SENATE
STATE OF MINNESOTA
EIGHTY-NINTH SESSION

S.F. No. 825

(SENATE AUTHORS: LOUREY)

DATE	D-PG	OFFICIAL STATUS
02/12/2015	280	Introduction and first reading Referred to Health, Human Services and Housing
03/02/2015	467a	Comm report: To pass as amended and re-refer to Judiciary
03/11/2015		Comm report: To pass as amended and re-refer to Finance

A bill for an act

relating to state government; establishing the health and human services budget; modifying provisions governing children and family services, chemical and mental health services, withdrawal management programs, direct care and treatment, operations, health care, continuing care, and Department of Health programs; making changes to medical assistance, general assistance, Minnesota supplemental aid, Northstar Care for Children, MinnesotaCare, child care assistance, and group residential housing programs; modifying child support provisions; establishing standards for withdrawal management programs; modifying requirements for background studies; making changes to provisions governing the health information exchange; requiring reports; making technical changes; modifying certain fees for Department of Health programs; modifying fees of certain health-related licensing boards; appropriating money; amending Minnesota Statutes 2014, sections 62A.045; 62J.498; 62J.4981; 62J.4982, subdivisions 4, 5; 119B.07; 119B.10, subdivision 1; 119B.11, subdivision 2a; 124D.165, subdivision 4; 144.057, subdivision 1; 144.3831, subdivision 1; 144.9501, subdivisions 22b, 26b, by adding a subdivision; 144.9505; 144.9508; 144A.70, subdivision 6, by adding a subdivision; 144A.71; 144A.72; 144A.73; 144D.01, by adding a subdivision; 145A.131, subdivision 1; 148.57, subdivisions 1, 2; 148.59; 148E.180, subdivisions 2, 5; 149A.20, subdivisions 5, 6; 149A.40, subdivision 11; 149A.65; 149A.92, subdivision 1; 149A.97, subdivision 7; 150A.091, subdivisions 4, 5, 11, by adding subdivisions; 150A.31; 151.065, subdivisions 1, 2, 3, 4; 157.16; 174.30, by adding a subdivision; 245.4661, subdivision 5; 245C.03, by adding subdivisions; 245C.08, subdivision 1; 245C.10, by adding subdivisions; 245C.12; 246.54, subdivision 1; 246B.01, subdivision 2b; 246B.10; 254B.05, subdivision 5; 256.01, by adding subdivisions; 256.015, subdivision 7; 256.017, subdivision 1; 256.478; 256.741, subdivisions 1, 2; 256.962, by adding a subdivision; 256.969, subdivisions 1, 2b, 9; 256.975, subdivision 8; 256B.059, subdivision 5; 256B.0615, subdivision 3; 256B.0622, subdivisions 1, 2, 3, 4, 5, 7, 8, 9, 10, by adding a subdivision; 256B.0624, subdivision 7; 256B.0625, subdivisions 9, 13h, 58, by adding a subdivision; 256B.0631; 256B.0757; 256B.092, subdivision 13; 256B.49, subdivision 24; 256B.75; 256B.76, subdivisions 2, 4; 256D.01, subdivision 1b; 256D.44, subdivisions 2, 5; 256I.01; 256I.02; 256I.03; 256I.04; 256I.05, subdivisions 1c, 1g, by adding a subdivision; 256I.06; 256L.01, subdivisions 3a, 5; 256L.03, subdivision 5; 256L.04, subdivisions 1a, 1c, 7b, 10; 256L.05, subdivisions 3, 3a, 4, by adding a subdivision; 256L.06, subdivision 3; 256L.11, subdivision 7; 256L.121, subdivision 1; 256L.15, subdivision 2; 256N.22, subdivisions 9, 10; 256N.24, subdivision 4; 256N.25, subdivision 1; 256N.27,

subdivision 2; 259A.75; 260C.007, subdivisions 27, 32; 260C.203; 260C.212, subdivision 1, by adding subdivisions; 260C.221; 260C.331, subdivision 1; 260C.451, subdivisions 2, 6; 260C.515, subdivision 5; 260C.521, subdivisions 1, 2; 260C.607, subdivision 4; 282.241, subdivision 1; 297A.70, subdivision 7; 514.73; 514.981, subdivision 2; 518A.32, subdivision 2; 518A.39, subdivision 1, by adding a subdivision; 518A.41, subdivisions 1, 3, 4, 14, 15; 518A.46, subdivision 3, by adding a subdivision; 518A.51; 518A.53, subdivision 4; 518C.802; 580.032, subdivision 1; Laws 2014, chapter 189, sections 5; 10; 11; 16; 17; 18; 19; 23; 24; 27; 28; 29; 31; 43; 50; 51; 73; proposing coding for new law in Minnesota Statutes, chapters 15; 119B; 144; 144D; 245; 256B; proposing coding for new law as Minnesota Statutes, chapter 245F; repealing Minnesota Statutes 2014, sections 124D.142; 256.969, subdivision 30; 256B.69, subdivision 32; 256L.02, subdivision 3; 256L.05, subdivisions 1b, 1c, 3c, 5; Minnesota Rules, part 8840.5900, subparts 12, 14.

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

ARTICLE 1

CHILDREN AND FAMILY SERVICES

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

119B.07 USE OF MONEY.

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

Subd. 2. **Eligibility.** ~~(b)~~ To be eligible, the student must be in good standing and be making satisfactory progress toward the degree. Time limitations for child care assistance do not apply to basic or remedial educational programs needed to prepare for postsecondary education or employment. These programs include: high school, general equivalency diploma, and English as a second language. Programs exempt from this time limit must not run concurrently with a postsecondary program. If an MFIP participant who is receiving MFIP child care assistance under this chapter moves to

another county, continues to participate in educational or training programs authorized in their employment plans, and continues to be eligible for MFIP child care assistance under this chapter, the MFIP participant must receive continued child care assistance from the county responsible for their current employment plan, under section 256G.07.

Subd. 3. **Amount of child care assistance authorized.** (a) If the student meets the conditions of subdivisions 1 and 2, child care assistance must be authorized for all hours of actual class time and credit hours, including independent study and internships; up to two hours of travel time per day; and, for postsecondary students, two hours per week per credit hour for study time and academic appointments. For an MFIP or DWP student whose employment plan specifies a different time frame, child care assistance must be authorized according to the time frame specified in the employment plan.

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

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

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

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

(2) the family requests a legal nonlicensed provider;

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

(4) an applicant or participant is employed by a child care center.

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

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

Subdivision 1. **Assistance for persons seeking and retaining employment.** (a) Persons who are seeking employment and who are eligible for assistance under this section are eligible to receive up to 240 hours of child care assistance per calendar year.

(b) Employed persons who work at least an average of 20 hours and full-time students who work at least an average of ten hours a week and receive at least a minimum wage for all hours worked are eligible for continued child care assistance for employment. For purposes of this section, work-study programs must be counted as employment. Child

care assistance ~~during employment~~ for employed participants must be authorized as provided in paragraphs (c) ~~and~~, (d), (e), (f), and (g).

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

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

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

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

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

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

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

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

(2) the family requests a legal nonlicensed provider;

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

(4) an applicant or participant is employed by a child care center.

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

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

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

be recovered, regardless of amount or time period, if the overpayment was caused by wrongfully obtaining assistance under section 256.98 or benefits paid while an action is pending appeal under section 119B.16, to the extent the commissioner finds on appeal that the appellant was not eligible for the amount of child care assistance paid.

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

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

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

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

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

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

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

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

(c) The county must recover an overpayment from a provider if the overpayment did not benefit the family by causing it to receive more child care assistance or to pay less for child care expenses than the family otherwise would have been eligible to receive or required to pay under child care assistance program requirements, and benefited the provider by causing the provider to receive more child care assistance than otherwise would have been paid on the family's behalf under child care assistance program

requirements. If the provider continues to care for children receiving child care assistance, the overpayment must be recovered through reductions in child care assistance payments for services as described in an agreement with the county. The provider may not charge families using that provider more to cover the cost of recouping the overpayment. If the provider no longer cares for children receiving child care assistance, the county may choose to initiate efforts to recover overpayments of less than $50 from the provider. If the overpayment is greater than or equal to $50, the county shall seek voluntary repayment of the overpayment from the provider. If the county is unable to recoup the overpayment through voluntary repayment, the county shall initiate civil court proceedings to recover the overpayment unless the county's costs to recover the overpayment will exceed the amount of the overpayment. A provider with an outstanding debt under this subdivision is not eligible to care for children receiving child care assistance until:

(1) the debt is paid in full; or

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

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

(e) An overpayment caused by agency error must not be established or collected. An overpayment caused by more than one reason must not be established or collected if any portion of the overpayment is due to agency error. This paragraph does not apply if the overpayment was caused in part by wrongfully obtaining assistance under section 256.98 or benefits paid pending appeal under section 119B.16, to the extent that the commissioner finds on appeal that the appellant was not eligible for the amount of child care assistance paid.

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

Sec. 4. **[119B.27] QUALITY RATING AND IMPROVEMENT SYSTEM.**

Subdivision 1. **Establishment; purpose.** A voluntary quality rating and improvement system is established to ensure that Minnesota's children have access to

high-quality early childhood programs in a range of settings in order to improve the educational outcomes of children so that they are ready for school.

Subd. 2. **Standards.** The commissioner of human services, in cooperation with the commissioner of health and the commissioner of education, shall create quality standards and indicators using research-based practices.

Subd. 3. **Eligible early childhood programs.** Early childhood programs eligible to participate in the voluntary quality rating and improvement system include:

(1) child care centers licensed under Minnesota Rules, chapter 9503;

(2) family and group family day care homes licensed under Minnesota Rules, chapter 9502;

(3) Head Start programs under section 119A.50;

(4) school readiness programs under section 124D.15;

(5) early childhood special education programs under chapter 125A;

(6) tribally licensed early childhood programs; and

(7) other program types as determined by the commissioner.

Subd. 4. **Duties.** For each eligible early childhood program that voluntarily seeks a rating, the commissioner shall:

(1) assess program quality using established quality standards and indicators;

(2) determine a rating or determine that no rating was earned;

(3) issue a rating;

(4) reassess a rating if the early childhood program:

(i) believes one or more errors was made in the program's quality assessment; and

(ii) requests reconsideration of the rating in writing to the commissioner within 60 days of the issuance date of the rating;

(5) revoke a rating under any of the following conditions:

(i) a licensed early childhood program is issued a conditional license or a licensing sanction under chapter 245A;

(ii) an early childhood program, provider, or person knowingly withholds relevant information from or gives false or misleading information to an assessor in the quality rating assessment process;

(iii) an early childhood program, provider, or person is disqualified from receiving payment for child care services from the child care assistance program under this chapter, due to wrongfully obtaining child care assistance under section 256.98, subdivision 8, paragraph (c);

(iv) an early childhood program, provider, or person has a determination of substantiated financial misconduct in early learning scholarships under section 124D.165; or

(v) an early childhood program is no longer eligible under subdivision 3; and

(6) make rating information publicly available to consumers.

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

Sec. 5. Minnesota Statutes 2014, section 124D.165, subdivision 4, is amended to read:

Subd. 4. **Early childhood program eligibility.** (a) In order to be eligible to accept an early learning scholarship, a program must:

(1) participate in the quality rating and improvement system under section ~~124D.142~~ 119B.27; and

(2) beginning July 1, 2016, have a three- or four-star rating in the quality rating and improvement system.

(b) Any program accepting scholarships must use the revenue to supplement and not supplant federal funding.

(c) Notwithstanding paragraph (a), all Minnesota early learning foundation scholarship program pilot sites are eligible to accept an early learning scholarship under this section.

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

Sec. 6. Minnesota Statutes 2014, section 245C.03, is amended by adding a subdivision to read:

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

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

Sec. 7. Minnesota Statutes 2014, section 245C.10, is amended by adding a subdivision to read:

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

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

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

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

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

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

Subdivision 1. **Authority and purpose.** The commissioner shall administer a compliance system for the Minnesota family investment program, the food stamp or food support program, emergency assistance, general assistance, medical assistance, emergency general assistance, Minnesota supplemental assistance, group residential housing and housing assistance, preadmission screening, alternative care grants, the child care assistance program, and all other programs administered by the commissioner or on behalf of the commissioner under the powers and authorities named in section 256.01, subdivision 2. The purpose of the compliance system is to permit the commissioner to supervise the administration of public assistance programs and to enforce timely and accurate distribution of benefits, completeness of service and efficient and effective program management and operations, to increase uniformity and consistency in the administration and delivery of public assistance programs throughout the state, and to reduce the possibility of sanctions and fiscal disallowances for noncompliance with federal regulations and state statutes. The commissioner, or the commissioner's representative, may issue administrative subpoenas as needed in administering the compliance system.

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

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

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

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

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

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

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

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

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

Subd. 2. **Assignment of support and maintenance rights.** (a) An individual receiving public assistance in the form of assistance under any of the following programs: the AFDC program formerly codified in sections 256.72 to 256.87, MFIP under chapter 256J, MFIP-R and MFIP formerly codified under chapter 256, or work first program formerly codified under chapter 256K is considered to have assigned to the state at the time of application all rights to child support and maintenance from any other person the applicant or recipient may have in the individual's own behalf or in the behalf of any other family member for whom application for public assistance is made. An assistance unit is ineligible for the Minnesota family investment program unless the caregiver assigns all rights to child support and maintenance benefits according to this section.

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

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

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

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

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

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

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

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

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

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

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

Sec. 12. Minnesota Statutes 2014, section 256D.01, subdivision 1b, is amended to read:

Subd. 1b. **Rules.** The commissioner shall adopt rules to set standards of assistance and methods of calculating payment to conform with subdivision 1a. When a recipient is receiving housing assistance according to section 256I.04, subdivision 1, paragraph (d), or is a resident of a licensed residential facility, except shelters for the homeless or shelters under section 611A.31, the recipient is not eligible for a full general assistance standard. The state standard of assistance for those recipients who have personal needs not

otherwise provided for is the personal needs allowance authorized for medical assistance recipients under section 256B.35.

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

Sec. 13. Minnesota Statutes 2014, section 256D.44, subdivision 2, is amended to read:

Subd. 2. **Standard of assistance for certain persons.** The state standard of assistance for a person who: (1) is eligible for a medical assistance home and community-based services waiver; or (2) has been determined by the local agency to meet the ~~plan~~ eligibility requirements ~~for placement in a group residential housing facility~~ under section 256I.04, subdivision 1a~~; or (3) is eligible for a shelter needy payment under subdivision 5, paragraph (f)~~, is the standard established in subdivision 3, paragraph (a) or (b).

EFFECTIVE DATE. The amendment to this section striking clause (3) is effective February 1, 2017.

