implementation date established by the commissioner. **Subd. 4. Legislative report.** Removes obsolete language.
42	**Direction to commissioner; skilled nurse visit rates.** Requires the commissioner of human services to ensure that skilled nurse visits reimbursed under MA are properly coded.
43	**Direction to commissioner; interagency agreements.** Requires the Department of Commerce, Public Utilities Commission, and Department of Human Services to amend all interagency agreements necessary to implement the changes to the Telecommunications Access Minnesota Program by October 1, 2019.
44	**Direction to commissioner; federal authority for reconfigured waiver services.** Requires the commissioner of human services to seek necessary federal authority to implement new and reconfigured waiver services and to notify the revisor when federal approval is obtained and when new services are fully implemented.
45	**Disability waiver reconfiguration.** **Subd. 1. Intent.** Specifies it is the intent of the legislature to reform the MA waiver programs for people with disabilities to simplify administration of the programs, encourage person-centered supports, enhance each person's personal authority over the person's service choice, align benefits across waivers, encourage equity across programs and populations, and promote long-term sustainability of needed services. **Subd. 2. Report.** By January 15, 2021, requires the commissioner to submit a report to the legislature on any necessary waivers, state plan amendments, requests for new funding or realignment of existing funds, any changes to

Section	Description
	statutes or rule, and any other federal authority necessary to implement the disability waiver reconfiguration. **Subd. 3. Proposal.** By January 15, 2021, requires the commissioner to develop a proposal to reconfigure the MA disability waivers and specifies the information that must be included in the proposal. Provides an immediate effective date.
46	**Individual providers of direct support services.** Ratifies the labor agreement between the state of Minnesota and SEIU Healthcare Minnesota.
47	**Rate increase for direct support services providers workforce negotiations.** Requires the commissioner of human services to increase reimbursement rates, individual budgets, grants, or allocations by 2.37 percent for services provided on or after July 1, 2019, to implement the minimum hourly wage, holiday, enhanced rate, and paid time off provisions of the labor agreement between the state of Minnesota and SEIU Healthcare Minnesota.
48	**Repealer.** Repeals Minn. Stat. §§ 256B.0705 (PCA; mandated service verification); 252.431 (supported employment services; departmental duties; coordination); 252.451 (business agreements; support and supervision of persons with disabilities); and 252.41, subd. 8 (supported employment).

Article 6: Chemical and Mental Health

This article modifies provisions related to payment for substance use disorder treatment services, waiver eligibility, and housing support eligibility, and modifies and establishes new requirements related to school-linked mental health grants, psychiatric residential treatment facility services, certified community behavioral health clinics, and the transition to community initiative.

Section	Description
1	**Establishment and authority.** Amends § 245.4889, subd. 1. Adds reference to new section detailing school-linked mental health grants; specifies that children's mental health grantees must obtain all available third-party funding and reimbursement sources. Makes this section effective the day following final enactment.

Section	Description
2	**School-linked mental health grants.** Proposes coding for § 245.4901. **Subd. 1. Establishment.** Directs the commissioner of human services to establish a school-linked mental health grant program. **Subd. 2. Eligible applicants.** Specifies that grant applicants must be: (1) certified as a mental health center or clinic; (2) a community mental health center; (3) an Indian health service facility or facility owned and operated by a tribe; (4) a provider of children's therapeutic services and supports; or (5) enrolled in MA as a mental health or substance use disorder provider agency, with certain staff requirements. **Subd. 3. Allowable grant activities and related expenses.** (a) Lists allowable grant activities and services, and related expenses. (b) Requires grantees to obtain all available third-party reimbursement sources, as a condition of receiving grant funds, excluding public schools. Requires grantees to serve students regardless of health coverage or ability to pay. **Subd. 4. Data collection and outcome measurement.** Requires grantees to provide data to the commissioner to evaluate the program's effectiveness. Makes this section effective the day following final enactment.
3	**Certified community behavioral health clinics (CCBHC).** Amends § 245.735, subd. 3. (a) Removes reference to the prospective payment system. Adds licensed alcohol and drug counselors to clinic staff for CCBHC services. Adds substance use to CCBHC services. Removes requirement for a CCBHC to be certified to provide integrated treatment for co-occurring mental illness and substance use disorders. Adds requirement for CCBHCs to comply with peer services standards under relevant statutes, if the CCBHC provides peer services.

Section	Description
	Modifies terminology throughout. (d) Allows the commissioner to grant a variance for a CCBHC that is certified but not approved for prospective payment, if the variance would not increase the state share of costs. Removes paragraphs (f), (g), and (h) relating to prospective payments, federal approval and financial participation, and limitations on CCBHC certifications. Makes this section effective the day following final enactment.
4	**Chemical dependency treatment allocation.** Amends § 254B.02, subd. 1. Removes language allowing transfer of funds from the chemical dependency fund for administrative purposes. Makes this section effective July 1, 2019.
5	**Chemical dependency fund payment.** Amends § 254B.03, subd. 2. Adds cross-reference to vendor requirements for payment from the chemical dependency fund for room and board costs. Makes this section effective July 1, 2019.
6	**Division of costs.** Amends § 254B.03, subd. 4. Updates terminology; adds chemical dependency room and board services exception to county share cost percentage. Removes obsolete language. Makes this section effective July 1, 2019.
7	**Eligibility.** Amends § 254B.04, subd. 1. Modifies eligibility for chemical dependency treatment fund services. Specifies that MA enrollees are eligible for substance use disorder treatment room and board services. Makes this section effective July 1, 2019.
8	**Room and board provider requirements.** Amends § 254B.05, subd. 1a. Specifies that intensive residential treatment services (IRTS) or residential crisis services providers are eligible vendors of room and board, and provides exemption. Makes this section effective September 1, 2019.
9	**State collections.** Amends § 254B.06, subd. 1. Removes language requiring the commissioner to deposit a percentage of state funds to be used for chemical dependency consolidated treatment fund operating costs. Makes this section effective July 1, 2019.

Section	Description
10	**Allocation of collections.** Amends § 254B.06, subd. 2. Removes requirement for the commissioner to allocate all federal financial participation collections to a special revenue account. Removes obsolete language. Makes this section effective July 1, 2019.
11	**Transition to community initiative.** Amends § 256.478. **Subd. 1. Eligibility.** Specifies criteria for eligibility for the transition to community initiative, to assist individuals with transitioning from a state-operated treatment center or hospital. **Subd. 2. Transition grants.** Requires the commissioner to make transition to community grants available to individuals who meet eligibility criteria. Makes this section effective July 1, 2019.
12	**Certified community behavioral health clinic services.** Amends § 256B.0625, by adding subd. 5m. (a) Specifies that medical assistance covers CCBHC services that meet the requirements of section 245.735, subdivision 3. (b) Directs the commissioner to establish standards and methodologies for a prospective payment system for medical assistance payments to CCBHCs. (c) Allows the commissioner to limit the number of CCBHCs for the prospective payment system to ensure that claims do not exceed the money appropriated. Requires the commissioner to prioritize CCBHCs that meet criteria listed in this paragraph, in the order listed. (d) Specifies that the prospective payment system must continue to be based on federal instructions for the CCBHC demonstration. Provides exceptions to the federal instructions for the prospective payment system. Makes this section effective July 1, 2019, or upon federal approval, whichever is later.
13	**Other medical or remedial care.** Amends § 256B.0625, subd. 24. Removes provision excluding licensed substance use disorder treatment programs from subdivision specifying that MA covers other medical or remedial care. Removes provision requiring these services to be paid from the chemical dependency treatment fund. Makes this section effective July 1, 2019.

Section	Description
14	**Substance use disorder services.** Amends § 256B.0625, by adding subd. 24a. Specifies that MA covers substance use disorder treatment services, except for room and board. Makes this section effective July 1, 2019.
15	**Psychiatric residential treatment facility (PRTF) services for persons younger than 21 years of age.** Amends § 256B.0625, subd. 45a. Increases allowed beds for PRTF services from 150 to 300; requires the commissioner to prioritize PRTF programs that demonstrate capacity to serve children and youth with specified behaviors. Makes this section effective July 1, 2019.
16	**Payment for Part B Medicare crossover claims.** Amends § 256B.0625, subd. 57. Excludes CCBHCs subject to the new prospective payment system from the limitation on medical assistance payment for an enrollee's cost-sharing associated with Medicare Part B. Makes this section effective July 1, 2019, contingent upon federal approval.
17	**Cost limits for elderly waiver applicants who reside in a nursing facility or other eligible facility.** Amends § 256B.0915, subd. 3b. Removes obsolete language and makes conforming changes in paragraph (a). Paragraph (b) makes persons who meet the eligibility criteria for elderly waiver and a home and community-based transition grant eligible for a special monthly budget limit under the elderly waiver program. Requires the special monthly budget limit to be adjusted annually and specifies the manner in which the special monthly budget limit must be reduced for persons using consumer-directed community supports. Paragraph (c) allows the commissioner to provide an additional payment for documented costs between a threshold determined by the commissioner and the special monthly budget limit to a managed care plan for elderly waiver services for persons who are: (1) eligible for the special monthly budget limit; and (2) enrolled in a managed care plan that provides elderly waiver services. Paragraph (d) allows service rate limits for adult foster care and customized living services to exceed the service rate limits under certain circumstances, providing that the total cost for all services does not exceed the monthly conversion or the special monthly budget limit. Requires service rates to be established using tools provided by the commissioner. Makes this section effective upon federal approval. Requires the commissioner of human services to notify the revisor when federal approval is obtained.