Sec. 14. Minnesota Statutes 2014, section 256D.44, subdivision 5, is amended to read:

Subd. 5. **Special needs.** In addition to the state standards of assistance established in subdivisions 1 to 4, payments are allowed for the following special needs of recipients of Minnesota supplemental aid who are not residents of a nursing home, a regional treatment center, or a group residential housing facility.

(a) The county agency shall pay a monthly allowance for medically prescribed diets if the cost of those additional dietary needs cannot be met through some other maintenance benefit. The need for special diets or dietary items must be prescribed by a licensed physician. Costs for special diets shall be determined as percentages of the allotment for a one-person household under the thrifty food plan as defined by the United States Department of Agriculture. The types of diets and the percentages of the thrifty food plan that are covered are as follows:

(1) high protein diet, at least 80 grams daily, 25 percent of thrifty food plan;

(2) controlled protein diet, 40 to 60 grams and requires special products, 100 percent of thrifty food plan;

(3) controlled protein diet, less than 40 grams and requires special products, 125 percent of thrifty food plan;

(4) low cholesterol diet, 25 percent of thrifty food plan;

(5) high residue diet, 20 percent of thrifty food plan;

(6) pregnancy and lactation diet, 35 percent of thrifty food plan;

(7) gluten-free diet, 25 percent of thrifty food plan;

(8) lactose-free diet, 25 percent of thrifty food plan;

(9) antidumping diet, 15 percent of thrifty food plan;

(10) hypoglycemic diet, 15 percent of thrifty food plan; or

(11) ketogenic diet, 25 percent of thrifty food plan.

(b) Payment for nonrecurring special needs must be allowed for necessary home repairs or necessary repairs or replacement of household furniture and appliances using the payment standard of the AFDC program in effect on July 16, 1996, for these expenses, as long as other funding sources are not available.

(c) A fee for guardian or conservator service is allowed at a reasonable rate negotiated by the county or approved by the court. This rate shall not exceed five percent of the assistance unit's gross monthly income up to a maximum of $100 per month. If the guardian or conservator is a member of the county agency staff, no fee is allowed.

(d) The county agency shall continue to pay a monthly allowance of $68 for restaurant meals for a person who was receiving a restaurant meal allowance on June 1, 1990, and who eats two or more meals in a restaurant daily. The allowance must continue until the person has not received Minnesota supplemental aid for one full calendar month or until the person's living arrangement changes and the person no longer meets the criteria for the restaurant meal allowance, whichever occurs first.

(e) A fee of ten percent of the recipient's gross income or $25, whichever is less, is allowed for representative payee services provided by an agency that meets the requirements under SSI regulations to charge a fee for representative payee services. This special need is available to all recipients of Minnesota supplemental aid regardless of their living arrangement.

~~(f)(1) Notwithstanding the language in this subdivision, an amount equal to the maximum allotment authorized by the federal Food Stamp Program for a single individual which is in effect on the first day of July of each year will be added to the standards of assistance established in subdivisions 1 to 4 for adults under the age of 65 who qualify as shelter needy and are: (i) relocating from an institution, or an adult mental health residential treatment program under section 256B.0622; or (ii) home and community-based waiver recipients living in their own home or rented or leased apartment which is not owned, operated, or controlled by a provider of service not related by blood or marriage, unless allowed under paragraph (g).~~

~~(2) Notwithstanding subdivision 3, paragraph (c), an individual eligible for the shelter needy benefit under this paragraph is considered a household of one. An eligible~~

~~individual who receives this benefit prior to age 65 may continue to receive the benefit after the age of 65.~~

~~(3) "Shelter needy" means that the assistance unit incurs monthly shelter costs that exceed 40 percent of the assistance unit's gross income before the application of this special needs standard. "Gross income" for the purposes of this section is the applicant's or recipient's income as defined in section 256D.35, subdivision 10, or the standard specified in subdivision 3, paragraph (a) or (b), whichever is greater. A recipient of a federal or state housing subsidy, that limits shelter costs to a percentage of gross income, shall not be considered shelter needy for purposes of this paragraph.~~

~~(g) Notwithstanding this subdivision, to access housing and services as provided in paragraph (f), the recipient may choose housing that may be owned, operated, or controlled by the recipient's service provider. When housing is controlled by the service provider, the individual may choose the individual's own service provider as provided in section 256B.49, subdivision 23, clause (3). When the housing is controlled by the service provider, the service provider shall implement a plan with the recipient to transition the lease to the recipient's name. Within two years of signing the initial lease, the service provider shall transfer the lease entered into under this subdivision to the recipient. In the event the landlord denies this transfer, the commissioner may approve an exception within sufficient time to ensure the continued occupancy by the recipient. This paragraph expires June 30, 2016.~~

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

Sec. 15. Minnesota Statutes 2014, section 256I.01, is amended to read:

256I.01 CITATION.

Sections 256I.01 to 256I.06 shall be cited as the "~~Group~~ Residential Housing Act."

Sec. 16. Minnesota Statutes 2014, section 256I.02, is amended to read:

256I.02 PURPOSE.

The ~~Group~~ Residential Housing Act establishes a comprehensive system of rates and payments for persons who reside in the community and who meet the eligibility criteria under section 256I.04, subdivision 1.

Sec. 17. Minnesota Statutes 2014, section 256I.03, is amended to read:

256I.03 DEFINITIONS.

Subdivision 1. **Scope.** For the purposes of sections 256I.01 to 256I.06, the terms defined in this section have the meanings given them.

Subd. 1a. **Agency.** "Agency" has the meaning given in section 256P.01, subdivision 2.

~~Subd. 2. **Group residential housing rate.** "Group residential housing rate" means a monthly rate set for shelter, fuel, food, utilities, household supplies, and other costs necessary to provide room and board for eligible individuals. Group residential housing rate does not include payments for foster care for children who are not blind, child welfare services, medical care, dental care, hospitalization, nursing care, drugs or medical supplies, program costs, or other social services. The rate is negotiated by the county agency according to the provisions of sections 256I.01 to 256I.06.~~

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

~~Subd. 5. **MSA equivalent rate.** "MSA equivalent rate" means an amount equal to the total of:~~

~~(1) the combined maximum shelter and basic needs standards for MSA recipients living alone specified in section 256D.44, subdivisions 2, paragraph (a); and 3, paragraph (a); plus~~

~~(2) the maximum allotment authorized by the federal Food Stamp Program for a single individual which is in effect on the first day of July each year; less~~

~~(3) the personal needs allowance authorized for medical assistance recipients under section 256B.35.~~

~~The MSA equivalent rate is to be adjusted on the first day of July each year to reflect changes in any of the component rates under clauses (1) to (3).~~

~~Subd. 6. **Medical assistance room and board rate.** "Medical assistance room and board rate" means an amount equal to the medical assistance income standard for a single individual living alone in the community less the medical assistance personal needs allowance under section 256B.35. For the purposes of this section, the amount of the group residential housing rate that exceeds the medical assistance room and board rate is considered a remedial care cost. A remedial care cost may be used to meet a spenddown obligation under section 256B.056, subdivision 5. The medical assistance room and board rate is to be adjusted on the first day of January of each year.~~

~~Subd. 7. **Countable income.** "Countable income" means all income received by an applicant or recipient less any applicable exclusions or disregards. For a recipient of any cash benefit from the SSI program, countable income means the SSI benefit limit in effect at the time the person is in a GRH, less the medical assistance personal needs allowance. If the SSI limit has been reduced for a person due to events occurring prior to the persons entering the GRH setting, countable income means actual income less any applicable exclusions and disregards.~~

~~Subd. 8. **Supplementary services.** "Supplementary services" means services provided to residents of group residential housing providers in addition to room and board including, but not limited to, oversight and up to 24-hour supervision, medication reminders, assistance with transportation, arranging for meetings and appointments, and arranging for medical and social services.~~

Subd. 9. **Countable income.** "Countable income" means all income received by an applicant or recipient less any applicable exclusions or disregards. For a recipient of any cash benefit from the SSI program, countable income means the SSI benefit limit in effect at the time the person is a recipient of group residential housing or housing assistance, less the medical assistance personal needs allowance under section 256B.35. If the SSI limit or benefit is reduced for a person due to events other than receipt of additional income, countable income means actual income less any applicable exclusions and disregards.

Subd. 10. **Direct contact.** "Direct contact" means providing face-to-face care, support, training, supervision, counseling, consultation, or medication assistance to recipients of group residential housing or supplementary services.

Subd. 11. **Group residential housing.** "Group residential housing" means a group living situation that provides at a minimum room and board to unrelated persons who meet the eligibility requirements of section 256I.04. To receive payment for a group residence rate, the residence must meet the requirements under section 256I.04, subdivisions 2a to 2f.

Subd. 12. **Group residential housing rate.** "Group residential housing rate" means a monthly rate set for shelter, fuel, food, utilities, household supplies, and other costs necessary to provide room and board for eligible individuals. Group residential housing rate does not include payments for foster care for children who are not blind, child welfare services, medical care, dental care, hospitalization, nursing care, drugs or medical supplies, program costs, or other social services. The rate is negotiated by the county agency according to the provisions of sections 256I.01 to 256I.06.

Subd. 13. **Habitability inspection.** "Habitability inspection" means an inspection to determine whether the housing occupied by an individual meets the habitability standards

specified by the commissioner. The standards must be provided to the applicant in written form and posted on the Department of Human Services Web site.

Subd. 14. **Housing assistance.** "Housing assistance" means a monthly rate provided to an individual who is living in the individual's own home that has passed a habitability inspection.

Subd. 15. **Housing costs.** "Housing costs" means actual monthly rent or mortgage amount, costs associated with heating, cooling, electricity, water, sewer, and garbage collection, and the basic service fee for one telephone.

Subd. 16. **Institution.** "Institution" means a hospital, a nursing facility, an intermediate care facility for persons with developmental disabilities, or regional treatment center inpatient services provided according to section 245.474.

Subd. 17. **Long-term homelessness.** "Long-term homelessness" means lacking a permanent place to live: (1) continuously for one year or more; or (2) at least four times in the past three years.

Subd. 18. **MSA equivalent rate.** "MSA equivalent rate" means an amount equal to the total of:

(1) the combined maximum shelter and basic needs standards for MSA recipients living alone specified in section 256D.44, subdivisions 2, paragraph (a); and 3, paragraph (a); plus

(2) the maximum allotment authorized by the federal Food Stamp Program for a single individual which is in effect on the first day of July each year; less

(3) the personal needs allowance authorized for medical assistance recipients under section 256B.35.

The MSA equivalent rate is to be adjusted on the first day of July each year to reflect changes in any of the component rates under clauses (1) to (3).

Subd. 19. **Medical assistance room and board rate.** "Medical assistance room and board rate" means an amount equal to the medical assistance income standard for a single individual living alone in the community less the medical assistance personal needs allowance under section 256B.35. For the purposes of this section, the amount of the group residential housing rate that exceeds the medical assistance room and board rate is considered a remedial care cost. A remedial care cost may be used to meet a spenddown obligation under section 256B.056, subdivision 5. The medical assistance room and board rate is to be adjusted on the first day of January of each year.

Subd. 20. **Own home.** "Own home" means an individual's residence that: (1) is owned, rented, or leased by an individual who is responsible for the individual's own

meals; (2) is not licensed according to section 256I.04, subdivision 2a; and (3) does not have program requirements that restrict residency.

Subd. 21. **Payment.** "Payment" means a group residential housing payment or a housing assistance program.

Subd. 22. **Professional certification.** "Professional certification" means a statement about an individual's illness, injury, or incapacity that is signed by a qualified professional. The statement must specify that the individual has an illness or incapacity which limits the individual's ability to work and provide self-support. The statement must also specify that the individual needs assistance to access or maintain housing, as evidenced by the need for two or more of the following services:

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

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

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

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

Subd. 23. **Prospective budgeting.** "Prospective budgeting" means estimating the amount of monthly income a person will have in the payment month.

Subd. 24. **Qualified professional.** "Qualified professional" means an individual as defined in section 256J.08, subdivision 73a, or Minnesota Rules, part 9530.6450, subpart 3, 4, or 5; or an individual approved by the director of human services or a designee of the director.

Subd. 25. **Supplementary services.** "Supplementary services" means services provided to recipients of group residential housing or housing assistance in addition to room and board including, but not limited to, oversight and up to 24-hour supervision, medication reminders, assistance with transportation, arranging for meetings and appointments, and arranging for medical and social services.

EFFECTIVE DATE. Subdivision 9 is effective August 1, 2015. Subdivision 25 is effective February 1, 2017.

Sec. 18. Minnesota Statutes 2014, section 256I.04, is amended to read:

256I.04 ELIGIBILITY FOR GROUP RESIDENTIAL HOUSING PAYMENT AND HOUSING ASSISTANCE PAYMENT.

Subdivision 1. **Individual eligibility requirements.** An individual is eligible for and entitled to a group residential housing payment ~~to be made on the individual's behalf if the agency has approved the individual's residence in a group residential housing setting and~~ or a housing assistance payment if the individual meets the requirements in paragraph (a) or (b), and demonstrates a need for services under paragraph (c). An applicant for housing assistance must also meet the requirements under paragraphs (d) and (e). An applicant for group residential housing must also meet the applicable countable income threshold under paragraph (f).

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

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

(c) The individual must demonstrate a need for services as shown by receipt of:

(1) an assessed need for supportive housing according to the continuum of care coordinated assessment system established under Code of Federal Regulations, title 24, section 578.3;

(2) home and community-based services identified in section 245D.03, subdivision 1; alternative care according to section 256B.0913; adult rehabilitative mental health services according to section 256B.0623; targeted case management services according to section 256B.0924, subdivision 3; assertive community treatment services according to section

256B.0622, subdivision 2; essential community supports according to section 256B.0922; nonresidential chemical dependency treatment services identified in Minnesota Rules, parts 9530.6620 and 9530.6622; community first services and supports according to section 256B.85; or a difficulty of care rate according to section 256I.05, subdivision 1c; or

(3) a professional certification for residence in group residential housing.

(d) Effective February 1, 2017, an individual is eligible for housing assistance if the individual:

(1) is relocating out of an institution or a licensed or registered setting according to subdivision 2a, within the last 90 days; was receiving group residential housing payments in the individual's own home as of February 1, 2017; or was receiving the shelter special need payment under section 256D.44, subdivision 5, paragraph (f), on January 31, 2017; and

(2) has monthly housing costs in the individual's own home that are more than 40 percent of the individual's monthly countable income.

(e) An individual who receives housing assistance is required to apply for federal rental assistance in the individual's own home, if applicable. An individual may not receive housing assistance and group residential housing or state or federal rental assistance at the same time.

(f) An individual is eligible for group residential housing if the amount of countable income under paragraph (a) or (b) is less than the monthly rate specified in the agency's agreement with the provider of group residential housing in which the individual resides. In addition, the countable income under paragraph (a) must be reduced by an amount equal to the income actually made available to a community spouse by an elderly waiver participant under sections 256B.0575, subdivision 1, paragraph (a), clause (4), and 256B.058, subdivision 2.

Subd. 1a. **County approval.** (a) A county agency may not approve a ~~group residential housing~~ payment for an individual in any setting with a rate in excess of the MSA equivalent rate ~~for more than 30 days in a calendar year~~ or for an individual in the individual's own home in excess of the housing assistance payment unless the ~~county agency has developed or approved~~ individual has a ~~plan for the individual which specifies that:~~ professional certification, under section 256I.03, subdivision 22.

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

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

~~The plan must be signed or countersigned by any of the following employees of the county of financial responsibility: the director of human services or a designee of the director; a social worker; or a case aide.~~

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

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

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

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

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

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

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

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

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

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

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

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

(2) a supportive housing establishment that has an approved habitability inspection and an individual lease agreement and that serves people who have experienced long-term homelessness and were referred through a coordinated assessment in subdivision 1, paragraph (c), clause (1).

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

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

(1) have the skills and knowledge acquired through:

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

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

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

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

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

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

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

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

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

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

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

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

(3) the provision of group residential housing;

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

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

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

~~Group residential housing~~

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

Subd. 2c. **~~Crisis shelters~~ Background study requirements.** ~~Secure crisis shelters for battered women and their children designated by the Minnesota Department of Corrections are not group residences under this chapter.~~

(a) Effective July 1, 2016, a provider of group residential housing or supplementary services must initiate background studies in accordance with chapter 245C on the following individuals:

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

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

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

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

(c) Effective July 1, 2017, for an individual to begin or continue employment with a provider of group residential housing or supplementary services, an individual who is required to receive a background study according to chapter 245C must receive either a notice stating that:

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

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

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

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

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

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

(b) A background study completed for the licensed service must also satisfy the background study requirements under this section, if the provider has established the

background study contact person according to chapter 245C and as directed by the Department of Human Services.

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

(1) food preparation and service for three nutritious meals a day on site;

(2) a bed, clothing storage, linen, bedding, laundering, and laundry supplies or service;

(3) housekeeping, including cleaning and lavatory supplies or service; and

(4) maintenance and operation of the building and grounds, including heat, water, garbage removal, electricity, telephone for the site, cooling, supplies, and parts and tools to repair and maintain equipment and facilities.

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

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

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

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

(3) notwithstanding the provisions of subdivision 2a, for up to 190 supportive housing units in Anoka, Dakota, Hennepin, or Ramsey County for homeless adults with a mental illness, a history of substance abuse, or human immunodeficiency virus or acquired immunodeficiency syndrome. For purposes of this section, "homeless adult" means a person who is living on the street or in a shelter or discharged from a regional treatment center, community hospital, or residential treatment program and has no appropriate housing available and lacks the resources and support necessary to access appropriate housing. At least 70 percent of the supportive housing units must serve homeless adults with mental illness, substance abuse problems, or human immunodeficiency virus or acquired immunodeficiency syndrome who are about to be or, within the previous six

months, has been discharged from a regional treatment center, or a state-contracted psychiatric bed in a community hospital, or a residential mental health or chemical dependency treatment program. If a person meets the requirements of subdivision 1, paragraph (a), and receives a federal or state housing subsidy, the group residential housing rate for that person is limited to the supplementary rate under section 256I.05, subdivision 1a, and is determined by subtracting the amount of the person's countable income that exceeds the MSA equivalent rate from the group residential housing supplementary rate. A resident in a demonstration project site who no longer participates in the demonstration program shall retain eligibility for a group residential housing payment in an amount determined under section 256I.06, subdivision 8, using the MSA equivalent rate. Service funding under section 256I.05, subdivision 1a, will end June 30, 1997, if federal matching funds are available and the services can be provided through a managed care entity. If federal matching funds are not available, then service funding will continue under section 256I.05, subdivision 1a;

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

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

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

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

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

(b) ~~A county~~ An agency may enter into a group residential housing agreement for beds with rates in excess of the MSA equivalent rate in addition to those currently covered under a group residential housing agreement if the additional beds are only a replacement of beds with rates in excess of the MSA equivalent rate which have been made available

due to closure of a setting, a change of licensure or certification which removes the beds from group residential housing payment, or as a result of the downsizing of a group residential housing setting. The transfer of available beds from one ~~county~~ agency to another can only occur by the agreement of both ~~counties~~ agencies.

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

EFFECTIVE DATE. Subdivisions 1a, 1b, and 1c are effective September 1, 2015.

Sec. 19. Minnesota Statutes 2014, section 256I.05, subdivision 1c, is amended to read:

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

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

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

(c) The room and board rates will be increased each year when the MSA equivalent rate is adjusted for SSI cost-of-living increases by the amount of the annual SSI increase,

less the amount of the increase in the medical assistance personal needs allowance under section 256B.35.

(d) When a group residential housing rate is used to pay for an individual's room and board, or other costs necessary to provide room and board, the rate payable to the residence must continue for up to 18 calendar days per incident that the person is temporarily absent from the residence, not to exceed 60 days in a calendar year, if the absence or absences have received the prior approval of the county agency's social service staff. Prior approval is not required for emergency absences due to crisis, illness, or injury.

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

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

(g) An agency may negotiate a difficulty of care rate approved by the commissioner for an individual receiving a group residential housing payment or housing assistance payment if necessary to provide housing for the individual due to the individual's extraordinary emotional, behavioral, or physical health needs and if necessary to secure housing for an individual transitioning into a more integrated setting.

Sec. 20. Minnesota Statutes 2014, section 256I.05, subdivision 1g, is amended to read:

Subd. 1g. **Supplementary service rate for certain facilities.** ~~On or after July 1, 2005, a county~~ An agency may negotiate a supplementary service rate for recipients of assistance under section 256I.04, subdivision 1, paragraph (a) or (b), who ~~relocate from a homeless shelter licensed and registered prior to December 31, 1996, by the Minnesota Department of Health under section 157.17, to~~ have experienced long-term homelessness and who live in a supportive housing establishment ~~developed and funded in whole or in part with funds provided specifically as part of the plan to end long-term homelessness~~

~~required under Laws 2003, chapter 128, article 15, section 9, not to exceed $456.75~~ under section 256I.04, subdivision 2a, paragraph (b), clause (2).

Sec. 21. Minnesota Statutes 2014, section 256I.05, is amended by adding a subdivision to read:

Subd. 1p. **Supplemental rate; relocation into an individual's own home.** Beginning February 1, 2017, an agency may negotiate a supplemental service rate in addition to the rate specified in subdivision 1, not to exceed the rate authorized by subdivision 1a, paragraph (a), for a provider authorized to provide supplemental services under this chapter to serve individuals who are receiving housing assistance.

Sec. 22. Minnesota Statutes 2014, section 256I.06, is amended to read:

256I.06 PAYMENT METHODS.

Subdivision 1. **Monthly payments.** Monthly payments made on an individual's behalf for group residential housing must be issued as a voucher or vendor payment. Monthly payments made on an individual's behalf for housing assistance must be issued as a voucher or vendor payment unless the individual is receiving Supplemental Security Income or Social Security Disability Insurance issued by the United States Social Security Administration.

Subd. 2. **Time of payment.** A county agency may make payments to a group residence in advance for an individual whose stay in the group residence is expected to last beyond the calendar month for which the payment is made ~~and who does not expect to receive countable earned income during the month for which the payment is made~~. Group residential housing payments made by a county agency on behalf of an individual who is not expected to remain in the group residence beyond the month for which payment is made must be made subsequent to the individual's departure from the group residence. ~~Group residential housing payments made by a county agency on behalf of an individual with countable earned income must be made subsequent to receipt of a monthly household report form.~~

Subd. 3. **Filing of application.** The county agency must immediately provide an application form to any person requesting ~~group residential housing~~ payments under this chapter. Application ~~for group residential housing~~ must be in writing on a form prescribed by the commissioner. The county agency must determine an applicant's eligibility for ~~group residential housing~~ payments under this chapter as soon as the required verifications are received by the county agency and within 30 days after a signed application is received by the county agency for the aged or blind or within 60 days for the disabled.

Subd. 4. **Verification.** The county agency must request, and applicants and recipients must provide and verify, all information necessary to determine initial and continuing eligibility and ~~group residential housing~~ payment amounts under this chapter. If necessary, the county agency shall assist the applicant or recipient in obtaining verifications. If the applicant or recipient refuses or fails without good cause to provide the information or verification, the county agency shall deny or terminate eligibility for ~~group residential housing~~ payments under this chapter.

Subd. 5. **Redetermination of eligibility.** The eligibility of each recipient must be redetermined at least once every 12 months.

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

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

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

(b) The amount of housing assistance payment is determined by subtracting 40 percent of the individual's countable income for a whole calendar month from the maximum United States Department of Housing and Urban Development fair market rent for the individual's area of residence or the individual's actual housing costs, whichever is lower. An individual living in a setting funded through a Minnesota Housing Finance

Agency multifamily award before July 1, 2015, shall use the MSA equivalent rate minus the maximum allotment authorized by the federal Food Stamp Program according to section 256I.03, subdivision 5, instead of the fair market rent.

(c) For an individual with earned income under paragraph (a) or (b), prospective budgeting must be used to determine the amount of the individual's payment for the following six-month period. An increase in income shall not affect an individual's eligibility or payment amount until the month following the reporting month. A decrease in income shall be effective the first day of the month after the month in which the decrease is reported.

EFFECTIVE DATE. Subdivisions 1 and 8, paragraph (b), are effective February 1, 2017. Subdivisions 2, 6, and 8, paragraph (c), are effective April 1, 2016.

Sec. 23. Minnesota Statutes 2014, section 256N.22, subdivision 9, is amended to read:

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

Sec. 24. Minnesota Statutes 2014, section 256N.22, subdivision 10, is amended to read:

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

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

(1) meet the background study requirements in subdivision 4;

(2) renegotiate the agreement consistent with section 256N.25, subdivision 2, including cooperating with an assessment under section 256N.24;

(3) be ordered by the court to be the child's legal relative custodian in a modification proceeding under section 260C.521, subdivision 2; and

(4) satisfy the requirements in this paragraph within one year of the relative custodian's death or incapacity unless the commissioner certifies that the named successor made reasonable attempts to satisfy the requirements within one year and failure to satisfy the requirements was not the responsibility of the named successor.

(c) Payment of Northstar kinship assistance to the successor guardian may be temporarily approved through the policies, procedures, requirements, and deadlines under section 256N.28, subdivision 2. Ongoing payment shall begin in the month when all the requirements in paragraph (b) are satisfied.

(d) Continued payment of Northstar kinship assistance may occur in the event of the death or incapacity of the relative custodian when no successor has been named in the benefit agreement when the commissioner gives written consent to an individual who is a guardian or custodian appointed by a court for the child upon the death of both relative custodians in the case of assignment of custody to two individuals, or the sole relative custodian in the case of assignment of custody to one individual, unless the child is under the custody of a county, tribal, or child-placing agency.

~~(b)~~ (e) Temporary assignment of Northstar kinship assistance may be approved for a maximum of six consecutive months from the death or incapacity of the relative custodian or custodians as provided in paragraph (a) and must adhere to the policies ~~and~~, procedures, requirements, and deadlines under section 256N.28, subdivision 2, that are prescribed by the commissioner. If a court has not appointed a permanent legal guardian or custodian within six months, the Northstar kinship assistance must terminate and must not be resumed.

~~(c)~~ (f) Upon assignment of assistance payments under ~~this subdivision~~ paragraphs (d) and (e), assistance must be provided from funds other than title IV-E.

Sec. 25. Minnesota Statutes 2014, section 256N.24, subdivision 4, is amended to read:

Subd. 4. **Extraordinary levels.** (a) The assessment tool established under subdivision 2 must provide a mechanism through which up to five levels can be added to the supplemental difficulty of care for a particular child under section 256N.26, subdivision 4. In establishing the assessment tool, the commissioner must design the tool so that the levels applicable to the portions of the assessment other than the extraordinary levels can accommodate the requirements of this subdivision.

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

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

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

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

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

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

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

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

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

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

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

(6) the extraordinary care and intense supervision provided by the foster, adoptive, or guardianship caregivers to maintain the child safely in the child's home and prevent

residential placement that cannot be supported by medical assistance or other programs that provide services, necessary care for children with disabilities, or other medical or behavioral conditions in the home or community.

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

Sec. 26. Minnesota Statutes 2014, section 256N.25, subdivision 1, is amended to read:

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

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

(1) duration of the agreement;

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

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

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

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

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

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

(8) the effective date of the agreement; and

(9) the successor relative custodian or custodians for Northstar kinship assistance, when applicable. The successor relative custodian or custodians may be added or changed by mutual agreement under subdivision 3.

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

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

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

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

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

Sec. 28. Minnesota Statutes 2014, section 259A.75, is amended to read:

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

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

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

(c) The commissioner shall set aside an amount not to exceed five percent of the total amount of the fiscal year appropriation from the state for the adoption assistance program to reimburse a Minnesota county or tribal social services placing ~~agencies~~ agency for child-specific adoption placement services. When adoption assistance payments for children's needs exceed 95 percent of the total amount of the fiscal year appropriation from

the state for the adoption assistance program, the amount of reimbursement available to placing agencies for adoption services is reduced correspondingly.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 29. Minnesota Statutes 2014, section 260C.007, subdivision 27, is amended to read:

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

Sec. 30. Minnesota Statutes 2014, section 260C.007, subdivision 32, is amended to read:

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

Sec. 31. Minnesota Statutes 2014, section 260C.203, is amended to read:

260C.203 ADMINISTRATIVE OR COURT REVIEW OF PLACEMENTS.

(a) Unless the court is conducting the reviews required under section 260C.202, there shall be an administrative review of the out-of-home placement plan of each child placed in foster care no later than 180 days after the initial placement of the child in foster

care and at least every six months thereafter if the child is not returned to the home of the parent or parents within that time. The out-of-home placement plan must be monitored and updated at each administrative review. The administrative review shall be conducted by the responsible social services agency using a panel of appropriate persons at least one of whom is not responsible for the case management of, or the delivery of services to, either the child or the parents who are the subject of the review. The administrative review shall be open to participation by the parent or guardian of the child and the child, as appropriate.