Section	Description
18	**Waiver allocations for transition populations.** Amends § 256B.092, subd. 13. Modifies transition developmental disability waiver language to incorporate the eligibility criteria established in section 256.478. Makes this section effective July 1, 2019.
19	**Waiver allocations for transition populations.** Amends § 256B.49, subd. 24. Modifies transition brain injury waiver language to incorporate the eligibility criteria established in section 256.478. Makes this section effective July 1, 2019.
20	**Individual eligibility requirements.** Amends § 256I.04, subd. 1. Specifies that an individual is eligible for housing support payments for up to three months if the individual lacks a fixed, adequate nighttime residence upon discharge from a residential behavioral health program. Makes this section effective September 1, 2019.
21	**Required services.** Amends § 256I.04, subd. 2f. Requires providers serving participants discharged from a residential behavioral health program to assist participants with applying for continuing housing support payments. Makes this section effective September 1, 2019.
22	**Amount of housing support payment.** Amends § 256I.06, subd. 8. Modifies cross-reference. Makes this section effective September 1, 2019.
23	**Effective date.** Amends Laws 2017, 1st Spec. Sess. ch. 6, § 71, the effective date. Extends provision governing state-only MA funding for mental health covered services provided in children's residential facilities that have been determined by the federal Centers for Medicare and Medicaid Services to be institutions for mental diseases, indefinitely. Makes this section effective April 30, 2019.
24	**Effective date.** Amends Laws 2017, 1st Spec. Sess. ch. 6, § 72, the effective date. Extends provision governing state-only MA payment rates for mental health services provided in children's residential facilities that have been determined by the federal Centers for Medicare and Medicaid Services to be institutions for mental diseases, indefinitely. Makes this section effective April 30, 2019.

Section	Description
25	**Direction to commissioner; improving school-linked mental health grant program.** Requires the commissioner to collaborate with the commissioner of education and other entities to assess the school-linked mental health grant program and make recommendations for improvement. Specifies what the assessment must include. Requires a report to the legislature. Makes this section effective the day following final enactment.
26	**Repealer.** Repeals § 254B.03, subd. 4a, relating to division of costs for chemical dependency services on or after October 1, 2008.

Article 7: Uniform Service Standards

This article simplifies and streamlines standards for publicly funded mental health services, creating a new chapter, 245I, the Mental Health Uniform Service Standards Act. Chapter 245I establishes common requirements for provider qualifications, administrative procedures, treatment planning, and conducting diagnostic assessments. The article also repeals outdated rules and statutes, codifies relevant rules in statute, and makes conforming cross-reference changes throughout statutes.

Sections 74 to 79 make changes to Mobile Crisis Response services, clarifying situations for mobile crisis team response, prioritizing certain calls and requests, and modifying requirements so a crisis team can gather information from a third party at the scene to establish a need for services.

Additionally, in section 131**,** this article directs the commissioner of human services, in collaboration with stakeholders, to develop a plan for a unified, comprehensive licensing structure for all publicly funded mental health services, prioritizing program integrity, the welfare of persons served, improved integration of mental health and substance use disorder treatment services, and the reduction of administrative burden on providers.

Article 8: Health Care

This article contains provisions related to the medical assistance and MinnesotaCare programs.

Section	Description
1	**Classifications.** Amends § 13.69, subd. 1. Requires the Department of Public Safety to provide the last four digits of the Social Security number to the Department of Human Services for

Section	Description
	recovery of Minnesota health care program benefits paid. Provides a July 1, 2019, effective date.
2	**Transfers.** Amends § 16A.724, subd. 2. Makes a conforming change related to another section in the bill (adding § 256B.688) which codifies a rider allowing a transfer from the health care access fund to the general fund.
3	**Controlling individual.** Amends § 245A.02, subd. 5a. Updates a cross-reference.
4	**Program management and oversight.** Amends § 245D.081, subd. 3. Updates a cross-reference and makes a technical edit.
5	**Incentive program.** Amends § 256.962, subd. 5. Increases from $25 to $70 the application assistance bonus paid to navigators for enrolling individuals in MinnesotaCare or MA. Provides a July 1, 2019, effective date.
6	**Disproportionate numbers of low-income patients served.** Amends § 256.969, subd. 9. Requires the commissioner to establish an additional payment adjustment for hospitals that provide high levels of administering high-cost drugs to enrollees in fee-for-service MA. Requires the commissioner to consider fee-for-service MA utilization rates and payments for drugs purchased through the 340B program and administered to fee-for-service enrollees. If the adjustment exceeds a hospital's specific disproportionate share hospital limit, requires the commissioner to make a payment to the hospital that equals the nonfederal share of the excess amount. Limits the total nonfederal share of adjustments to $1.5 million. States that the section is effective for discharges on or after April 1, 2019.
7	**Provider enrollment.** Amends § 256B.04, subd. 21. (a) Requires the commissioner to enroll providers and conduct screening activities as required by federal regulations and specifies related requirements. (b) Requires the commissioner to revalidate each provider at least once every five years, and personal care assistance agencies once every three years. (c) Specifies criteria for conducting revalidations.

Section	Description
	(d) Allows the commissioner to suspend a provider's ability to bill, if a provider fails to comply with any individual provider requirement or condition of participation. Provides that suspension is not subject to an administrative appeal. (e) Requires all correspondence and notifications to be delivered electronically, or by first-class mail if a provider does not have a MN-ITS account and mailbox. States that this does not apply to communications related to background studies. Provides a July 1, 2019, effective date.
8	**Application fee.** Amends § 256B.04, subd. 22. Strikes language that is reinstated in section 256B.04, subdivision 21. Provides a July 1, 2019, effective date.
9	**Subsidized foster children.** Amends § 256B.055, subd. 2. Provides MA eligibility for children who are not eligible for Title IV-E assistance (federal payments for foster care) but are determined eligible for foster care or kinship assistance under chapter 256N. Provides a January 1, 2020, effective date.
10	**Asset limitations for certain individuals.** Amends § 256B.056, subd. 3. Provides that MA will disregard a designated employment incentives asset account when determining MA eligibility for a person who is age 65 or older. Allows such an account to be designated only by a person enrolled in MA as an employed person with a disability (MA-EPD) for a 24-consecutive month period. Strikes existing language which allows a higher asset disregard ($20,000 for an individual after exclusions) for persons formerly eligible under MA-EPD who turn 65 and seek MA eligibility as a person who is elderly, blind, or has a disability (an asset limit of $3,000 for a household of one/$6,000 for a household of two normally applies to this group). Specifies criteria for a designated employment incentives asset account. Provides a July 1, 2019, effective date.
11	**Drugs.** Amends § 256B.0625, subd. 13. Strikes language relating to the quantity of over-the-counter medications that may be dispensed. States that the section is effective April 1, 2019, or upon federal approval, whichever is later.
12	**Payment rates.** Amends § 256B.0625, subd. 13e. Amends § 256B.0625, subd. 13e. Makes a variety of changes to MA payment methods for outpatient prescription drugs. The changes made in paragraph (a) include: ▪ setting payment based on the ingredient cost of the drugs plus a professional dispensing fee

Section	Description

- defining usual and customary price
- setting the dispensing fee for drugs meeting the federal definition of "covered outpatient drugs" at $10.48 and specifying dispensing fees for other types of drugs
- requiring dispensing fees to be pro-rated based upon the quantity of a drug dispensed
- setting the ingredient cost for providers participating in the federal 340B program at the 340B ceiling price or the National Average Drug Acquisition Cost (NADAC), whichever is lower
- requiring the maximum allowable cost of a multisource drug to be comparable to the actual acquisition cost and no higher than the NADAC of the generic product (current law sets the maximum amount as that paid by third party payors with maximum allowable cost programs)

The amendment to paragraph (c) eliminates add-ons to the dispensing fee for certain drugs dispensed to long-term care facility residents using a unit dose blister card system.

The amendment to paragraph (d) sets the ingredient cost of a multisource drug at the NADAC of the generic product, or the maximum allowable cost established by the commissioner.

The amendment to paragraph (e) increases, from 20 to 28.6 percent, the discount from the payment rate for drugs obtained through the 340B program.

The amendment to paragraph (f) adds references to the maximum allowable cost and makes changes in terminology, in a provision of law dealing with specialty pharmacy products.

A new paragraph (h) requires the commissioner to contract with a vendor to conduct cost of dispensing surveys for Minnesota pharmacies. Specifies criteria for the survey. Requires the initial survey to be completed by January 1, 2021, and repeated every three years.

A new paragraph (i) requires the commissioner to increase the ingredient cost by two percent for prescription and nonprescription drugs subject to the MinnesotaCare wholesale distributor tax.

States that the section is effective April 1, 2019, or upon federal approval, whichever is later.

13 **Prior authorization.**

Amends § 256B.0625, subd. 13f. Eliminates the prohibition on use of prior authorization for certain antihemophilic factor drugs. Provides an immediate effective date.

Section	Description
14	**Transportation costs.** Amends § 256B.0625, subd. 17. Requires all nonemergency medical transportation drivers to be individually enrolled with the commissioner and reported on the claim as the individual providing the service. Removes language requiring consultation with the Minnesota Department of Transportation. Provides a July 1, 2019, effective date.
15	**Transportation services oversight.** Amends § 256B.0625, by adding subd. 17d. Requires the commissioner to contract with a vendor or dedicate staff to oversee providers of nonemergency medical transportation (NEMT) services. Provides a July 1, 2019, effective date.
16	**Transportation provider termination.** Amends § 256B.0625, by adding subd. 17e. Prohibits a terminated NEMT provider from enrolling as a NEMT provider for five years following termination. If the provider seeks reenrollment after the five-year period, requires the provider to be placed on a one-year probation, during which the commissioner shall complete unannounced site visits and request documentation to review compliance with program requirements. Provides an immediate effective date.
17	**Payment for Part B Medicare crossover claims.** Amends § 256B.0625, subd. 57. Exempts Indian Health Services from a provision that limits MA payment of an enrollee's Medicare Part B cost-sharing to the MA allowed amount, when the MA rate exceeds the amount paid by Medicare. Provides an immediate effective date.
18	**Grounds for sanctions against vendors.** Amends § 256B.064, subd. 1a. Allows the commissioner to impose sanctions against a pharmacy for failure to respond to a cost of dispensing survey. Provides an effective date of April 1, 2019.
19	**Requirements for provider enrollment of personal care assistance provider agencies.** Amends § 256B.0659, subd. 21. The amendment to paragraph (a) clarifies that personal care provider agencies must provide to the commissioner at the time of enrollment, reenrollment, and revalidation, bond coverage and other information for each business location. Also makes related changes. The amendment to paragraph (c) requires specified employees of personal care provider agencies to complete required training before submitting an application for agency enrollment. A new paragraph (d) requires all surety bonds, fidelity bonds, workers compensation insurance, and liability insurance to be maintained continuously, and specifies related requirements.

Section	Description
	Provides an immediate effective date.
20	**Provider tax rate increase.** Adds § 256B.688. Reinstates as codified law rider language that is stricken in section 23. (a) Requires the commissioner to increase payments to managed care plans by an amount equal to the cost increases to the plans from the elimination of: (1) the exemption from the one percent gross premiums tax for HMOs, nonprofit health services plans, and community integrated service networks; and (2) the exemption from the MinnesotaCare provider tax of gross revenues from MA and MinnesotaCare. (b) Requires the commissioner to increase by two percent fee-for-service payments under MA and MinnesotaCare for services subject to the MinnesotaCare provider taxes.
21	**Reimbursement for basic care services.** Amends § 256B.766, by adding subd. 2. (a) Sets payment rates for durable medical equipment, prosthetics, orthotics, or supplies that are not subject to a volume purchase contract, preferred product program, or competitively bid contract, and not reimbursed under paragraph (c), at the lesser of the submitted charges or the Medicare nonrural fee schedule amount, with no increase or decrease as provided in existing law. (b) For items for which Medicare has not established a payment amount, sets the payment rate at the lesser of submitted charges or an alternative payment methodology described in paragraphs (c) to (h), with no increase or decrease as provided in existing law. (c) Requires the alternate payment methodology rate to be calculated from paid claim lines. (d) States that the alternative payment methodology rate is the payment per unit of the claim lines, excluding the top and bottom ten percent of claim lines. (e) Requires the rate to be added to the commissioner's fee schedule and provides that the rate may be subject to the Medicare inflation or deflation factors. (f) Requires the commissioner to evaluate the alternative payment rate methodology for reasonableness, no more than once every three years, and allows the commissioner to recalculate the rate if certain criteria are met. (g) Bases payment on the provider's actual acquisition cost plus 20 percent, until sufficient data is available to calculate the alternative payment methodology rate.

Section	Description
	(h) Specifies the method the commissioner may use to establish a payment rate for goods or services procured under competitive bidding. The section also strikes existing payment language for durable medical equipment, prosthetics, orthotics, or supplies.
22	**Medicare payment limit.** Amends § 256B.767. Updates a cross-reference (an amendment is needed to correct this citation).
23	**Basic health care grants.** Amends Laws 2003, 1st Spec. Sess. ch. 14, art. 13C, § 2, subd. 6, as further amended. Strikes rider language that increased MA and MinnesotaCare managed care payment rates for costs related to elimination of the exemption from the insurance premium and MinnesotaCare provider taxes, and increased fee-for-service rates for payments related to the MinnesotaCare provider tax. (These provisions are reinstated in this bill as codified language in § 256B.688.)
24	**Repealer.** Repeals § 256B.0659, subd. 22 (annual review of information submitted by personal care assistance provider agencies).

Article 9: OneCare Buy-In

This bill directs the commissioner of human services to make various changes in the delivery of health care services. The bill requires the commissioner to:

- contract with a dental administrator for dental services to MA and MinnesotaCare recipients;
- provide a 54 percent MA rate increase for adult dental services, and an increase for children's dental services sufficient to equalize adult and children's rates, and eliminate the critical access dental provider payment rate and other higher payment rates;
- administer an outpatient prescription drug program for MA, MinnesotaCare, and the One-Care Buy-In program; and
- establish the OneCare Buy-In program through the MNsure website for persons not eligible for a government-sponsored program, that would include a platinum product in all areas of the state, and silver and gold products in certain rating areas, and seek necessary federal waivers.

Section	Description
1	**Definitions.** Amends § 62J.497, subd. 1. Excludes state and federal programs under chapters 256B (MA), 256L (MinnesotaCare), and 256T (OneCare Buy-in) from the definition of "group purchaser" used in the electronic prescription drug program.
2	**Administration of dental services.** Adds § 256B.0371. (a) Directs the commissioner of human services, effective January 1, 2022, to contract with up to two dental administrators, to administer dental services to all recipients of MA and MinnesotaCare. (b) Requires the administrator to provide administrative services, including but not limited to: 1) provider recruitment, contracting, and assistance; 2) recipient outreach and assistance; 3) utilization management and medical necessity review for dental services; 4) dental claims processing; 5) coordination with other services; 6) management of fraud and abuse; 7) monitoring access to dental services; 8) performance measurement; 9) quality improvement and evaluation requirements; and 10) management of third-party liability. (c) Sets payments to contracted dental providers at the rates established under § 256B.76 (the MA reimbursement rate). Provides a January 1, 2022, effective date.
3	**Reimbursement under other state health care programs.** Amends § 256B.0644. Requires a vendor of medical care under MA that dispenses outpatient prescription drugs to participate as a provider or contractor in MinnesotaCare, as a condition of participating as an MA provider. Provides a January 1, 2022, effective date.
4	**Prescription drugs.** Amends § 256B.69, subd. 6d. Allows the commissioner to exclude coverage for prescription drugs from managed care contracts. Strikes a reference to managed care plans administering a prescription drug benefit under MA. Provides a January 1, 2022, effective date.

Section	Description
5	**Dental reimbursement.** Amends § 256B.76, subd. 2. Sunsets, effective January 1, 2022, a 9.65 percent rate increase for dental services provided outside of the seven-county metropolitan area and a 23.8 percent increase for dental services provided to children. Effective January 1, 2022, increases MA dental payment rates by 54 percent. States that this increase does not apply to state-operated dental clinics, federally qualified health centers, rural health centers, or Indian health centers. (This provision has the effect of setting MinnesotaCare dental payment rates at this level, since MinnesotaCare pays providers at the MA rate unless otherwise specified.)
6	**Critical access dental providers.** Amends § 256B.76, subd. 4. Sunsets, effective January 1, 2022, the 37.5 percent MA rate increase paid to critical access dental providers.
7	**Outpatient prescription drugs.** Amends § 256L.03, by adding subd. 7. States that outpatient prescription drugs for all MinnesotaCare enrollees are covered according to § 256L.30. Provides a January 1, 2022, effective date.
8	**Critical access dental providers.** Amends § 256L.11, subd. 7. Sunsets, effective January 1, 2022, the 20 percent MinnesotaCare rate increase paid to critical access dental providers.
9	**Outpatient prescription drugs.** Adds § 256L.30. **Subd. 1. Establishment of program.** Requires the commissioner to administer and oversee the outpatient prescription drug program for MinnesotaCare. Prohibits the commissioner from including the outpatient pharmacy benefit in a contract with a public or private entity. **Subd. 2. Covered outpatient prescription drugs.** (a) Requires the commissioner, in consultation with the drug formulary committee, to establish an outpatient prescription drug formulary for MinnesotaCare that satisfies the federal essential health benefit requirements. Allows the commissioner to modify the formulary after consulting with the formulary committee and providing for public notice and comment. Exempts the establishment of the formulary from rulemaking. Directs the commissioner to make the formulary available to the public on the agency website.