(b) As an alternative to the administrative review required in paragraph (a), the court may, as part of any hearing required under the Minnesota Rules of Juvenile Protection Procedure, conduct a hearing to monitor and update the out-of-home placement plan pursuant to the procedure and standard in section 260C.201, subdivision 6, paragraph (d). The party requesting review of the out-of-home placement plan shall give parties to the proceeding notice of the request to review and update the out-of-home placement plan. A court review conducted pursuant to section 260C.141, subdivision 2; 260C.193; 260C.201, subdivision 1; 260C.202; 260C.204; 260C.317; or 260D.06 shall satisfy the requirement for the review so long as the other requirements of this section are met.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(f) For a child who will be discharged from foster care at age 18 or older, the responsible social services agency is required to develop a personalized transition plan as

directed by the youth. The transition plan must be developed during the 90-day period immediately prior to the expected date of discharge. The transition plan must be as detailed as the child may elect and include specific options on housing, health insurance, education, local opportunities for mentors and continuing support services, and work force supports and employment services. The agency shall ensure that the youth receives, at no cost to the youth, a copy of the youth's consumer credit report as defined in section 13C.001 and assistance in interpreting and resolving any inaccuracies in the report. The plan must include information on the importance of designating another individual to make health care treatment decisions on behalf of the child if the child becomes unable to participate in these decisions and the child does not have, or does not want, a relative who would otherwise be authorized to make these decisions. The plan must provide the child with the option to execute a health care directive as provided under chapter 145C. The agency shall also provide the youth with appropriate contact information if the youth needs more information or needs help dealing with a crisis situation through age 21.

Sec. 32. Minnesota Statutes 2014, section 260C.212, subdivision 1, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) when a child cannot return to or be in the care of either parent, documentation of steps to finalize adoption as the permanency plan for the child~~, including: (i)~~ through reasonable efforts to place the child for adoption. At a minimum, the documentation must include consideration of whether adoption is in the best interests of the child, child-specific recruitment efforts such as relative search and the use of state, regional, and national adoption exchanges to facilitate orderly and timely placements in and outside of the state.

A copy of this documentation shall be provided to the court in the review required under section 260C.317, subdivision 3, paragraph (b); ~~and~~

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

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

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

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

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

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

(ii) the child's grade level performance;

(iii) the child's school record;

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

(v) any other relevant educational information;

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

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

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

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

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

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

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

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

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

(i) the names and addresses of the child's health care and dental care providers;

(ii) a record of the child's immunizations;

(iii) the child's known medical problems, including any known communicable diseases as defined in section 144.4172, subdivision 2;

(iv) the child's medications; and

(v) any other relevant health care information such as the child's eligibility for medical insurance or medical assistance;

~~(11)~~ (12) an independent living plan for a child age ~~16~~ 14 or older. The plan should include, but not be limited to, the following objectives:

(i) educational, vocational, or employment planning;

(ii) health care planning and medical coverage;

(iii) transportation including, where appropriate, assisting the child in obtaining a driver's license;

(iv) money management, including the responsibility of the agency to ensure that the youth annually receives, at no cost to the youth, a consumer report as defined under section 13C.001 and assistance in interpreting and resolving any inaccuracies in the report;

(v) planning for housing;

(vi) social and recreational skills; ~~and~~

(vii) establishing and maintaining connections with the child's family and community; and

(viii) regular opportunities to engage in age-appropriate or developmentally appropriate activities typical for the child's age group, taking into consideration the capacities of the individual child; and

~~(12)~~ (13) for a child in voluntary foster care for treatment under chapter 260D, diagnostic and assessment information, specific services relating to meeting the mental health care needs of the child, and treatment outcomes.

(d) The parent or parents or guardian and the child each shall have the right to legal counsel in the preparation of the case plan and shall be informed of the right at the time of placement of the child. The child shall also have the right to a guardian ad litem. If unable to employ counsel from their own resources, the court shall appoint counsel upon the request of the parent or parents or the child or the child's legal guardian. The parent or parents may also receive assistance from any person or social services agency in preparation of the case plan.

After the plan has been agreed upon by the parties involved or approved or ordered by the court, the foster parents shall be fully informed of the provisions of the case plan and shall be provided a copy of the plan.

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

Sec. 33. Minnesota Statutes 2014, section 260C.212, is amended by adding a subdivision to read:

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

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

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

(d) The local social services agency shall determine the primary factors that contributed to the child's running away or otherwise being absent from care and, to

the extent possible and appropriate, respond to those factors in current and subsequent placements.

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

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

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

Sec. 34. Minnesota Statutes 2014, section 260C.212, is amended by adding a subdivision to read:

Subd. 14. **Support age-appropriate and developmentally appropriate activities for foster children.** Responsible social services agencies and child-placing agencies shall support a foster child's emotional and developmental growth by permitting the child to participate in activities or events that are generally accepted as suitable for children of the same chronological age or are developmentally appropriate for the child. Foster parents and residential facility staff are permitted to allow foster children to participate in extracurricular, social, or cultural activities that are typical for the child's age by applying reasonable and prudent parenting standards. Reasonable and prudent parenting standards are characterized by careful and sensible parenting decisions that maintain the child's health and safety, and are made in the child's best interest.

Sec. 35. Minnesota Statutes 2014, section 260C.221, is amended to read:

260C.221 RELATIVE SEARCH.

(a) The responsible social services agency shall exercise due diligence to identify and notify adult relatives prior to placement or within 30 days after the child's removal from the parent. The county agency shall consider placement with a relative under this section without delay and whenever the child must move from or be returned to foster care. The relative search required by this section shall be comprehensive in scope. After a finding that the agency has made reasonable efforts to conduct the relative search under this paragraph, the agency has the continuing responsibility to appropriately involve relatives, who have responded to the notice required under this paragraph, in planning

for the child and to continue to consider relatives according to the requirements of section 260C.212, subdivision 2. At any time during the course of juvenile protection proceedings, the court may order the agency to reopen its search for relatives when it is in the child's best interest to do so.

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

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

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

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

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

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

~~(b)~~ (c) A responsible social services agency may disclose private data, as defined in sections 13.02 and 626.556, to relatives of the child for the purpose of locating and assessing a suitable placement and may use any reasonable means of identifying and locating relatives including the Internet or other electronic means of conducting a search. The agency shall disclose data that is necessary to facilitate possible placement with relatives and to ensure that the relative is informed of the needs of the child so the relative can participate in planning for the child and be supportive of services to the child and family. If the child's parent refuses to give the responsible social services agency information sufficient to identify the maternal and paternal relatives of the child, the agency shall ask the juvenile court to order the parent to provide the necessary information. If a parent makes an explicit request that a specific relative not be contacted or considered for placement due to safety reasons including past family or domestic violence, the agency shall bring the parent's request to the attention of the court to determine whether the parent's request is consistent with the best interests of the child and the agency shall not contact the specific relative when the juvenile court finds that contacting the specific relative would endanger the parent, guardian, child, sibling, or any family member.

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

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

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

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

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

~~(f)~~ (g) When the placing agency determines that permanent placement proceedings are necessary because there is a likelihood that the child will not return to a parent's care, the agency must send the notice provided in paragraph ~~(g)~~ (h), may ask the court to modify the duty of the agency to send the notice required in paragraph ~~(g)~~ (h), or may ask the court to completely relieve the agency of the requirements of paragraph ~~(g)~~ (h). The relative notification requirements of paragraph ~~(g)~~ (h) do not apply when the child is placed with an appropriate relative or a foster home that has committed to adopting the child or taking permanent legal and physical custody of the child and the agency approves of that foster home for permanent placement of the child. The actions ordered by the court under this section must be consistent with the best interests, safety, permanency, and welfare of the child.

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

Sec. 36. Minnesota Statutes 2014, section 260C.331, subdivision 1, is amended to read:

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

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

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

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

(b) The court shall order, and the responsible social services agency shall require, the parents or custodian of a child, while the child is under the age of 18, to use the total income and resources attributable to the child for the period of care, examination, or treatment, except for clothing and personal needs allowance as provided in section 256B.35, to reimburse the county for the cost of care, examination, or treatment. Income and resources attributable to the child include, but are not limited to, Social Security benefits, Supplemental Security Income (SSI), veterans benefits, railroad retirement benefits and child support. When the child is over the age of 18, and continues to receive care, examination, or treatment, the court shall order, and the responsible social services agency shall require, reimbursement from the child for the cost of care, examination, or treatment from the income and resources attributable to the child less the clothing and personal needs allowance. Income does not include earnings from a child over the age of 18 who is working as part of a plan under section 260C.212, subdivision 1, paragraph (c), clause ~~(11)~~ (12), to transition from foster care, or the income and resources from sources other than Supplemental Security Income and child support that are needed to complete the requirements listed in section 260C.203.

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

(d) The court shall order the amount of reimbursement attributable to the parents or custodian, or attributable to the child, or attributable to both sources, withheld under chapter 518A from the income of the parents or the custodian of the child. A parent or custodian who fails to pay without good reason may be proceeded against for contempt, or

the court may inform the county attorney, who shall proceed to collect the unpaid sums, or both procedures may be used.

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

(f) Notwithstanding paragraph (b), (c), or (d), a parent, custodian, or guardian of the child is not required to use income and resources attributable to the child to reimburse the county for costs of care and is not required to contribute to the cost of care of the child during any period of time when the child is returned to the home of that parent, custodian, or guardian pursuant to a trial home visit under section 260C.201, subdivision 1, paragraph (a).

Sec. 37. Minnesota Statutes 2014, section 260C.451, subdivision 2, is amended to read:

Subd. 2. **Independent living plan.** Upon the request of any child in foster care immediately prior to the child's 18th birthday and who is in foster care at the time of the request, the responsible social services agency shall, in conjunction with the child and other appropriate parties, update the independent living plan required under section 260C.212, subdivision 1, paragraph (c), clause ~~(11)~~ (12), related to the child's employment, vocational, educational, social, or maturational needs. The agency shall provide continued services and foster care for the child including those services that are necessary to implement the independent living plan.

Sec. 38. Minnesota Statutes 2014, section 260C.451, subdivision 6, is amended to read:

Subd. 6. **Reentering foster care and accessing services after age 18.** (a) Upon request of an individual between the ages of 18 and 21 who had been under the guardianship of the commissioner and who has left foster care without being adopted, the responsible social services agency which had been the commissioner's agent for purposes of the guardianship shall develop with the individual a plan to increase the individual's ability to live safely and independently using the plan requirements of section 260C.212, subdivision 1, paragraph ~~(b)~~ (c), clause ~~(11)~~ (12), and to assist the individual to meet one or more of the eligibility criteria in subdivision 4 if the individual wants to reenter

foster care. The agency shall provide foster care as required to implement the plan. The agency shall enter into a voluntary placement agreement under section 260C.229 with the individual if the plan includes foster care.

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

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

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

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

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

Sec. 39. Minnesota Statutes 2014, section 260C.515, subdivision 5, is amended to read:

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

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

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

(3) the responsible social services agency has made reasonable efforts to locate and place the child with an adoptive family or a fit and willing relative who would either agree

to adopt the child or to a transfer of permanent legal and physical custody of the child, but these efforts have not proven successful; and

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

Sec. 40. Minnesota Statutes 2014, section 260C.521, subdivision 1, is amended to read:

Subdivision 1. **Child in permanent custody of responsible social services agency.** (a) Court reviews of an order for permanent custody to the responsible social services agency for placement of the child in foster care must be conducted at least yearly at an in-court appearance hearing.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 41. Minnesota Statutes 2014, section 260C.521, subdivision 2, is amended to read:

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

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

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

Sec. 42. Minnesota Statutes 2014, section 260C.607, subdivision 4, is amended to read:

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

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

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

(i) placement;

(ii) visitation and contact with siblings;

(iii) visitation and contact with relatives;

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

(v) education.

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

Sec. 43. Minnesota Statutes 2014, section 518A.32, subdivision 2, is amended to read:

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

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

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

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

Sec. 44. Minnesota Statutes 2014, section 518A.39, subdivision 1, is amended to read:

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

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

Sec. 45. Minnesota Statutes 2014, section 518A.39, is amended by adding a subdivision to read:

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

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

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

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

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

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

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

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

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

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

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

Sec. 46. Minnesota Statutes 2014, section 518A.41, subdivision 1, is amended to read:

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

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

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

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

(1) provided on an individual or group basis;

(2) provided by an employer or union;

(3) purchased in the private market; or

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

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

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

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

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

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

(h) "Unreimbursed medical expenses" means a joint child's reasonable and necessary health-related expenses if a joint child is covered by a health plan or public coverage and the plan or coverage does not pay for the total cost of the expenses when the expenses are incurred. Unreimbursed medical expenses do not include the cost of premiums. Unreimbursed medical expenses include, but are not limited to, deductibles, co-payments,

and expenses for orthodontia, and prescription eyeglasses and contact lenses, but not over-the-counter medications if coverage is under a health plan.

Sec. 47. Minnesota Statutes 2014, section 518A.41, subdivision 3, is amended to read:

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

(1) comprehensiveness of health care coverage providing medical benefits. Dependent health care coverage providing medical benefits is presumed comprehensive if it includes medical and hospital coverage and provides for preventive, emergency, acute, and chronic care; or if it meets the minimum essential coverage definition in United States Code, title 26, section 500A(f). If both parents have health care coverage providing medical benefits that is presumed comprehensive under this paragraph, the court must determine which parent's coverage is more comprehensive by considering what other benefits are included in the coverage;

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

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

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

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

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

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

Sec. 48. Minnesota Statutes 2014, section 518A.41, subdivision 4, is amended to read:

Subd. 4. **Ordering health care coverage.** (a) If a joint child is presently enrolled in health care coverage, the court must order that the parent who currently has the joint child enrolled continue that enrollment unless the parties agree otherwise or a party

requests a change in coverage and the court determines that other health care coverage is more appropriate.

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

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

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

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

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

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

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

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

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

(2) if the joint child is receiving any form of public coverage, the parent with whom the joint child does not reside shall contribute a monthly amount toward the actual cost of public coverage. The amount of the noncustodial parent's contribution is determined by applying the noncustodial parent's PICS to the premium ~~schedule for public coverage~~ scale for MinnesotaCare under section 256L.15, subdivision 2, paragraph (c). If the noncustodial parent's PICS meets the eligibility requirements for ~~public coverage~~ MinnesotaCare, the contribution is the amount the noncustodial parent would pay for the child's premium. If the noncustodial parent's PICS exceeds the eligibility requirements ~~for public coverage~~, the contribution is the amount of the premium for the highest eligible income on the ~~appropriate~~ premium ~~schedule for public coverage~~ scale for MinnesotaCare under section 256L.15,

subdivision 2, paragraph (c). For purposes of determining the premium amount, the noncustodial parent's household size is equal to one parent plus the child or children who are the subject of the child support order. The custodial parent's obligation is determined under the requirements for public coverage as set forth in chapter 256B ~~or 256L.~~; or

(3) if the noncustodial parent's PICS meet the eligibility requirement for public coverage under chapter 256B or the noncustodial parent receives public assistance, the noncustodial parent must not be ordered to contribute toward the cost of public coverage.