Section	Description
	(b) Requires the formulary to contain at least one drug in every U.S. Pharmacopeia category and class or the same number of drugs in each category and class as the essential health benefit benchmark plan, whichever is greater. (c) Allows the commissioner to negotiate drug rebates or discounts directly with a drug manufacturer to place a drug on the formulary. Also allows negotiation of rebates or discounts through a contract with a vendor. (d) Allows the commissioner to use prior authorization, and allows the formulary committee to recommend drugs for prior authorization. Allows the commissioner to request that the committee review a drug for prior authorization. (e) Specifies procedures to be followed by the commissioner before requiring prior authorization for a drug. (f) Allows the commissioner to automatically require prior authorization for up to 180 days for any drug approved by the Food and Drug Administration after July 1, 2019. Specifies related criteria. (g) Allows the commissioner to require prior authorization before nonformulary drugs are eligible for payment. (h) Requires prior authorization requests to be processed according to federal regulations on essential health benefits and prescription drugs. **Subd. 3. Pharmacy provider participation.** (a) Requires pharmacies participating in MA to participate as a provider in the MinnesotaCare outpatient prescription drug program. (b) Prohibits a pharmacy from refusing services to an enrollee, unless specified conditions apply. **Subd. 4. Covered outpatient prescription drug reimbursement rate.** (a) Specifies the basis for determining the amount of payment for prescription drugs. (b) Specifies the basis for determining the amount of payment for a pharmacy that acquires drugs through the 340B Drug Pricing Program. (c) Defines the usual and customary price for purposes of the subdivision. Provides a January 1, 2022, effective date.
10	**Purpose.** Adds § 256T.01. Provides a purpose statement for the OneCare Buy-In.

Section	Description
11	**Definitions.** Adds § 256T.02. Defines the following terms: commissioner, department, essential health benefits, individual market, and MNsure website. Provides an immediate effective date.
12	**OneCare Buy-in.** Adds § 256T.03. **Subd. 1. Establishment.** (a) Requires the commissioner of human services to establish a program to offer products developed for the OneCare Buy-In through the MNsure website. (b) Directs the commissioner, in collaboration with the commissioner of commerce and MNsure board, to: 1) establish a cost allocation methodology to reimburse MNsure operations in lieu of the premium withhold; 2) implement mechanisms for financial sustainability and mitigate adverse financial impacts; and 3) coordinate eligibility, coverage, and provider networks to ensure, to the extent possible, continuity of care between MA, MinnesotaCare, and the OneCare Buy-in. (c) States that the buy-in shall be considered a public health care program for purposes of chapter 62V, and the MinnesotaCare program for purposes of state health care program participation requirements. (d) States that DHS is deemed to be certified as an HMO, and in compliance with state laws that apply to HMOs. Gives the commissioner the authority to accept and expend federal funds. **Subd. 2. Premium administration and payment.** (a) Requires the commissioner to annually establish a per-enrollee monthly premium rate, and to publish the rate by August 1 of each year. (b) Requires premium administration under the buy-in to be consistent with federal requirements under the Affordable Care Act. Requires premium rates to be established in accordance with § 62A.65, subd. 3 (premium rate restrictions). **Subd. 3. Rates to providers.** Requires provider payment rates to be targeted to the current MinnesotaCare rates, plus the aggregate difference between those rates and Medicare rates. Provides that the aggregate must not consider services that receive a Medicare encounter payment.

Section	Description

Subd. 4. Reserve and other financial requirements. Establishes a OneCare Buy-In reserve account and requires enrollee premiums to be deposited into the account. Specifies related requirements.

Subd. 5. Covered benefits. Requires each health plan established under this chapter to include the essential health benefits under the ACA, dental benefits as provided under MA for adults, and coverage of eyeglasses as provided in Minnesota rules. Allows a health plan to include other services covered under MinnesotaCare.

Subd. 6. Third-party administrator. (a) Allows the commissioner to enter into a contract with a third-party administrator to perform the operational management of the buy-in. Specifies duties of the administrator.

(b) Requires the solicitation of vendors to serve as administrator to meet the requirements of § 16C.06 (procurement requirements).

Subd. 7. Eligibility. (a) In order to be eligible for the buy-in, requires persons to be:

1) a resident of Minnesota; and
2) not eligible for a government-sponsored program as defined under the ACA. Provides that persons entitled to Medicare Part A or enrolled in Medicare Part B are considered eligible for a government-sponsored program. Prohibits persons entitled to premium-free Medicare Part A from refusing to apply for or enroll in Medicare in order to establish eligibility for the buy-in.

(b) Allows persons eligible for a qualified health plan (with or without premium tax credits or cost-sharing reductions) to be eligible to purchase and enroll in the buy-in.

Subd. 8. Enrollment. (a) Allows a person to apply for the buy-in during the annual open and special enrollment periods for MNsure.

(b) Requires annual reenrollment for the buy-in.

Subd. 9. Premium tax credits, cost-sharing reductions, and subsidies. Provides that a person eligible under this chapter, with income not exceeding 400 percent of FPG, may qualify for advance premium tax credits and cost-sharing reductions to purchase a health plan under this chapter.

Subd. 10. Covered benefits and payment rate modifications. Allows the commissioner, after public notice and comment, to modify covered benefits and payment rates.

Section	Description
	Subd. 11. Request for federal authority. Requires the commissioner to seek all necessary federal waivers to establish the buy-in. Provides that subdivisions 1 to 10 are effective January 1, 2023, and that subdivision 11 is effective the day following final enactment.
13	**OneCare Buy-in products.** Adds § 256T.04.
	Subd. 1. Platinum product. Requires the commissioner to establish a buy-in coverage option at the platinum level, to be made available in all rating areas in the state. **Subd. 2. Silver and gold products.** (a) If a rating area lacks an affordable or comprehensive health care coverage option according to standards developed by the commissioner of health, directs the commissioner of human services to offer the following year silver and gold products in the rating area for a five-year period. Allows the commissioner of health to use encounter and pricing data to monitor triggers in the individual market. Also allows that commissioner, effective January 1, 2020, to require additional data elements to be submitted to conduct the necessary analysis. (b) Requires the commissioner of human services to establish the following coverage options: one silver level plan at 70 percent of the actuarial value of the buy-in option and one gold level plan at 80 percent of the actuarial value. **Subd. 3. Qualified health plan rules.** (a) Provides that the coverage options developed under this section are subject to the process under § 62K.06 (metal level mandatory offering). Also deems the coverage options as meeting the requirements of chapters 62A, 62K, and 62V that apply to qualified health plans. (b) Provides that benefits under this section are secondary. Requires the commissioner to use cost-avoidance techniques to coordinate with other health coverage and identify persons with other coverage. (c) States that DHS is not an insurance company for purposes of this chapter. **Subd. 4. Actuarial value.** Requires actuarial value to be calculated in accordance with federal regulations (45 CFR 156.135). Provides a January 1, 2023, effective date.
14	**Outpatient prescription drugs.** Adds § 256T.05.

Section	Description
	Subd. 1. Establishment of program. Requires the commissioner to administer and oversee the outpatient prescription drug program for the OneCare Buy-in program. Prohibits the commissioner from including the outpatient pharmacy benefit in a contract with a public or private entity. **Subd. 2. Covered outpatient prescription drugs.** States that outpatient prescription drugs are covered as provided in chapter 256L (MinnesotaCare). **Subd. 3. Pharmacy provider participation.** Specifies requirements for pharmacy participation. **Subd. 4. Reimbursement rate.** Requires the commissioner to establish outpatient prescription drug reimbursement rates according to chapter 256L (MinnesotaCare). Provides a January 1, 2023, effective date.
15	**Direction to commissioner; state-based risk adjustment analysis.** Requires the commissioner of commerce, in consultation with the commissioner of health, to study the design and implementation of a state-based risk adjustment program. Requires the commissioner to report findings and recommendations to the legislature by February 15, 2021.
16	**Repealer.** Repeals § 256L.11, subd. 6a (MinnesotaCare 54 percent payment rate increase for dental providers). Provides a January 1, 2022, effective date.

Article 10: Opioids

This article establishes the opioid stewardship fund and the Opioid Stewardship Advisory Council. The article requires various entities to pay controlled substance registration fees to the Board of Pharmacy and requires manufacturers and wholesalers to pay opiate product registration fees, and requires these fees to be deposited into the opioid stewardship fund. The article also requires the commissioner of human services, in consultation with the advisory council, to awards grants from the fund to address the opioid addiction and overdose epidemic.

Section	Description
1	**Chain pharmacy.** Amends § 151.01, by adding subd. 2b. Defines “chain pharmacy” as a pharmacy that is part of ten or more establishments that conduct business under the same business name

Section	Description
	or operate under common ownership or management or pursuant to a franchise agreement.
2	**Unit.** Amends § 151.01, by adding subd. 42. Defines "unit" as the individual dosage form of a drug product that is most commonly prescribed to a patient, including but not limited to tablet, capsule, patch, syringe, milliliter, or gram.
3	**Controlled substance registration fees.** Amends § 151.065, by adding subd. 3a. Sets the following initial and annual renewal controlled substance registration fees: (1) controlled substance drug manufacturer, large (5,000,000 or more units), $75,000 (2) controlled substance drug manufacturer, medium (more than 1,000,000 but less than 5,000,000 units), $5,000 (3) controlled substance drug manufacturer, small (1,000,000 or fewer units), $500 (4) drug wholesaler distributing controlled substances, large (5,000,000 or more units), $75,000 (5) drug wholesaler distributing controlled substances, small (less than 5,000,000 units), $2,500 (6) pharmacy dispensing controlled substances, other than hospital or chain, $2,500 (7) pharmacy other than a hospital, independent, $500 (8) pharmacy, hospital (50 or more beds), $2,500 (9) pharmacy, hospital (fewer than 50 beds), $500 (10) practitioner prescribing, administering, or dispensing controlled substances, $125 (11) controlled substances researcher, $125
4	**Requirements.** Amends § 151.252, subd. 1. Requires a manufacturer of a Schedule II through IV opiate controlled substance to pay the opiate product registration fee, by June 1 of each year, beginning June 1, 2020. Allows the board to assess a 10 percent late fee for each month or portion of a month of noncompliance.

Section	Description
5	**Controlled substance wholesale drug distributor requirements.** Amends § 151.47, by adding subd. 1a. Requires a wholesale drug distributor distributing a Schedule II though IV opiate controlled substance to pay the opiate product registration fee, by June 1 of each year, beginning June 1, 2020. Allows the board to assess a 10 percent late fee for each month or portion of a month of noncompliance.
6	**Opiate product registration fee.** Adds § 151.77. **Subd. 1. Definition.** Defines the following terms: manufacturer, opiate, and wholesaler. **Subd. 2. Reporting requirements.** (a) By March 1 of each year, beginning March 1, 2020, requires manufacturers and wholesale drug distributors to report to the board every sale, delivery, or other distribution within or into the state of any opiate that occurred during the previous calendar year, using the automation of reports and consolidated orders system (ARCOS) format, unless otherwise specified by the board. Allows the board to assess an administrative penalty of $500 per day for noncompliance. (b) By March 1 of each year, beginning March 1, 2020, requires owners of pharmacies with at least one location in the state to report to the board the intracompany delivery or distribution into the state of any opiate, if this is not reported by a licensed wholesale drug distributor. Requires reporting to be done as specified by the board, for deliveries and distributions for the previous calendar year. **Subd. 3. Determination of each manufacturer's registration fee.** (a) Requires the board to annually assess manufacturer registration fees in the aggregate amount of $12 million, and to determine each manufacturer's annual registration on a pro-rated basis based on the manufacturer's percentage of the total number of units reported. (b) Requires the board to notify each manufacturer, by April 1 of each year beginning April 1, 2020, of the annual fee amount that must be paid by June 1. (c) Allows the board to use data reported by dispensers through the prescription monitoring program to determine registration fees, in conjunction with the data reported under this section. (d) Allows a manufacturer to dispute the registration fee within 30 days after notification, and specifies the procedures to be used. Requires a manufacturer disputing the fee to still remit the fee. **Subd. 4. Determination of each wholesaler's registration fee.** (a) Requires the board to annually assess wholesaler registration fees in the aggregate amount of

Section	Description

$8 million, and to determine each wholesaler's annual registration on a pro-rated basis based on the wholesaler's percentage of the total number of units reported.

(b) Requires the board to notify each wholesaler, by April 1 of each year beginning April 1, 2020, of the annual fee amount that must be paid by June 1.

(c) Allows a wholesaler to dispute the registration fee within 30 days after notification, and specifies the procedures to be used. Requires a wholesaler disputing the fee to still remit the fee.

Subd. 5. Report. (a) Requires the Board of Pharmacy to evaluate the registration fee on drug manufacturers and wholesalers, and whether the fee has impacted prescribing practices by reducing the number of opiate prescriptions issued during calendar years 2020, 2021, and 2022. Allows the board to use data reported by dispensers through the prescription monitoring program to conduct this evaluation.

(b) Requires the board to submit evaluation results to the legislative committees with jurisdiction over health and human services policy and finance by March 1, 2023.

Subd. 6. Legislative review. Requires the legislature to review the reports from the advisory council, the Board of Pharmacy under subdivision 5, and other relevant information, to determine whether the opiate product registration fee should continue beyond July 1, 2023.

7 **Practitioner.**

Amends § 152.01, by adding subd. 25. States that "practitioner" has the meaning provided in section 151.01, subdivision 23.

8 **Controlled substance registration.**

Amends § 152.10.

Subd. 1. Generally. Prohibits individuals from selling a controlled substance except as provided in this chapter, and when any required registration has been obtained and is active.

Subd. 2. Registration requirement. Requires a person to obtain a registration from the Board of Pharmacy, in order to:

(1) manufacture, distribute, prescribe, or dispense any controlled substance within the state;

Section	Description

(2) propose to engage in the manufacture, distribution, prescription, or dispensing of any controlled substance within the state;

(3) dispense, distribute, or propose to dispense or distribute any controlled substance for use in the state by shipping, mailing, or otherwise delivering the controlled substance from a location outside the state; or

(4) use or propose to use controlled substances in the course of a bona fide research project.

(b) Requires registered persons to comply with all other applicable statutes or rules.

(c) Lists exemptions from the controlled substance registration requirement.

(d) Allows persons for whom a controlled substance has been dispensed to designate a family member, caregiver, or other individual to provide assistance in obtaining, administering, or disposing of the controlled substance.

(e) Requires a separate registration for each principal place of business or professional practice, except as otherwise provided in the paragraph.

(f) Provides that the Board of Pharmacy has the authority to inspect the establishment of a registrant or applicant for registration.

(g) Allows the board to require a registrant to submit documents or other information the board deems necessary to act on a registration request, and specifies related criteria.

(h) States that failure to renew a registration on a timely basis shall cause the registration to be forfeited. Allows a forfeited registration to be reinstated.

Subd. 3. Registration. Requires the board to register an applicant unless it determines this would be inconsistent with the public interest, based upon a consideration of specified factors. Also provides additional criteria related to registration.

Subd. 4. Revocation and suspension of registration. Specifies the procedure and criteria for revoking or suspending a registration.

Subd. 5. Reporting. Requires drug wholesalers, at least quarterly, to report to the board all distributions within or into the state of Schedule II controlled substances, and all Schedule III controlled substances that contain narcotics or gamma hydroxybutyric acid.

Section	Description
9	**General prescription requirements for controlled substances.** Amends § 152.11, subd. 1. Requires prescriptions to include the prescriber's current state controlled substance registration number, and makes related changes.
10	**Prescription requirements for Schedule II controlled substances.** Amends § 152.11, subd. 1a. Adds references to practitioners and state controlled substance registration numbers.
11	**Prescription requirements for Schedule III or IV controlled substances.** Amends § 152.11, subd. 2. Adds references to practitioners and state controlled substance registration numbers.
12	**Federal and state registration number exemption.** Amends § 152.11, subd. 2a. Adds a reference to state controlled substance registration numbers.
13	**Restriction on release of federal and state registration number.** Amends § 152.11, subd. 2b. Adds a reference to state controlled substance registration numbers.
14	**Restrictions on use of federal and state registration number.** Amends § 152.11, subd. 2c. Adds a reference to state controlled substance registration numbers.
15	**Prescribing, dispensing, administering controlled substances in Schedules II through V.** Amends § 152.12, subd. 1. Adds references to practitioners and state controlled substance registration numbers.
16	**Doctor of veterinary medicine.** Amends § 152.12, subd. 2. Adds a reference to state controlled substance registration numbers.
17	**Research project use of controlled substances.** Amends § 152.12, subd. 3. Requires persons conducting research using controlled substances to register with the board under section 152.10.
18	**Sale of controlled substances not prohibited for certain persons and entities.** Amends § 152.12, subd. 4. Adds references to registration with the board under section 152.10.