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

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

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

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

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

Sec. 49. Minnesota Statutes 2014, section 518A.41, subdivision 14, is amended to read:

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

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

Sec. 50. Minnesota Statutes 2014, section 518A.41, subdivision 15, is amended to read:

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

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

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

(2) dental coverage;

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

(4) liabilities established under this subdivision.

(c) A party who fails to carry court-ordered dependent health care coverage is liable for the joint child's uninsured medical expenses unless a court order provides otherwise. A party's failure to carry court-ordered coverage, or to provide other medical support as ordered, is a basis for modification of ~~a~~ a medical support ~~order~~ under section 518A.39, subdivision ~~2~~ 8, unless it meets the presumption in section 518A.39, subdivision 2.

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

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

Sec. 51. Minnesota Statutes 2014, section 518A.46, subdivision 3, is amended to read:

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

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

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

(3) other support obligations of the obligor;

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

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

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

(7) health insurance coverage of parties;

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

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

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

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

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

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

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

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

Sec. 52. Minnesota Statutes 2014, section 518A.46, is amended by adding a subdivision to read:

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

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

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

(3) a copy of the full support order being modified;

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

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

(6) health insurance coverage of the parties; and

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

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

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

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

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

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

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

Sec. 53. Minnesota Statutes 2014, section 518A.51, is amended to read:

518A.51 FEES FOR IV-D SERVICES.

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

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

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

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

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

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

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

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

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

~~(h)~~ (g) The limitations of this section on the assessment of fees shall not apply to the extent inconsistent with the requirements of federal law for receiving funds for the programs under title IV-A and title IV-D of the Social Security Act, United States Code, title 42, sections 601 to 613 and United States Code, title 42, sections 651 to 662.

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

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

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

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

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

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

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

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

Sec. 54. Minnesota Statutes 2014, section 518A.53, subdivision 4, is amended to read:

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

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

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

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

(e) When a person terminates IV-D services, if an arrearage for public assistance as defined in section 256.741 exists, the public authority may continue income withholding, as well as use any other enforcement remedy for the collection of child support, until all

public assistance arrears are paid in full. Income withholding shall be in an amount equal to 20 percent of the support order in effect at the time the services terminated.

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

Sec. 55. Minnesota Statutes 2014, section 518C.802, is amended to read:

518C.802 CONDITIONS OF RENDITION.

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

(b) If, under this chapter or a law substantially similar to this chapter, ~~the Uniform Reciprocal Enforcement of Support Act, or the Revised Uniform Reciprocal Enforcement of Support Act,~~ the governor of another state makes a demand that the governor of this state surrender an individual charged criminally in that state with having failed to provide for the support of a child or other individual to whom a duty of support is owed, the governor may require a prosecutor to investigate the demand and report whether a proceeding for support has been initiated or would be effective. If it appears that a proceeding would be effective but has not been initiated, the governor may delay honoring the demand for a reasonable time to permit the initiation of a proceeding.

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

Sec. 56. Laws 2014, chapter 189, section 5, is amended to read:

Sec. 5. Minnesota Statutes 2012, section 518C.201, is amended to read:

518C.201 BASES FOR JURISDICTION OVER NONRESIDENT.

(a) In a proceeding to establish~~,~~ or enforce~~, or modify~~ a support order or to determine parentage of a child, a tribunal of this state may exercise personal jurisdiction over a nonresident individual or the individual's guardian or conservator if:

(1) the individual is personally served with a summons or comparable document within this state;

(2) the individual submits to the jurisdiction of this state by consent, by entering a general appearance, or by filing a responsive document having the effect of waiving any contest to personal jurisdiction;

(3) the individual resided with the child in this state;

(4) the individual resided in this state and provided prenatal expenses or support for the child;

(5) the child resides in this state as a result of the acts or directives of the individual;

(6) the individual engaged in sexual intercourse in this state and the child may have been conceived by that act of intercourse;

(7) the individual asserted parentage of a child under sections 257.51 to 257.75; or

(8) there is any other basis consistent with the constitutions of this state and the United States for the exercise of personal jurisdiction.

(b) The bases of personal jurisdiction in paragraph (a) or in any other law of this state may not be used to acquire personal jurisdiction for a tribunal of this state to modify a child support order of another state unless the requirements of section 518C.611 are met, or, in the case of a foreign support order, unless the requirements of section 518C.615 are met.

Sec. 57. Laws 2014, chapter 189, section 10, is amended to read:

Sec. 10. Minnesota Statutes 2012, section 518C.206, is amended to read:

518C.206 ~~ENFORCEMENT AND MODIFICATION OF SUPPORT ORDER BY TRIBUNAL HAVING~~ CONTINUING JURISDICTION TO ENFORCE CHILD SUPPORT ORDER.

(a) A tribunal of this state that has issued a child support order consistent with the law of this state may serve as an initiating tribunal to request a tribunal of another state to enforce:

(1) the order if the order is the controlling order and has not been modified by a tribunal of another state that assumed jurisdiction pursuant to ~~this chapter or a law substantially similar to this chapter~~ the Uniform Interstate Family Support Act; or

(2) a money judgment for arrears of support and interest on the order accrued before a determination that an order of a tribunal of another state is the controlling order.

(b) A tribunal of this state having continuing~~, exclusive~~ jurisdiction over a support order may act as a responding tribunal to enforce the order.

Sec. 58. Laws 2014, chapter 189, section 11, is amended to read:

Sec. 11. Minnesota Statutes 2012, section 518C.207, is amended to read:

518C.207 ~~RECOGNITION~~ DETERMINATION OF CONTROLLING CHILD SUPPORT ORDER.

(a) If a proceeding is brought under this chapter and only one tribunal has issued a child support order, the order of that tribunal ~~is controlling~~ controls and must be recognized.

(b) If a proceeding is brought under this chapter, and two or more child support orders have been issued by tribunals of this state, another state, or a foreign country with regard to the same obligor and child, a tribunal of this state having personal jurisdiction over both the obligor and the individual obligee shall apply the following rules and by order shall determine which order controls and must be recognized:

(1) If only one of the tribunals would have continuing, exclusive jurisdiction under this chapter, the order of that tribunal ~~is controlling~~ controls.

(2) If more than one of the tribunals would have continuing, exclusive jurisdiction under this chapter:

(i) an order issued by a tribunal in the current home state of the child controls; or

(ii) if an order has not been issued in the current home state of the child, the order most recently issued controls.

(3) If none of the tribunals would have continuing, exclusive jurisdiction under this chapter, the tribunal of this state shall issue a child support order, which controls.

(c) If two or more child support orders have been issued for the same obligor and child, upon request of a party who is an individual or that is a support enforcement agency, a tribunal of this state having personal jurisdiction over both the obligor and the obligee who is an individual shall determine which order controls under paragraph (b). The request may be filed with a registration for enforcement or registration for modification pursuant to sections 518C.601 to 518C.616, or may be filed as a separate proceeding.

(d) A request to determine which is the controlling order must be accompanied by a copy of every child support order in effect and the applicable record of payments. The requesting party shall give notice of the request to each party whose rights may be affected by the determination.

(e) The tribunal that issued the controlling order under paragraph (a), (b), or (c) has continuing jurisdiction to the extent provided in section 518C.205, or 518C.206.

(f) A tribunal of this state which determines by order which is the controlling order under paragraph (b), clause (1) or (2), or paragraph (c), or which issues a new controlling child support order under paragraph (b), clause (3), shall state in that order:

(1) the basis upon which the tribunal made its determination;

(2) the amount of prospective support, if any; and

(3) the total amount of consolidated arrears and accrued interest, if any, under all of the orders after all payments made are credited as provided by section 518C.209.

(g) Within 30 days after issuance of the order determining which is the controlling order, the party obtaining that order shall file a certified copy of it with each tribunal that issued or registered an earlier order of child support. A party or support enforcement agency obtaining the order that fails to file a certified copy is subject to appropriate sanctions by a tribunal in which the issue of failure to file arises. The failure to file does not affect the validity or enforceability of the controlling order.

(h) An order that has been determined to be the controlling order, or a judgment for consolidated arrears of support and interest, if any, made pursuant to this section must be recognized in proceedings under this chapter.

Sec. 59. Laws 2014, chapter 189, section 16, is amended to read:

Sec. 16. Minnesota Statutes 2012, section 518C.301, is amended to read:

518C.301 PROCEEDINGS UNDER THIS CHAPTER.

(a) Except as otherwise provided in this chapter, sections 518C.301 to 518C.319 apply to all proceedings under this chapter.

~~(b) This chapter provides for the following proceedings:~~

~~(1) establishment of an order for spousal support or child support pursuant to section 518C.401;~~

~~(2) enforcement of a support order and income-withholding order of another state or a foreign country without registration pursuant to sections 518C.501 and 518C.502;~~

~~(3) registration of an order for spousal support or child support of another state or a foreign country for enforcement pursuant to sections 518C.601 to 518C.612;~~

~~(4) modification of an order for child support or spousal support issued by a tribunal of this state pursuant to sections 518C.203 to 518C.206;~~

~~(5) registration of an order for child support of another state or a foreign country for modification pursuant to sections 518C.601 to 518C.612;~~

~~(6) determination of parentage of a child pursuant to section 518C.701; and~~

~~(7) assertion of jurisdiction over nonresidents pursuant to sections 518C.201 and 518C.202.~~

~~(c)~~ (b) An individual petitioner or a support enforcement agency may commence a proceeding authorized under this chapter by filing a petition in an initiating tribunal for forwarding to a responding tribunal or by filing a petition or a comparable pleading directly in a tribunal of another state or a foreign country which has or can obtain personal jurisdiction over the respondent.

Sec. 60. Laws 2014, chapter 189, section 17, is amended to read:

Sec. 17. Minnesota Statutes 2012, section 518C.303, is amended to read:

518C.303 APPLICATION OF LAW OF THIS STATE.

Except as otherwise provided by this chapter, a responding tribunal of this state shall:

(1) apply the procedural and substantive law~~, including the rules on choice of law,~~ generally applicable to similar proceedings originating in this state and may exercise all powers and provide all remedies available in those proceedings; and

(2) determine the duty of support and the amount payable in accordance with the law and support guidelines of this state.

Sec. 61. Laws 2014, chapter 189, section 18, is amended to read:

Sec. 18. Minnesota Statutes 2012, section 518C.304, is amended to read:

518C.304 DUTIES OF INITIATING TRIBUNAL.

(a) Upon the filing of a petition authorized by this chapter, an initiating tribunal of this state shall forward the petition and its accompanying documents:

(1) to the responding tribunal or appropriate support enforcement agency in the responding state; or

(2) if the identity of the responding tribunal is unknown, to the state information agency of the responding state with a request that they be forwarded to the appropriate tribunal and that receipt be acknowledged.

(b) If requested by the responding tribunal, a tribunal of this state shall issue a certificate or other documents and make findings required by the law of the responding state. If the responding tribunal is in a foreign country, upon request the tribunal of this state shall specify the amount of support sought, convert that amount into the equivalent amount in the foreign currency under applicable official or market exchange rate as publicly reported, and provide other documents necessary to satisfy the requirements of the responding foreign tribunal.

Sec. 62. Laws 2014, chapter 189, section 19, is amended to read:

Sec. 19. Minnesota Statutes 2012, section 518C.305, is amended to read:

518C.305 DUTIES AND POWERS OF RESPONDING TRIBUNAL.

(a) When a responding tribunal of this state receives a petition or comparable pleading from an initiating tribunal or directly pursuant to section 518C.301, paragraph ~~(c)~~ (b), it shall cause the petition or pleading to be filed and notify the petitioner where and when it was filed.

(b) A responding tribunal of this state, to the extent ~~otherwise authorized by~~ not prohibited by other law, may do one or more of the following:

(1) establish or enforce a support order, modify a child support order, determine the controlling child support order, or to determine parentage of a child;

(2) order an obligor to comply with a support order, specifying the amount and the manner of compliance;

(3) order income withholding;

(4) determine the amount of any arrearages, and specify a method of payment;

(5) enforce orders by civil or criminal contempt, or both;

(6) set aside property for satisfaction of the support order;

(7) place liens and order execution on the obligor's property;

(8) order an obligor to keep the tribunal informed of the obligor's current residential address, electronic mail address, telephone number, employer, address of employment, and telephone number at the place of employment;

(9) issue a bench warrant for an obligor who has failed after proper notice to appear at a hearing ordered by the tribunal and enter the bench warrant in any local and state computer systems for criminal warrants;

(10) order the obligor to seek appropriate employment by specified methods;

(11) award reasonable attorney's fees and other fees and costs; and

(12) grant any other available remedy.

(c) A responding tribunal of this state shall include in a support order issued under this chapter, or in the documents accompanying the order, the calculations on which the support order is based.

(d) A responding tribunal of this state may not condition the payment of a support order issued under this chapter upon compliance by a party with provisions for visitation.

(e) If a responding tribunal of this state issues an order under this chapter, the tribunal shall send a copy of the order to the petitioner and the respondent and to the initiating tribunal, if any.

(f) If requested to enforce a support order, arrears, or judgment or modify a support order stated in a foreign currency, a responding tribunal of this state shall convert the amount stated in the foreign currency to the equivalent amount in dollars under the applicable official or market exchange rate as publicly reported.

Sec. 63. Laws 2014, chapter 189, section 23, is amended to read:

Sec. 23. Minnesota Statutes 2012, section 518C.310, is amended to read:

518C.310 DUTIES OF STATE INFORMATION AGENCY.

(a) The unit within the Department of Human Services that receives and disseminates incoming interstate actions under title IV-D of the Social Security Act is the State Information Agency under this chapter.

(b) The State Information Agency shall:

(1) compile and maintain a current list, including addresses, of the tribunals in this state which have jurisdiction under this chapter and any support enforcement agencies in this state and transmit a copy to the state information agency of every other state;

(2) maintain a register of names and addresses of tribunals and support enforcement agencies received from other states;

(3) forward to the appropriate tribunal in the place in this state in which the individual obligee or the obligor resides, or in which the obligor's property is believed to be located, all documents concerning a proceeding under this chapter received from another state or a foreign country; and

(4) obtain information concerning the location of the obligor and the obligor's property within this state not exempt from execution, by such means as postal verification and federal or state locator services, examination of telephone directories, requests for the obligor's address from employers, and examination of governmental records, including, to the extent not prohibited by other law, those relating to real property, vital statistics, law enforcement, taxation, motor vehicles, driver's licenses, and Social Security.

Sec. 64. Laws 2014, chapter 189, section 24, is amended to read:

Sec. 24. Minnesota Statutes 2012, section 518C.311, is amended to read:

518C.311 PLEADINGS AND ACCOMPANYING DOCUMENTS.