Section	Description
19	**Prescription and administration of controlled substances for intractable pain.** Amends § 152.125, subd. 2. Adds references to practitioners and registration under section 152.10.
20	**Limits on applicability.** Amends § 152.125, subd. 3. Adds references to practitioners.
21	**Notice of risks.** Amends § 152.125, subd. 4. Adds references to practitioners.
22	**Services and programs.** Amends § 245.4661, subd. 9. Allows adult mental health service pilot projects to provide grant funding for traditional healing provided to American Indians. Provides a July 1, 2019, effective date.
23	**Rules for substance use disorder care.** Amends § 245A.03, subd. 3. Provides that if a screen result is positive for alcohol or substance misuse, a brief screening for alcohol or substance use disorder establishes medical necessity and approval for an initial set of substance use disorder services. Specifies the services that may be included as part of this initial set of services. Requires that a recipient obtain an assessment to be approved for additional treatment services. Provides a July 1, 2019, effective date, contingent upon federal approval.
24	**Opioid Stewardship Advisory Council.** Adds § 256.042. **Subd. 1. Establishment of advisory council**. (a) Establishes the Opioid Stewardship Advisory Council to confront the opioid addiction and overdose epidemic in the state and focus on specified policy areas and services. (b) Requires the council to: (1) review local, state, and federal initiatives and funding related to prevention, education, treatment, and services related to opioid addiction; (2) establish priorities for allocating funds; (3) ensure available funding is aligned with existing funding; (4) develop criteria and procedures to be used in awarding grants and allocating funds from the opiate epidemic response account; and

Section	Description
	(5) in consultation with the commissioner of management and budget and within available appropriations, select from the awarded grants projects for evaluation. **Subd. 2. Membership.** (a) States that the council shall consist of 19 members, and specifies membership. (b) Requires the commissioner to coordinate appointments to provide geographic diversity and ensure that at least one-half of members reside outside of the seven-county metropolitan area. (c) Specifies that the council is governed by section 15.059, except that members receiving compensation for their appointed role are reimbursed only for expenses. Provides that the council does not expire. (d) Requires the chair to convene the council at least quarterly. Requires the council to meet at different locations in the state, with at least one-half of the meetings held at locations outside of the seven-county metropolitan area. (e) Requires the commissioner to provide staff and administrative services for the council. (f) States that the council is subject to chapter 13D (open meeting law). **Subd. 3. Conflict of interest.** Requires disclosure and recusal in cases of a conflict of interest. **Subd. 4. Council recommendations.** Requires the council to make recommendations on awards to be made from the funds annually appropriated to the commissioner. **Subd. 5. Grants.** Requires the commissioner to award grants from the opioid stewardship fund to address the opioid addiction and overdose epidemic, based on recommendations of the advisory council. **Subd. 6. Reports.** (a) Requires the commissioner, in consultation with the advisory council, to report annually to the legislature by March 1 of each year, beginning March 1, 2022, on the projects that receive grants. Specifies requirements for the report. (b) Requires the commissioner of management and budget, in consultation with the advisory council and the commissioner of human services, to report to the legislature on the projects selected for evaluation. Specifies report requirements.
25	**Opioid stewardship fund.** Adds § 256.043. Establishes the opioid stewardship fund in the state treasury. Requires the registration fees assessed by the Board of Pharmacy under section 151.77 and the

Section	Description
	license fees identified in section 151.065, subdivision 3a, to be deposited into the fund. Requires all interest earnings to be credited to the fund.
26	**Opioid Stewardship Advisory Council first meeting.** Requires the commissioner of human services to convene the first meeting of the council by October 1, 2029. Requires members to elect a chair at the first meeting.

Article 11: Health-Related Licensing Boards

This article modifies fees for the following health-related licensing boards and professions by moving fees from rule to statute, increasing licensing fees, or adding new fees:

- Board of Nursing Home Administrators
- Traditional midwives
- Naturopathic doctors
- Genetic counselors
- Board of Optometry
- Board of Occupational Therapy Practice
- Athletic trainers
- Board of Psychology
- Board of Social Work
- Board of Dentistry
- Board of Pharmacy

Section	Description
1	**Fees.** Proposes coding for § 144A.39. Moves the Board of Nursing Home Administrators fees from Minnesota Rules, part 6400.6970 to this section, adds fees, and increases fee amounts.
2	**Additional fees.** Amends § 147D.27, by adding subd. 5. Makes technical correction to codify all current traditional midwife licensing fees. Makes this section effective the day following final enactment.
3	**Fees.** Amends § 147E.40, subd. 1. Makes technical correction to codify all current naturopathic doctor licensing fees.

Section	Description
	Makes this section effective the day following final enactment.
4	**Fees.** Amends § 147F.17, subd. 1. Makes technical correction to codify all current genetic counselor licensing fees. Makes this section effective the day following final enactment.
5	**License renewal; license and registration fees.** Amends § 148.59. Increases Board of Optometry annual licensure renewal fee; adds fees for state juris prudence examination and miscellaneous labels and data retrieval.
6	**Initial licensure fee.** Amends § 148.6445, subd. 1. Increases initial licensure fee for occupational therapists and occupational therapy assistants.
7	**Licensure renewal fee.** Amends § 148.6445, subd. 2. Increases biennial licensure renewal fee for occupational therapists and occupational therapy assistants.
8	**Duplicate license fee.** Amends § 148.6445, subd. 2a. Increases occupational therapy duplicate license fee.
9	**Late fee.** Amends § 148.6445, subd. 3. Increases occupational therapy late renewal fee.
10	**Temporary licensure fee.** Amends § 148.6445, subd. 4. Increases occupational therapy temporary licensure fee.
11	**Limited licensure fee.** Amends § 148.6445, subd. 5. Increases occupational therapy limited licensure fee.
12	**Fee for course approval after lapse of licensure.** Amends § 148.6445, subd. 6. Increases occupational therapy fee for course approval after lapse of licensure.
13	**Use of fees.** Amends § 148.6445, subd. 10. Specifies that occupational therapy licensure fees are for the exclusive use of the board and shall not exceed the amounts listed in the section.

Section	Description
14	**Fees.** Amends § 148.7815, subd. 1. Makes technical correction to codify all current athletic trainer licensing fees. Makes this section effective the day following final enactment.
15	**Fees.** Proposes coding for § 148.981. **Subd. 1. Licensing fees.** Moves psychology licensure fees from rule to statute. Adds fee for optional post-doctoral supervised experience pre-approval. **Subd. 2. Continuing education sponsor fee.** Moves fee from rule to statute. Makes this section effective the day following final enactment.
16	**Fee amounts.** Amends § 148E.180. **Subd. 1. Application fees.** Increases social work licensing application fees. **Subd. 2. License fees.** Increases social work licensing fees. **Subd. 3. Renewal fees.** Increases social work licensure renewal fees. **Subd. 4. Continuing education provider fees.** Clarifies that fees are nonrefundable. **Subd. 5. Late fees.** Clarifies that fees are nonrefundable. **Subd. 6. License cards and wall certificates.** Clarifies that fees are nonrefundable. **Subd. 7. Reactivation fees.** Clarifies that fees are nonrefundable.
17	**Emeritus inactive license.** Amends § 150A.06, by adding subd. 10. Establishes an emeritus inactive license for a licensed dental professional who retires from active practice. Specifies that the emeritus inactive licensee may not practice in a dental profession, and that the license is a formal recognition of the completion of the licensee's career in good standing. Requires onetime fee for an emeritus inactive license. Makes this section effective July 1, 2019.

Section	Description
18	**Emeritus active license.** Amends § 150A.06, by adding subd. 11. Establishes an emeritus active license for a licensed dental professional who retires, to practice only on a pro bono or volunteer basis, or limited paid consulting or supervision practice. Requires application fee. Specifies practice limitations and renewal requirements. Makes this section effective July 1, 2019.
19	**Emeritus inactive license.** Amends § 150A.091, by adding subd. 19. Adds application fee for emeritus inactive dental license. Makes this section effective July 1, 2019.
20	**Emeritus active license.** Amends § 150A.091, by adding subd. 20. Adds application fees for emeritus active licenses in dentistry, dental therapy, dental hygiene, and dental assisting. Makes this section effective July 1, 2019.
21	**Application fees.** Amends § 151.065, subd. 1. Increases Board of Pharmacy licensure and registration application fees.
22	**Original license fee.** Amends § 151.065, subd. 2. Increases pharmacist original licensure fee.
23	**Annual renewal fees.** Amends § 151.065, subd. 3. Increases Board of Pharmacy annual renewal fees.
24	**Reinstatement fees.** Amends § 151.065, subd. 6. Clarifies language for Board of Pharmacy controlled substance registrant reinstatement.
25	**Repealer.** Repeals Minnesota Rules, parts 6400.6970; 7200.6100; and 7200.6105 (Board of Nursing Home Administrators and Board of Psychology fees). Makes this section effective the day following final enactment.

Article 12: Health Department

This article modifies Health Department authority and programs, including increasing the annual service connection fee to public water supplies; requiring the commissioner of health to administer or contract to administer statewide tobacco cessation services; establishing an opioid and other drug abuse pilot grant program and a community solutions for healthy child development grant program; allowing spouses to serve as patient caregivers in the medical cannabis program without registering as designated caregivers; and repealing the HIV, HBV, and HCV prevention program.