(a) A petitioner seeking to establish or modify a support order, determine parentage of a child, or register and modify a support order of a tribunal of another state or a foreign country, in a proceeding under this chapter must file a petition. Unless otherwise ordered under section 518C.312, the petition or accompanying documents must provide, so far as known, the name, residential address, and Social Security numbers of the obligor and the obligee or parent and alleged parent, and the name, sex, residential address, Social Security number, and date of birth of each child for whom support is sought or whose ~~parenthood~~ parentage is to be determined. Unless filed at the time of registration, the petition must be accompanied by a ~~certified~~ copy of any support order ~~in effect~~ known to have been issued by another tribunal. The petition may include any other information that may assist in locating or identifying the respondent.

(b) The petition must specify the relief sought. The petition and accompanying documents must conform substantially with the requirements imposed by the forms mandated by federal law for use in cases filed by a support enforcement agency.

Sec. 65. Laws 2014, chapter 189, section 27, is amended to read:

Sec. 27. Minnesota Statutes 2012, section 518C.314, is amended to read:

518C.314 LIMITED IMMUNITY OF PETITIONER.

(a) Participation by a petitioner in a proceeding under this chapter before a responding tribunal, whether in person, by private attorney, or through services provided by the support enforcement agency, does not confer personal jurisdiction over the petitioner in another proceeding.

(b) A petitioner is not amenable to service of civil process while physically present in this state to participate in a proceeding under this chapter.

(c) The immunity granted by this section does not extend to civil litigation based on acts unrelated to a proceeding under this chapter committed by a party while physically present in this state to participate in the proceeding.

Sec. 66. Laws 2014, chapter 189, section 28, is amended to read:

Sec. 28. Minnesota Statutes 2012, section 518C.316, is amended to read:

518C.316 SPECIAL RULES OF EVIDENCE AND PROCEDURE.

(a) The physical presence of ~~the petitioner~~ a nonresident party who is an individual in a ~~responding~~ tribunal of this state is not required for the establishment, enforcement, or modification of a support order or the rendition of a judgment determining parentage of a child.

(b) ~~A verified petition,~~ An affidavit, a document substantially complying with federally mandated forms, ~~and~~ or a document incorporated by reference in any of them, not excluded under the hearsay rule if given in person, is admissible in evidence if given under ~~oath~~ penalty of perjury by a party or witness residing outside this state.

(c) A copy of the record of child support payments certified as a true copy of the original by the custodian of the record may be forwarded to a responding tribunal. The copy is evidence of facts asserted in it, and is admissible to show whether payments were made.

(d) Copies of bills for testing for parentage of a child, and for prenatal and postnatal health care of the mother and child, furnished to the adverse party at least ten days before trial, are admissible in evidence to prove the amount of the charges billed and that the charges were reasonable, necessary, and customary.

(e) Documentary evidence transmitted from outside this state to a tribunal of this state by telephone, telecopier, or other electronic means that do not provide an original record may not be excluded from evidence on an objection based on the means of transmission.

(f) In a proceeding under this chapter, a tribunal of this state shall permit a party or witness residing outside this state to be deposed or to testify under penalty of perjury by telephone, audiovisual means, or other electronic means at a designated tribunal or other location. A tribunal of this state shall cooperate with other tribunals in designating an appropriate location for the deposition or testimony.

(g) If a party called to testify at a civil hearing refuses to answer on the ground that the testimony may be self-incriminating, the trier of fact may draw an adverse inference from the refusal.

(h) A privilege against disclosure of communications between spouses does not apply in a proceeding under this chapter.

(i) The defense of immunity based on the relationship of husband and wife or parent and child does not apply in a proceeding under this chapter.

(j) A voluntary acknowledgment of paternity, certified as a true copy, is admissible to establish parentage of a child.

Sec. 67. Laws 2014, chapter 189, section 29, is amended to read:

Sec. 29. Minnesota Statutes 2012, section 518C.317, is amended to read:

518C.317 COMMUNICATIONS BETWEEN TRIBUNALS.

A tribunal of this state may communicate with a tribunal outside this state in ~~writing, by e-mail, or~~ a record, or by telephone, electronic mail, or other means, to obtain information concerning the laws of that state, the legal effect of a judgment, decree, or order of that tribunal, and the status of a proceeding. A tribunal of this state may furnish similar information by similar means to a tribunal outside this state.

Sec. 68. Laws 2014, chapter 189, section 31, is amended to read:

Sec. 31. Minnesota Statutes 2012, section 518C.319, is amended to read:

518C.319 RECEIPT AND DISBURSEMENT OF PAYMENTS.

(a) A support enforcement agency or tribunal of this state shall disburse promptly any amounts received pursuant to a support order, as directed by the order. The agency or tribunal shall furnish to a requesting party or tribunal of another state or a foreign country a certified statement by the custodian of the record of the amounts and dates of all payments received.

(b) If neither the obligor, ~~not~~ nor the obligee who is an individual, nor the child resides in this state, upon request from the support enforcement agency of this state or another state, the support enforcement agency of this state or a tribunal of this state shall:

(1) direct that the support payment be made to the support enforcement agency in the state in which the obligee is receiving services; and

(2) issue and send to the obligor's employer a conforming income-withholding order or an administrative notice of change of payee, reflecting the redirected payments.

(c) The support enforcement agency of this state receiving redirected payments from another state pursuant to a law similar to paragraph (b) shall furnish to a requesting party or tribunal of the other state a certified statement by the custodian of the record of the amount and dates of all payments received.

Sec. 69. Laws 2014, chapter 189, section 43, is amended to read:

Sec. 43. Minnesota Statutes 2012, section 518C.604, is amended to read:

518C.604 CHOICE OF LAW.

(a) Except as otherwise provided in paragraph (d), the law of the issuing state or foreign country governs:

(1) the nature, extent, amount, and duration of current payments under a registered support order;

(2) the computation and payment of arrearages and accrual of interest on the arrearages under the support order; and

(3) the existence and satisfaction of other obligations under the support order.

(b) In a proceeding for arrearages under a registered support order, the statute of limitation under the laws of this state or of the issuing state or foreign country, whichever is longer, applies.

(c) A responding tribunal of this state shall apply the procedures and remedies of this state to enforce current support and collect arrears and interest due on a support order of another state or a foreign country registered in this state.

(d) After a tribunal of this state or another state determines which is the controlling order and issues an order consolidating arrears, if any, a tribunal of this state shall prospectively apply the law of the state or foreign country issuing the controlling order, including its law on interest on arrears, on current and future support, and on consolidated arrears.

Sec. 70. Laws 2014, chapter 189, section 50, is amended to read:

Sec. 50. Minnesota Statutes 2012, section 518C.611, is amended to read:

518C.611 MODIFICATION OF CHILD SUPPORT ORDER OF ANOTHER STATE.

(a) If section 518C.613 does not apply, upon petition a tribunal of this state may modify a child support order issued in another state that is registered in this state if, after notice and hearing, it finds that:

(1) the following requirements are met:

(i) neither the child, nor the obligee who is an individual, nor the obligor resides in the issuing state;

(ii) a petitioner who is a nonresident of this state seeks modification; and

(iii) the respondent is subject to the personal jurisdiction of the tribunal of this state; or

(2) this state is the residence of the child, or a party who is an individual is subject to the personal jurisdiction of the tribunal of this state and all of the parties who are individuals have filed ~~written~~ consents in a record in the issuing tribunal for a tribunal of this state to modify the support order and assume continuing, exclusive jurisdiction ~~over the order~~.

(b) Modification of a registered child support order is subject to the same requirements, procedures, and defenses that apply to the modification of an order issued by a tribunal of this state and the order may be enforced and satisfied in the same manner.

(c) A tribunal of this state may not modify any aspect of a child support order that may not be modified under the law of the issuing state, including the duration of the obligation of support. If two or more tribunals have issued child support orders for the same obligor and child, the order that controls and must be recognized under section 518C.207 establishes the aspects of the support order which are nonmodifiable.

(d) In a proceeding to modify a child support order, the law of the state that is determined to have issued the initial controlling order governs the duration of the obligation of support. The obligor's fulfillment of the duty of support established by that order precludes imposition of a further obligation of support by a tribunal of this state.

(e) On issuance of an order by a tribunal of this state modifying a child support order issued in another state, a tribunal of this state becomes the tribunal having continuing, exclusive jurisdiction.

(f) Notwithstanding paragraphs (a) to ~~(d)~~ (e) and section 518C.201, paragraph (b), a tribunal of this state retains jurisdiction to modify an order issued by a tribunal of this state if:

(1) one party resides in another state; and

(2) the other party resides outside the United States.

Sec. 71. Laws 2014, chapter 189, section 51, is amended to read:

Sec. 51. Minnesota Statutes 2012, section 518C.612, is amended to read:

518C.612 RECOGNITION OF ORDER MODIFIED IN ANOTHER STATE.

If a child support order issued by a tribunal of this state is modified by a tribunal of another state which assumed jurisdiction ~~according to this chapter or a law substantially similar to this chapter~~ pursuant to the Uniform Interstate Family Support Act, a tribunal of this state:

(1) may enforce its order that was modified only as to arrears and interest accruing before the modification;

(2) may provide appropriate relief for violations of its order which occurred before the effective date of the modification; and

(3) shall recognize the modifying order of the other state, upon registration, for the purpose of enforcement.

Sec. 72. Laws 2014, chapter 189, section 73, is amended to read:

Sec. 73. **EFFECTIVE DATE.**

This act ~~becomes~~ is effective ~~on the date that the United States deposits the instrument of ratification for the Hague Convention on the International Recovery of Child Support and Other Forms of Family Maintenance with the Hague Conference on Private International Law~~ July 1, 2015.

EFFECTIVE DATE. This section is effective July 1, 2015.

Sec. 73. **REPEALER.**

Minnesota Statutes 2014, section 124D.142, is repealed effective the day following final enactment.

ARTICLE 2

CHEMICAL AND MENTAL HEALTH SERVICES

Section 1. Minnesota Statutes 2014, section 245.4661, subdivision 5, is amended to read:

Subd. 5. **Planning for pilot projects.** (a) Each local plan for a pilot project, with the exception of the placement of a Minnesota specialty treatment facility as defined in paragraph (c), must be developed under the direction of the county board, or multiple county boards acting jointly, as the local mental health authority. The planning process for each pilot shall include, but not be limited to, mental health consumers, families, advocates, local mental health advisory councils, local and state providers, representatives

of state and local public employee bargaining units, and the department of human services. As part of the planning process, the county board or boards shall designate a managing entity responsible for receipt of funds and management of the pilot project.

(b) For Minnesota specialty treatment facilities, the commissioner shall issue a request for proposal for regions in which a need has been identified for services.

(c) For purposes of this section, "Minnesota specialty treatment facility" is defined as an intensive ~~rehabilitative mental health~~ residential treatment service under section 256B.0622, subdivision 2, paragraph (b).

Sec. 2. **[245.735] EXCELLENCE IN MENTAL HEALTH DEMONSTRATION PROJECT.**

Subdivision 1. **Excellence in Mental Health demonstration project.** The commissioner shall develop and execute projects to reform the mental health system by participating in the Excellence in Mental Health demonstration project.

Subd. 2. **Federal proposal.** The commissioner shall develop and submit to the United States Department of Health and Human Services a proposal for the Excellence in Mental Health demonstration project. The proposal shall include any necessary state plan amendments, waivers, requests for new funding, realignment of existing funding, and other authority necessary to implement the projects specified in subdivision 4.

Subd. 3. **Rules.** By January 15, 2017, the commissioner shall adopt rules that meet the criteria in subdivision 4, paragraph (a), to establish standards for state certification of community behavioral health clinics, and rules that meet the criteria in subdivision 4, paragraph (b), to implement a prospective payment system for medical assistance payment of mental health services delivered in certified community behavioral health clinics. These rules shall comply with federal requirements for certification of community behavioral health clinics and the prospective payment system and shall apply to community mental health centers, mental health clinics, mental health residential treatment centers, essential community providers, federally qualified health centers, and rural health clinics. The commissioner may adopt rules under this subdivision using the expedited process in section 14.389.

Subd. 4. **Reform projects.** (a) The commissioner shall establish standards for state certification of clinics as certified community behavioral health clinics, in accordance with the criteria published on or before September 1, 2015, by the United States Department of Health and Human Services. Certification standards established by the commissioner shall require that:

(1) clinic staff have backgrounds in diverse disciplines, include licensed mental health professionals, and are culturally and linguistically trained to serve the needs of the clinic's patient population;

(2) clinic services are available and accessible and that crisis management services are available 24 hours per day;

(3) fees for clinic services are established using a sliding fee scale and services to patients are not denied or limited due to a patient's inability to pay for services;

(4) clinics provide coordination of care across settings and providers to ensure seamless transitions for patients across the full spectrum of health services, including acute, chronic, and behavioral needs. Care coordination may be accomplished through partnerships or formal contracts with federally qualified health centers, inpatient psychiatric facilities, substance use and detoxification facilities, community-based mental health providers, and other community services, supports, and providers including schools, child welfare agencies, juvenile and criminal justice agencies, Indian Health Services clinics, tribally licensed health care and mental health facilities, urban Indian health clinics, Department of Veterans Affairs medical centers, outpatient clinics, drop-in centers, acute care hospitals, and hospital outpatient clinics;

(5) services provided by clinics include crisis mental health services, emergency crisis intervention services, and stabilization services; screening, assessment, and diagnosis services, including risk assessments and level of care determinations; patient-centered treatment planning; outpatient mental health and substance use services; targeted case management; psychiatric rehabilitation services; peer support and counselor services and family support services; and intensive community-based mental health services, including mental health services for members of the armed forces and veterans; and

(6) clinics comply with quality assurance reporting requirements and other reporting requirements, including any required reporting of encounter data, clinical outcomes data, and quality data.

(b) The commissioner shall establish standards and methodologies for a prospective payment system for medical assistance payments for mental health services delivered by certified community behavioral health clinics, in accordance with guidance issued on or before September 1, 2015, by the Centers for Medicare and Medicaid Services. During the operation of the demonstration project, payments shall comply with federal requirements for a 90 percent enhanced federal medical assistance percentage.

Subd. 5. **Public participation.** In developing the projects under subdivision 4, the commissioner shall consult with mental health providers, advocacy organizations, licensed

mental health professionals, and Minnesota health care program enrollees who receive mental health services and their families.

Subd. 6. **Information systems support.** The commissioner and the state chief information officer shall provide information systems support to the projects as necessary to comply with federal requirements and the deadlines in subdivision 3.

Sec. 3. Minnesota Statutes 2014, section 254B.05, subdivision 5, is amended to read:

Subd. 5. **Rate requirements.** (a) The commissioner shall establish rates for chemical dependency services and service enhancements funded under this chapter.