Section	Description
1	**Fee setting.** Amends § 144.3831, subd. 1. Increases the annual service connection fee assessed by the commissioner of health for every service connection to a public water supply owned or operated by a city or town, from $6.36 to $9.72.
2	**Statewide tobacco cessation services.** Adds § 144.397. Requires the commissioner of health to administer or contract for the administration of statewide tobacco cessation services to help Minnesotans quit using tobacco products. Requires the commissioner to establish statewide public awareness activities, and lists services that may be provided. Requires services to be consistent with evidence-based best practices and coordinated with tobacco prevention and cessation services offered by health plan companies.
3	**Community-based opioid and other drug abuse prevention; pilot grant program.** Adds § 145.9275. Requires the commissioner to establish a grant program to fund community opioid abuse prevention pilot grants to reduce emergency room and other health care provider visits and to reduce rates of opioid addiction. Lists activities that may be funded under this grant program. Also requires the commissioner to establish a grant program to fund organizations working directly with African Americans, urban American Indians, and the 11 tribal nations in Minnesota, and provides that tribal governments shall determine how to use funds allocated to tribal nations in order to address and prevent substance use disorder.
4	**Community solutions for healthy child development grant program.** Amends § 145.9285. Establishes the program, establishes duties for the commissioner of health, creates a Community Solutions Advisory Council, specifies organizations eligible for grants, requires the commissioner to develop a request for proposals for grants, requires grants to be prioritized and awarded to organizations and entities in counties with higher proportions of people of color and American Indians, and requires grant recipients to report grant outcomes to the commissioner. **Subd. 1. Establishment.** Directs the commissioner of health to establish the community solutions for healthy child development grant program, and establishes purposes for the program.

Section	Description
	Subd. 2. Commissioner's duties. Requires the commissioner of health to develop a request for proposals for this program; provide outreach, technical assistance, and program development; review responses to the RFP; communicate with the ethnic councils, the Minnesota Indian Affairs Council, and the governor's early learning council; establish an accountability process; give grantees access to data; maintain outcomes data; and contract with a third party to conduct evaluations. **Subd. 3. Community Solutions Advisory Council; establishment; duties; compensation.** Requires the commissioner to appoint 12 people to a Community Solutions Advisory Council, requires at least three of these members to come from greater Minnesota, and lists duties for the advisory council. Also provides for compensation of advisory council members. **Subd. 4. Eligible grantees.** Provides that organizations eligible to receive grants include organizations that work with communities of color and American Indian communities, tribal nations and tribal organizations, and organizations focused on supporting healthy child development. **Subd. 5. Strategic considerations and priority of proposals; eligible populations; grant awards.** Directs the commissioner, in developing the request for proposals (RFP), to consider building on community capacity to promote child development and family well-being and to address social determinants of healthy child development. In awarding grants, requires the commissioner to give priority to proposals from organizations led by and serving people of color, led by and serving American Indians, or with proposals focused on prenatal to grade 3 healthy development, focused on multigenerational solutions, located in or proposing to serve communities in moderate to high risk counties, or community-based organizations that have historically served communities of color and American Indians but have not had access to state grant funding. Requires initial grants to be awarded by April 15, 2020, and annually thereafter, and provides that grants are awarded for three-year periods. **Subd. 6. Geographic distribution of grants.** Requires the commissioner and the advisory council to ensure that grants are prioritized and awarded to organizations in counties with a higher proportion of people of color and American Indians than the state average, to the extent possible. **Subd. 7. Report.** Requires grant recipients to report grant outcomes to the commissioner.
5	**Registry verification.** Amends § 152.22, subd. 13. Amends the definition of registry verification for the medical cannabis statutes to allow it to include the name of the patient's spouse, if the spouse is acting as the patient's caregiver.

Section	Description
6	**Notice to patients.** Amends § 152.27, subd. 1c. Requires the commissioner to notify a medical cannabis patient's spouse, if the spouse is acting as the patient's caregiver, if a manufacturer's registration is revoked or not renewed by the commissioner.
7	**Patient application.** Amends § 152.27, subd. 3. Requires a patient's application for enrollment in the medical cannabis registry to include the name of the patient's spouse, if the spouse is acting as the patient's caregiver.
8	**Registered designated caregiver.** Amends § 152.27, subd. 4. Requires the commissioner to renew the background check of a patient's registered designated caregiver every two years.
9	**Parents, legal guardians, and spouses.** Amends § 152.27, subd. 5. Allows a spouse of a patient to act as a patient's caregiver without having to register as a designated caregiver under the registry. (Current law allows parents and legal guardians to act as patient caregivers without registering as designated caregivers.)
10	**Patient enrollment.** Amends § 152.27, subd. 6. Adds a patient's spouse, if the spouse is acting as the patient's caregiver, to the list of caregivers who the commissioner must enroll in the registry program along with the patient.
11	**Health care practitioner duties.** Amends § 152.28, subd. 1. Requires health care practitioners to advise patient spouses, if acting as caregivers to patients enrolled in the registry program, about patient support groups.
12	**Manufacturer; distribution.** Amends § 152.29, subd. 3. Before distributing medical cannabis, requires a manufacturer to verify that the patient's spouse to whom the cannabis is to be distributed is listed on the patient's registry verification.
13	**Criminal and civil protections.** Amends § 152.32, subd. 2. Provides that medical cannabis possession by the spouse of a patient, if the spouse is acting as a caregiver to a patient enrolled in the registry program and is listed on the registry verification, is not a violation of controlled substance laws.

Section	Description
14	**Intentional diversion; criminal penalty.** Amends § 152.33, subd. 1. Adds a spouse of a patient, if acting as a patient's caregiver, to the list of people a manufacturer may distribute medical cannabis without being subject to criminal penalties.
15	**Diversion by patient, registered designated caregiver, parent, legal guardian, or patient's spouse; criminal penalties.** Amends § 152.33, subd. 2. Makes a patient's spouse who intentionally sells or otherwise transfers medical cannabis to a person other than the patient, subject to criminal penalties.
16	**Commissioner of health data.** Amends § 214.25, subd. 2. Amends a subdivision classifying data held by the commissioner of health under the HIV, HBV, and HCV prevention program, by striking language specifying when program data may be disclosed.
17	**Revisor instruction.** Instructs the revisor to correct internal cross-references as needed because of the repeal of sections 214.17 to 214.24.
18	**Repealer.** Repeals sections 214.17 to 214.24 (sections establishing the HIV, HBV, and HCV prevention program) effective January 1, 2020, and provides the commissioner shall not investigate new cases after June 1, 2019.

Article 13: Adult Protection

This article requires the commissioner of human services to allocate grants to counties and tribal governments for staffing to protect vulnerable adults or to expand adult protective services.

Section	Description
1	**Adult protection grant allocation.** Adds § 256M.42. Provides for allocation of adult protection grants by the commissioner of human services. **Subd. 1. Formula.** Requires the commissioner of human services to annually allocate money to each county board and tribal government approved by the commissioner to assume county agency duties for adult protective services or as a lead investigative agency, according to the specified formula. Prohibits the

Section	Description

commissioner from changing this formula or recommending a change without public review and input.

Subd. 2. Payment. Requires the commissioner to make these allocations on or before July 10 each year.

Subd. 3. Prohibition on supplanting existing money. Requires money allocated under this section to be used to fund staffing to protect vulnerable adults or to expand adult protective services, and prohibits this money from being used to supplant current county or tribal expenditures for these purposes.

Article 14: Assisted Living Licensure

This article establishes a framework to license assisted living establishments in the state. In order to operate or hold itself out as an assisted living establishment, an entity must be licensed under this new chapter, chapter 144I. The chapter establishes three levels of licensure:

- basic licensure, for an assisted living establishment that provides basic home care services as defined in home care statutes, assistance with activities of daily living and instrumental activities of daily living, and assistance with self-administered medications;

- comprehensive licensure, for an assisted living establishment that provides comprehensive home care services as defined in home care statutes; and

- comprehensive plus licensure, for an assisted living establishment that provides both comprehensive home care services and services in a secure or separate dementia care unit.

New entities must be licensed under the chapter beginning July 1, 2021, and existing housing with services establishments with arranged home care providers must be licensed under the chapter by July 1, 2022.

The commissioner is given authority to license, survey, and monitor assisted living establishments. Establishments must be surveyed once a year, and the commissioner must also conduct construction reviews to ensure physical plant standards are met. The commissioner is given expedited rulemaking authority to adopt rules on physical plant requirements, staffing, notices and disclosures to families, staff training, assessments, nutrition and dietary standards, background studies, discharge planning, compliance with home and community-based services (HCBS) requirements, core dementia care requirements, and requirements for comprehensive plus licenses.

This article establishes requirements for provisional licensure for new applicants, license applications, changes of ownership, issuance of licenses, fees, administrators, resident

councils, grievances, reporting crimes and maltreatment, and protecting resident rights. A licensed establishment must provide health-related services in compliance with home care licensure requirements and the Nurse Practice Act; have a system for delegating health care activities to unlicensed personnel; have a system to visually check on all assisted living residents at least once a day; have certain nursing personnel on-site and available to residents; provide certain supportive services to residents; and provide for a nursing assessment to be conducted before a resident signs a contract or moves in. If a licensed establishment uses a manager, the establishment must have a written management agreement, and the licensed establishment remains responsible for the daily operation and provision of services in the establishment and compliance with all applicable laws and rules. Additionally, this article establishes minimum site and fire safety requirements.

This article also establishes resident protections. It prohibits assisted living establishments from retaliating against residents, resident representatives, employees of assisted living establishments, or other interested persons for certain conduct. It creates requirements for resident contracts that must be executed between establishments and residents, and specifies circumstances and procedures for residency contract terminations and terminations of services.