(b) Eligible chemical dependency treatment services include:

(1) outpatient treatment services that are licensed according to Minnesota Rules, parts 9530.6405 to 9530.6480, or applicable tribal license;

(2) medication-assisted therapy services that are licensed according to Minnesota Rules, parts 9530.6405 to 9530.6480 and 9530.6500, or applicable tribal license;

(3) medication-assisted therapy plus enhanced treatment services that meet the requirements of clause (2) and provide nine hours of clinical services each week;

(4) high, medium, and low intensity residential treatment services that are licensed according to Minnesota Rules, parts 9530.6405 to 9530.6480 and 9530.6505, or applicable tribal license which provide, respectively, 30, 15, and five hours of clinical services each week;

(5) hospital-based treatment services that are licensed according to Minnesota Rules, parts 9530.6405 to 9530.6480, or applicable tribal license and licensed as a hospital under sections 144.50 to 144.56;

(6) adolescent treatment programs that are licensed as outpatient treatment programs according to Minnesota Rules, parts 9530.6405 to 9530.6485, or as residential treatment programs according to Minnesota Rules, parts 2960.0010 to 2960.0220, and 2960.0430 to 2960.0490, or applicable tribal license; ~~and~~

(7) room and board facilities that meet the requirements of section 254B.05, subdivision 1a.; and

(8) services that:

(i) are licensed according to Minnesota Rules, parts 9530.6405 to 9530.6480 and 9530.6505, or with an applicable tribal license, and provide 30 hours of clinical services each week;

(ii) are certified according to Minnesota Rules, parts 9533.0010 to 9533.0180;

(iii) are provided by a state-operated or nonstate-operated vendor, to clients who have been civilly committed to the commissioner, present the most complex and difficult care needs, and are a potential threat to the community; and

(iv) meet staffing requirements established by the commissioner for serving this population.

(c) The commissioner shall establish higher rates for programs that meet the requirements of paragraph (b) and the following additional requirements:

(1) programs that serve parents with their children if the program:

(i) provides on-site child care during hours of treatment activity that meets the requirements in Minnesota Rules, part 9530.6490, or section 245A.03, subdivision 2; or

(ii) arranges for off-site child care during hours of treatment activity at a facility that is licensed under chapter 245A as:

(A) a child care center under Minnesota Rules, chapter 9503; or

(B) a family child care home under Minnesota Rules, chapter 9502;

(2) culturally specific programs as defined in section 254B.01, subdivision ~~8~~ 4a, if the program meets the requirements in Minnesota Rules, part 9530.6605, subpart 13;

(3) programs that offer medical services delivered by appropriately credentialed health care staff in an amount equal to two hours per client per week if the medical needs of the client and the nature and provision of any medical services provided are documented in the client file; and

(4) programs that offer services to individuals with co-occurring mental health and chemical dependency problems if:

(i) the program meets the co-occurring requirements in Minnesota Rules, part 9530.6495;

(ii) 25 percent of the counseling staff are licensed mental health professionals, as defined in section 245.462, subdivision 18, clauses (1) to (6), or are students or licensing candidates under the supervision of a licensed alcohol and drug counselor supervisor and licensed mental health professional, except that no more than 50 percent of the mental health staff may be students or licensing candidates with time documented to be directly related to provisions of co-occurring services;

(iii) clients scoring positive on a standardized mental health screen receive a mental health diagnostic assessment within ten days of admission;

(iv) the program has standards for multidisciplinary case review that include a monthly review for each client that, at a minimum, includes a licensed mental health professional and licensed alcohol and drug counselor, and their involvement in the review is documented;

(v) family education is offered that addresses mental health and substance abuse disorders and the interaction between the two; and

(vi) co-occurring counseling staff will receive eight hours of co-occurring disorder training annually.

(d) In order to be eligible for a higher rate under paragraph (c), clause (1), a program that provides arrangements for off-site child care must maintain current documentation at the chemical dependency facility of the child care provider's current licensure to provide child care services. Programs that provide child care according to paragraph (c), clause (1), must be deemed in compliance with the licensing requirements in Minnesota Rules, part 9530.6490.

(e) Adolescent residential programs that meet the requirements of Minnesota Rules, parts 2960.0430 to 2960.0490 and 2960.0580 to 2960.0690, are exempt from the requirements in paragraph (c), clause (4), items (i) to (iv).

EFFECTIVE DATE. The amendments to paragraph (b) are effective January 1, 2016, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 4. Minnesota Statutes 2014, section 256B.0615, subdivision 3, is amended to read:

Subd. 3. **Eligibility.** Peer support services may be made available to consumers of (1) intensive ~~rehabilitative mental health~~ residential treatment services under section 256B.0622; (2) adult rehabilitative mental health services under section 256B.0623; and (3) crisis stabilization and mental health mobile crisis intervention services under section 256B.0624.

Sec. 5. Minnesota Statutes 2014, section 256B.0622, subdivision 1, is amended to read:

Subdivision 1. **Scope.** Subject to federal approval, medical assistance covers medically necessary, ~~intensive nonresidential~~ assertive community treatment and intensive residential ~~rehabilitative mental health~~ treatment services as defined in subdivision 2, for recipients as defined in subdivision 3, when the services are provided by an entity meeting the standards in this section.

Sec. 6. Minnesota Statutes 2014, section 256B.0622, subdivision 2, is amended to read:

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

(a) ~~"Intensive nonresidential rehabilitative mental health services" means adult rehabilitative mental health services as defined in section 256B.0623, subdivision 2,~~

~~paragraph (a), except that these services are provided by a multidisciplinary staff using a total team approach consistent with assertive community treatment, the Fairweather Lodge treatment model, as defined by the standards established by the National Coalition for Community Living, and other evidence-based practices, and directed to recipients with a serious mental illness who require intensive services.~~ "Assertive community treatment" means intensive nonresidential rehabilitative mental health services provided according to the evidence-based practice of assertive community treatment. Core elements of this service include, but are not limited to:

(1) a multidisciplinary staff who utilize a total team approach and who serve as a fixed point of responsibility for all service delivery;

(2) providing services 24 hours per day and 7 days per week;

(3) providing the majority of services in a community setting;

(4) offering a low ratio of recipients to staff; and

(5) providing service that is not time-limited.

(b) "Intensive residential ~~rehabilitative mental health~~ treatment services" means short-term, time-limited services provided in a residential setting to recipients who are in need of more restrictive settings and are at risk of significant functional deterioration if they do not receive these services. Services are designed to develop and enhance psychiatric stability, personal and emotional adjustment, self-sufficiency, and skills to live in a more independent setting. Services must be directed toward a targeted discharge date with specified client outcomes ~~and must be consistent with the Fairweather Lodge treatment model as defined in paragraph (a), and other evidence-based practices~~.

(c) "Evidence-based practices" are nationally recognized mental health services that are proven by substantial research to be effective in helping individuals with serious mental illness obtain specific treatment goals.

(d) "Overnight staff" means a member of the intensive residential rehabilitative mental health treatment team who is responsible during hours when recipients are typically asleep.

(e) "Treatment team" means all staff who provide services under this section to recipients. At a minimum, this includes the clinical supervisor, mental health professionals as defined in section 245.462, subdivision 18, clauses (1) to (6); mental health practitioners as defined in section 245.462, subdivision 17; mental health rehabilitation workers under section 256B.0623, subdivision 5, clause (3); and certified peer specialists under section 256B.0615.

Sec. 7. Minnesota Statutes 2014, section 256B.0622, subdivision 3, is amended to read:

Subd. 3. **Eligibility.** An eligible recipient is an individual who:

(1) is age 18 or older;

(2) is eligible for medical assistance;

(3) is diagnosed with a mental illness;

(4) because of a mental illness, has substantial disability and functional impairment in three or more of the areas listed in section 245.462, subdivision 11a, so that self-sufficiency is markedly reduced;

(5) has one or more of the following: a history of ~~two or more~~ recurring or prolonged inpatient hospitalizations in the past year, significant independent living instability, homelessness, or very frequent use of mental health and related services yielding poor outcomes; and

(6) in the written opinion of a licensed mental health professional, has the need for mental health services that cannot be met with other available community-based services, or is likely to experience a mental health crisis or require a more restrictive setting if intensive rehabilitative mental health services are not provided.

Sec. 8. Minnesota Statutes 2014, section 256B.0622, subdivision 4, is amended to read:

Subd. 4. **Provider certification and contract requirements.** (a) The ~~intensive nonresidential rehabilitative mental health services~~ assertive community treatment provider must:

(1) have a contract with the host county to provide intensive adult rehabilitative mental health services; and

(2) be certified by the commissioner as being in compliance with this section and section 256B.0623.

(b) The intensive residential ~~rehabilitative mental health~~ treatment services provider must:

(1) be licensed under Minnesota Rules, parts 9520.0500 to 9520.0670;

(2) not exceed 16 beds per site;

(3) comply with the additional standards in this section; and

(4) have a contract with the host county to provide these services.

(c) The commissioner shall develop procedures for counties and providers to submit contracts and other documentation as needed to allow the commissioner to determine whether the standards in this section are met.

Sec. 9. Minnesota Statutes 2014, section 256B.0622, subdivision 5, is amended to read:

Subd. 5. **Standards applicable to both ~~nonresidential~~ assertive community treatment and residential providers.** (a) Services must be provided by qualified staff as defined in section 256B.0623, subdivision 5, who are trained and supervised according to section 256B.0623, subdivision 6, except that mental health rehabilitation workers acting as overnight staff are not required to comply with section 256B.0623, subdivision 5, clause ~~(3)~~ (4), item (iv).

(b) The clinical supervisor must be an active member of the treatment team. The treatment team must meet with the clinical supervisor at least weekly to discuss recipients' progress and make rapid adjustments to meet recipients' needs. The team meeting shall include recipient-specific case reviews and general treatment discussions among team members. Recipient-specific case reviews and planning must be documented in the individual recipient's treatment record.

(c) Treatment staff must have prompt access in person or by telephone to a mental health practitioner or mental health professional. The provider must have the capacity to promptly and appropriately respond to emergent needs and make any necessary staffing adjustments to assure the health and safety of recipients.

(d) The initial functional assessment must be completed within ten days of intake and updated at least every ~~three months~~ 30 days for intensive residential treatment services and every six months for assertive community treatment, or prior to discharge from the service, whichever comes first.

(e) The initial individual treatment plan must be completed within ten days of intake ~~and~~ for assertive community treatment and within 24 hours of admission for intensive residential treatment services. Within ten days of admission, the initial treatment plan must be refined and further developed for intensive residential treatment services, except for providers certified according to Minnesota Rules, parts 9533.0010 to 9533.0180. The individual treatment plan must be reviewed with the recipient and updated at least monthly ~~with the recipient~~ for intensive residential treatment services and at least every six months for assertive community treatment.

Sec. 10. Minnesota Statutes 2014, section 256B.0622, subdivision 7, is amended to read:

Subd. 7. **Additional standards for ~~nonresidential services~~ assertive community treatment.** The standards in this subdivision apply to ~~intensive nonresidential rehabilitative mental health~~ assertive community treatment services.

(1) The treatment team must use team treatment, not an individual treatment model.

(2) The clinical supervisor must function as a practicing clinician at least on a part-time basis.

(3) The staffing ratio must not exceed ten recipients to one full-time equivalent treatment team position.

(4) Services must be available at times that meet client needs.

(5) The treatment team must actively and assertively engage and reach out to the recipient's family members and significant others, after obtaining the recipient's permission.

(6) The treatment team must establish ongoing communication and collaboration between the team, family, and significant others and educate the family and significant others about mental illness, symptom management, and the family's role in treatment.

(7) The treatment team must provide interventions to promote positive interpersonal relationships.

Sec. 11. Minnesota Statutes 2014, section 256B.0622, subdivision 8, is amended to read:

Subd. 8. **Medical assistance payment for intensive rehabilitative mental health services.** (a) Payment for intensive residential ~~and nonresidential~~ treatment services and assertive community treatment in this section shall be based on one daily rate per provider inclusive of the following services received by an eligible recipient in a given calendar day: all rehabilitative services under this section, staff travel time to provide rehabilitative services under this section, and nonresidential crisis stabilization services under section 256B.0624.

(b) Except as indicated in paragraph (c), payment will not be made to more than one entity for each recipient for services provided under this section on a given day. If services under this section are provided by a team that includes staff from more than one entity, the team must determine how to distribute the payment among the members.

(c) The commissioner shall determine one rate for each provider that will bill medical assistance for residential services under this section and one rate for each ~~nonresidential~~ assertive community treatment provider. If a single entity provides both services, one rate is established for the entity's residential services and another rate for the entity's nonresidential services under this section. A provider is not eligible for payment under this section without authorization from the commissioner. The commissioner shall develop rates using the following criteria:

~~(1) the cost for similar services in the local trade area;~~

~~(2)~~ (1) the provider's cost for services shall include direct services costs, other program costs, and other costs determined as follows:

(i) the direct services costs must be determined using actual costs of salaries, benefits, payroll taxes, and training of direct service staff and service-related transportation;

(ii) other program costs not included in item (i) must be determined as a specified percentage of the direct services costs as determined by item (i). The percentage used shall be determined by the commissioner based upon the average of percentages that represent the relationship of other program costs to direct services costs among the entities that provide similar services;

(iii) ~~in situations where a provider of intensive residential services can demonstrate actual program-related physical plant costs in excess of the group residential housing reimbursement, the commissioner may include these costs in the program rate, so long as the additional reimbursement does not subsidize the room and board expenses of the program~~ physical plant costs calculated based on the percentage of space within the program that is entirely devoted to treatment and programming. This does not include administrative or residential space;

(iv) ~~intensive nonresidential services~~ assertive community treatment physical plant costs must be reimbursed as part of the costs described in item (ii); and

(v) subject to federal approval, up to an additional five percent of the total rate ~~must~~ may be added to the program rate as a quality incentive based upon the entity meeting performance criteria specified by the commissioner;

~~(3)~~ (2) actual cost is defined as costs which are allowable, allocable, and reasonable, and consistent with federal reimbursement requirements under Code of Federal Regulations, title 48, chapter 1, part 31, relating to for-profit entities, and Office of Management and Budget Circular Number A-122, relating to nonprofit entities;

~~(4)~~ (3) the number of service units;

~~(5)~~ (4) the degree to which recipients will receive services other than services under this section; and

~~(6)~~ (5) the costs of other services that will be separately reimbursed~~; and~~.

~~(7) input from the local planning process authorized by the adult mental health initiative under section 245.4661, regarding recipients' service needs.~~

(d) The rate for intensive ~~rehabilitative mental health~~ residential treatment services and assertive community treatment must exclude room and board, as defined in section 256I.03, subdivision 6, and services not covered under this section, such as partial hospitalization, home care, and inpatient services.