Article 15: Dementia Care Services For Comprehensive Plus Licensees

This article establishes specific requirements for assisted living establishments with a comprehensive plus license. An assisted living establishment must hold a comprehensive plus license if it offers or provides care to residents with dementia in a dementia care unit.

An establishment with a comprehensive plus license must have policies and procedures that address evaluation of behaviors and intervention plans for those behaviors; wandering and egress prevention; use of medications and supportive devices; life enrichment programs and family support programs; transportation; and safekeeping of resident possessions. Staff at these establishments must have an understanding of the needs of people with dementia and be trained to work with people with dementia.

This article establishes minimum services that must be provided for residents with dementia, including assistance with activities of daily living, health care services, a daily meal program, and meaningful activities that promote physical and emotional wellbeing. Establishments must develop an individualized activity plan for each resident, and a selection of structured and non-structured activities must be made available.

Dementia care units must be located on the ground level of a building and must provide a secure outdoor recreation area for residents. Common areas of these units must include a multipurpose room for dining, activities, and visits, and safe corridors and passageways. Residents cannot be locked in their rooms or out of their rooms; residents must be allowed to decorate their rooms; and resident rooms must be individually identified to help residents recognize their rooms.

Article 16: Deceptive Marketing and Business Practices

This article prohibits deceptive marketing and business practice in certain facilities and authorizes fines for violations.

Section	Description
1	**Definitions.** Adds § 144I.20. Defines facility and resident representative for a section prohibiting deceptive marketing and business practices. Facility is defined to mean a nursing home, boarding care home, housing with services establishment, home care provider providing services in a housing with services establishment, or assisted living establishment.
2	**Deceptive marketing and business practices.** Adds § 144I.21. Prohibits facilities from engaging in deceptive marketing and business practices, including: • making false, fraudulent, deceptive, or misleading oral or written statements regarding care or services; • providing health or supportive services substantially different from or more expensive than those offered; • failing to deliver any services that were promised; • failing to inform a resident of limitations to services before the resident executes a contract with the establishment; • discharging a resident or terminating a lease or services if a resident moves from private pay to medical assistance waivered programs and if the establishment previously promised to continue services when the resident moves to a waivered program; • failing to disclose and clearly explain any nonrefundable fee before a contract is executed; • representing orally or in writing that the establishment has a special care unit without complying with required training requirements for staff in those units; and • misstating or falsely asserting that state law is the cause of a business decision. Provides that a violation of this section shall result in a level 2, level 3, or level 4 fine, depending on the level of harm, and allows the commissioner to suspend, refuse to renew, or revoke a license or provisional license for repeated violations. Makes this section effective the day following final enactment.

Article 17: Housing With Services Conforming Changes

This article provides that effective July 1, 2022, housing with services establishments registered under chapter 144D may provide supportive services but may no longer provide health-related services. An establishment that provides health-related services must be licensed as an assisted living establishment under chapter 144I.

Section	Description
1	**Housing with services establishment or establishment.** Amends § 144D.01, subd. 4. Amends the definition of housing with services establishment in chapter 144D, to provide that it can only provide supportive services and cannot provide one or more regularly scheduled health-related services.
2	**Definition for purposes of long-term care insurance.** Amends § 144D.015. Specifies that a housing with services establishment that provides home care services must be licensed as an assisted living establishment.
3	**Contents of contract.** Amends § 144D.04, subd. 2. Modifies the required content of a housing with services contract to conform with the requirement that housing with services establishments cannot provide home care services.
4	**Repealer.** Repeals sections in the housing with services establishments chapter, effective July 1, 2022: 144D.01, subdivisions 2a, 3a, and 6 (arranged home care provider, direct-care staff, and health-related services); 144D.04, subdivision 2a (additional contract requirements for residents receiving health-related services); 144D.045 (arranged home care providers); 144D.06 (other laws that apply to housing with services establishments); 144D.09 (termination of lease); and 144D.10 (manager requirements).

Article 18: Home Care Changes

This article makes changes to home care statutes to conform with the licensing requirements for assisted living establishments in chapter 144I, and modifies enforcement authority of the commissioner of health regarding home care providers.

Section	Description
1	**License.** Amends § 144A.43, subd. 6. Amends the definition of license in the home care statutes to provide that effective July 1, 2022, a provider licensed under these statutes is one that provides services outside an assisted living setting.

Section	Description
2	**Applicability of home care statutes to assisted living license requirements in chapter 144I.** Adds § 144A.431. Provides a cross-reference to the home care statutes that apply to assisted living establishments licensed under chapter 144I.
3	**Statement of rights.** Amends § 144A.44, subd. 1. Provides that the home care bill of rights applies to assisted living residents as well as home care clients, clarifies rights, and changes rights by providing clients and residents have the right to: • 30 days advance notice of a termination of a service or housing, rather than ten days as in current law; • recommend changes in policies and services free from retaliation, including the threat of termination of services; • Internet service at the client's own expense; and • place an electronic monitoring device. If a provider violates a right, the provider is subject to fines and license actions. Lists steps providers must take to inform residents and clients of rights and allow them to exercise these rights.
4	**Interpretation and enforcement of rights.** Amends § 144A.44, subd. 2. Clarifies that home care rights also apply to assisted living residents.
5	**Assisted living bill of rights addendum.** Amends § 144A.441. Changes terms used and statutory citations in the assisted living bill of rights addendum, to refer to assisted living residents rather than clients, and makes a conforming change.
6	**Assisted living residents; service termination.** Amends § 144A.442. Requires assisted living establishments to conform with requirements in chapter 144I regarding terminations of services or housing, beginning July 1, 2021.
7	**License required.** Amends § 144A.471, subd. 1. Effective July 1, 2021, requires assisted living providers licensed under chapter 144I to comply with chapter 144A for the provision of basic and comprehensive home care services.

Section	Description
8	**Basic and comprehensive levels of licensure.** Amends § 144A.471, subd. 5. Effective July 1, 2021, requires a home care provider that also provides housing to apply for an assisted living license under chapter 144I.
9	**Exclusions from home care licensure.** Amends § 144A.471, subd. 9. Eliminates two exclusions from home care licensure for employees of nursing homes, home care providers, or boarding care homes who respond to occasional emergency calls or provide occasional minor services to residents in an attached or nearby residential setting.
10	**Fees; application, change of ownership, and renewal.** Amends § 144A.472, subd. 7. Establishes a $1,000 fee for failing to comply with certain notification requirements, requires fines to be deposited in a dedicated special revenue account, and annually appropriates this money to the commissioner to implement advisory council recommendations.
11	**Follow-up surveys.** Amends § 144A.474, subd. 9. Strikes language prohibiting a fine from being imposed if a new violation is found in a follow-up survey of a home care provider.
12	**Fines.** Amends § 144A.474, subd. 11. Requires fines to be immediately imposed with no opportunity to correct violations; increases fine amounts for level 2, 3, and 4 violations; and establishes fine amounts for maltreatment violations. Allows fines to be imposed in addition to other enforcement mechanisms, and allows fines to be appealed. Requires fines to be deposited in a special revenue account and annually appropriated to the commissioner to implement the recommendations of the advisory council.
13	**Expedited hearing.** Amends § 144A.475, subd. 3b. Adds a cross-reference to rules governing hearings conducted by an administrative law judge.
14	**Plan required.** Amends § 144A.475, subd. 5. Requires a plan for transferring clients' care to other providers when the commissioner refuses to renew a provider's license, expands the list of individuals who the provider must provide with client information if the provider's license is revoked, suspended, or not renewed, and makes the notice of action on the provider's license public data. Allows a home care provider to continue operating while home care clients are transferred to other providers.

Section	Description
15	**Prior criminal convictions; owner and managerial officials.** Amends § 144A.476, subd. 1. Requires background studies of an owner or managerial official issued a license as a result of an approved change of ownership, and required background studies of controlling persons of assisted living establishments.
16	**Termination of service plan.** Amends § 144A.4791, subd. 10. Requires 30-day notice of a termination of a client's service plan.
17	**Department of Health Licensed Home Care and Assisted Living Provider Advisory Council.** Amends § 144A.4799. Expands this advisory council to include representatives of assisted living establishments, persons who have received home care within the past five years, and a representative of county health and human services or county adult protection. Also modifies duties of the advisory council.
18	**Repealer.** Repeals section 144A.472, subd. 4 (requiring separate licenses for multiple units or branches of a home care provider in certain circumstances).

Article 19: Forecast Adjustments

This article adjusts appropriations for fiscal year 2019 to certain forecasted programs administered by the Department of Human Services.

Article 20: Appropriations

This article appropriates money for fiscal years 2020 and 2021 for the Department of Human Services, Department of Health, health-related licensing boards, the Emergency Medical Services Regulatory Board, the Council on Disability, the Ombudsman for Mental Health and Developmental Disabilities, and the Ombudspersons for Families. It also modifies certain appropriations for fiscal year 2019 and transfers money from the health care access fund to the opioid stewardship fund.