(e) Physician services that are not separately billed may be included in the rate to the extent that a psychiatrist is a member of the treatment team. Physician services, whether billed separately or included in the rate, may be delivered by telemedicine. For purposes of this paragraph, "telemedicine" has the meaning given to "mental health telemedicine"

in section 256B.0625, subdivision 46, when telemedicine is used to provide intensive residential treatment services.

~~(e)~~ (f) When services under this section are provided by an ~~intensive nonresidential service~~ assertive community treatment provider, case management functions must be an integral part of the team.

~~(f)~~ (g) The rate for a provider must not exceed the rate charged by that provider for the same service to other payors.

~~(g)~~ (h) The rates for existing programs must be established prospectively based upon the expenditures and utilization over a prior 12-month period using the criteria established in paragraph (c). The rates for new programs must be established based upon estimated expenditures and estimated utilization using the criteria established in paragraph (c).

~~(h)~~ (i) Entities who discontinue providing services must be subject to a settle-up process whereby actual costs and reimbursement for the previous 12 months are compared. In the event that the entity was paid more than the entity's actual costs plus any applicable performance-related funding due the provider, the excess payment must be reimbursed to the department. If a provider's revenue is less than actual allowed costs due to lower utilization than projected, the commissioner may reimburse the provider to recover its actual allowable costs. The resulting adjustments by the commissioner must be proportional to the percent of total units of service reimbursed by the commissioner and must reflect a difference of greater than five percent.

~~(i)~~ (j) A provider may request of the commissioner a review of any rate-setting decision made under this subdivision.

Sec. 12. Minnesota Statutes 2014, section 256B.0622, subdivision 9, is amended to read:

Subd. 9. **Provider enrollment; rate setting for county-operated entities.** Counties that employ their own staff to provide services under this section shall apply directly to the commissioner for enrollment and rate setting. In this case, a county contract is not required ~~and the commissioner shall perform the program review and rate setting duties which would otherwise be required of counties under this section~~.

Sec. 13. Minnesota Statutes 2014, section 256B.0622, subdivision 10, is amended to read:

Subd. 10. **Provider enrollment; rate setting for specialized program.** A county contract is not required for a provider proposing to serve a subpopulation of eligible recipients ~~may bypass the county approval procedures in this section and receive approval~~

~~for provider enrollment and rate setting directly from the commissioner~~ under the following circumstances:

(1) the provider demonstrates that the subpopulation to be served requires a specialized program which is not available from county-approved entities; and

(2) the subpopulation to be served is of such a low incidence that it is not feasible to develop a program serving a single county or regional group of counties.

~~For providers meeting the criteria in clauses (1) and (2), the commissioner shall perform the program review and rate setting duties which would otherwise be required of counties under this section.~~

Sec. 14. Minnesota Statutes 2014, section 256B.0622, is amended by adding a subdivision to read:

Subd. 11. **Sustainability grants.** The commissioner may disburse grant funds directly to intensive residential treatment services providers and assertive community treatment providers to maintain access to these services.

Sec. 15. Minnesota Statutes 2014, section 256B.0624, subdivision 7, is amended to read:

Subd. 7. **Crisis stabilization services.** (a) Crisis stabilization services must be provided by qualified staff of a crisis stabilization services provider entity and must meet the following standards:

(1) a crisis stabilization treatment plan must be developed which meets the criteria in subdivision 11;

(2) staff must be qualified as defined in subdivision 8; and

(3) services must be delivered according to the treatment plan and include face-to-face contact with the recipient by qualified staff for further assessment, help with referrals, updating of the crisis stabilization treatment plan, supportive counseling, skills training, and collaboration with other service providers in the community.

(b) If crisis stabilization services are provided in a supervised, licensed residential setting, the recipient must be contacted face-to-face daily by a qualified mental health practitioner or mental health professional. The program must have 24-hour-a-day residential staffing which may include staff who do not meet the qualifications in subdivision 8. The residential staff must have 24-hour-a-day immediate direct or telephone access to a qualified mental health professional or practitioner.

(c) If crisis stabilization services are provided in a supervised, licensed residential setting that serves no more than four adult residents, and ~~no more than two are recipients of crisis stabilization services~~ one or more individuals are present at the setting to receive

residential crisis stabilization services, the residential staff must include, for at least eight hours per day, at least one individual who meets the qualifications in subdivision 8, paragraph (a), clause (1) or (2).

(d) If crisis stabilization services are provided in a supervised, licensed residential setting that serves more than four adult residents, and one or more are recipients of crisis stabilization services, the residential staff must include, for 24 hours a day, at least one individual who meets the qualifications in subdivision 8. During the first 48 hours that a recipient is in the residential program, the residential program must have at least two staff working 24 hours a day. Staffing levels may be adjusted thereafter according to the needs of the recipient as specified in the crisis stabilization treatment plan.

Sec. 16. Minnesota Statutes 2014, section 256B.0625, is amended by adding a subdivision to read:

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

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

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

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

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

Sec. 17. **RATE-SETTING METHODOLOGY FOR COMMUNITY-BASED MENTAL HEALTH SERVICES.**

The commissioner of human services shall conduct a comprehensive analysis of the current rate-setting methodology for all community-based mental health services for children and adults. The report shall include an assessment of alternative payment structures, consistent with the intent and direction of the federal Centers for Medicare and Medicaid Services, that could provide adequate reimbursement to sustain community-based mental health services regardless of geographic location. The report shall also include recommendations for establishing pay-for-performance measures for providers delivering services consistent with evidence-based practices. In developing the report, the commissioner shall consult with stakeholders and with outside experts in Medicaid financing. The commissioner shall provide a report on the analysis to the chairs of the legislative committees with jurisdiction over health and human services finance by January 1, 2017.

Sec. 18. **EXCELLENCE IN MENTAL HEALTH DEMONSTRATION PROJECT.**

By January 15, 2016, the commissioner of human services shall report to the legislative committees in the house of representatives and senate with jurisdiction over human services issues on the progress of the Excellence in Mental Health demonstration project under Minnesota Statutes, section 245.735. The commissioner shall include in the report any recommendations for legislative changes needed to implement the reform projects specified in Minnesota Statutes, section 245.735, subdivision 4.

ARTICLE 3

WITHDRAWAL MANAGEMENT PROGRAMS

Section 1. **[245F.01] PURPOSE.**

It is hereby declared to be the public policy of this state that the public interest is best served by providing efficient and effective withdrawal management services to persons in need of appropriate detoxification, assessment, intervention, and referral services. The services shall vary to address the unique medical needs of each patient and shall be responsive to the language and cultural needs of each patient. Services shall not be denied on the basis of a patient's inability to pay.

Sec. 2. **[245F.02] DEFINITIONS.**

Subdivision 1. **Scope.** The terms used in this chapter have the meanings given them in this section.

Subd. 2. **Administration of medications.** "Administration of medications" means performing a task to provide medications to a patient, and includes the following tasks performed in the following order:

(1) checking the patient's medication record;

(2) preparing the medication for administration;

(3) administering the medication to the patient;

(4) documenting administration of the medication or the reason for not administering the medication as prescribed; and

(5) reporting information to a licensed practitioner or a registered nurse regarding problems with the administration of the medication or the patient's refusal to take the medication.

Subd. 3. **Alcohol and drug counselor.** "Alcohol and drug counselor" means an individual qualified under Minnesota Rules, part 9530.6450, subpart 5.

Subd. 4. **Applicant.** "Applicant" means an individual, partnership, voluntary association, corporation, or other public or private organization that submits an application for licensure under this chapter.

Subd. 5. **Care coordination.** "Care coordination" means activities intended to bring together health services, patient needs, and streams of information to facilitate the aims of care. Care coordination includes an ongoing needs assessment, life skills advocacy, treatment follow-up, disease management, education, and other services as needed.

Subd. 6. **Chemical.** "Chemical" means alcohol, solvents, controlled substances as defined in section 152.01, subdivision 4, and other mood-altering substances.

Subd. 7. **Clinically managed program.** "Clinically managed program" means a residential setting with staff comprised of a medical director and a licensed practical nurse. A licensed practical nurse must be on site 24 hours a day, seven days a week. An individual who meets the qualification requirements of a medical director must be available by telephone or in person for consultation 24 hours a day. Patients admitted to this level of service receive medical observation, evaluation, and stabilization services during the detoxification process; access to medications administered by trained, licensed staff to manage withdrawal; and a comprehensive assessment pursuant to Minnesota Rules, part 9530.6422.

Subd. 8. **Commissioner.** "Commissioner" means the commissioner of human services or the commissioner's designated representative.

Subd. 9. **Department.** "Department" means the Department of Human Services.

Subd. 10. **Direct patient contact.** "Direct patient contact" has the meaning given for "direct contact" in section 245C.02, subdivision 11.

Subd. 11. **Discharge plan.** "Discharge plan" means a written plan that states with specificity the services the program has arranged for the patient to transition back into the community.

Subd. 12. **Licensed practitioner.** "Licensed practitioner" means a practitioner as defined in section 151.01, subdivision 23, who is authorized to prescribe.

Subd. 13. **Medical director.** "Medical director" means an individual licensed in Minnesota as a doctor of osteopathy or physician, or an individual licensed in Minnesota as an advanced practice registered nurse by the Board of Nursing and certified to practice as a clinical nurse specialist or nurse practitioner by a national nurse organization acceptable to the board. The medical director must be employed by or under contract with the license holder to direct and supervise health care for patients of a program licensed under this chapter.

Subd. 14. **Medically monitored program.** "Medically monitored program" means a residential setting with staff that includes a registered nurse and a medical director. A registered nurse must be on site 24 hours a day. A medical director must be on site seven days a week, and patients must have the ability to be seen by a medical director within 24 hours. Patients admitted to this level of service receive medical observation, evaluation, and stabilization services during the detoxification process; medications administered by trained, licensed staff to manage withdrawal; and a comprehensive assessment pursuant to Minnesota Rules, part 9530.6422.

Subd. 15. **Nurse.** "Nurse" means a person licensed and currently registered to practice practical or professional nursing as defined in section 148.171, subdivisions 14 and 15.

Subd. 16. **Patient.** "Patient" means an individual who presents or is presented for admission to a withdrawal management program that meets the criteria in section 245F.05.

Subd. 17. **Peer recovery support services.** "Peer recovery support services" means mentoring and education, advocacy, and nonclinical recovery support provided by a recovery peer.

Subd. 18. **Program director.** "Program director" means the individual who is designated by the license holder to be responsible for all operations of a withdrawal management program and who meets the qualifications specified in section 245F.15, subdivision 3.

Subd. 19. **Protective procedure.** "Protective procedure" means an action taken by a staff member of a withdrawal management program to protect a patient from imminent danger of harming self or others. Protective procedures include the following actions:

(1) seclusion, which means the temporary placement of a patient, without the patient's consent, in an environment to prevent social contact; and

(2) physical restraint, which means the restraint of a patient by use of physical holds intended to limit movement of the body.

Subd. 20. **Recovery peer.** "Recovery peer" means a person who has progressed in the person's own recovery from substance use disorder and is willing to serve as a peer to assist others in their recovery.

Subd. 21. **Responsible staff person.** "Responsible staff person" means the program director, the medical director, or a staff person with current licensure as a nurse in Minnesota. The responsible staff person must be on the premises and is authorized to make immediate decisions concerning patient care and safety.

Subd. 22. **Substance.** "Substance" means "chemical" as defined in subdivision 6.

Subd. 23. **Substance use disorder.** "Substance use disorder" means a pattern of substance use as defined in the current edition of the Diagnostic and Statistical Manual of Mental Disorders.

Subd. 24. **Technician.** "Technician" means a person who meets the qualifications in section 245F.15, subdivision 6.

Subd. 25. **Withdrawal management program.** "Withdrawal management program" means a licensed program that provides short-term medical services on a 24-hour basis for the purpose of stabilizing intoxicated patients, managing their withdrawal, and facilitating access to substance use disorder treatment as indicated by a comprehensive assessment.

Sec. 3. **[245F.03] APPLICATION.**

(a) This chapter establishes minimum standards for withdrawal management programs licensed by the commissioner that serve one or more unrelated persons.

(b) This chapter does not apply to a withdrawal management program licensed as a hospital under sections 144.50 to 144.581. A withdrawal management program located in a hospital licensed under sections 144.50 to 144.581 that chooses to be licensed under this chapter is deemed to be in compliance with section 245F.13.

Sec. 4. **[245F.04] PROGRAM LICENSURE.**

Subdivision 1. **General application and license requirements.** An applicant for licensure as a clinically managed withdrawal management program or medically monitored withdrawal management program must meet the following requirements, except where otherwise noted. All programs must comply with federal requirements and

the general requirements in chapters 245A and 245C and sections 626.556, 626.557, and 626.5572. A withdrawal management program must be located in a hospital licensed under sections 144.50 to 144.581, or must be a supervised living facility with a class B license from the Department of Health under Minnesota Rules, parts 4665.0100 to 4665.9900.

Subd. 2. **Contents of application.** Prior to the issuance of a license, an applicant must submit, on forms provided by the commissioner, documentation demonstrating the following:

(1) compliance with this section;

(2) compliance with applicable building, fire, and safety codes; health rules; zoning ordinances; and other applicable rules and regulations or documentation that a waiver has been granted. The granting of a waiver does not constitute modification of any requirement of this section;

(3) completion of an assessment of need for a new or expanded program as required by Minnesota Rules, part 9530.6800; and

(4) insurance coverage, including bonding, sufficient to cover all patient funds, property, and interests.

Subd. 3. **Changes in license terms.** (a) A license holder must notify the commissioner before one of the following occurs and the commissioner must determine the need for a new license:

(1) a change in the Department of Health's licensure of the program;

(2) a change in the medical services provided by the program that affects the program's capacity to provide services required by the program's license designation as a clinically managed program or medically monitored program;

(3) a change in program capacity; or

(4) a change in location.

(b) A license holder must notify the commissioner and apply for a new license when a change in program ownership occurs.

Subd. 4. **Variances.** The commissioner may grant variances to the requirements of this chapter under section 245A.04, subdivision 9.

Sec. 5. **[245F.05] ADMISSION AND DISCHARGE POLICIES.**

Subdivision 1. **Admission policy.** A license holder must have a written admission policy containing specific admission criteria. The policy must describe the admission process and the point at which an individual who is eligible under subdivision 2 is admitted to the program. A license holder must not admit individuals who do not meet the admission criteria. The admission policy must be approved and signed by the medical

director of the facility and must designate which staff members are authorized to admit and discharge patients. The admission policy must be posted in the area of the facility where patients are admitted and given to all interested individuals upon request.

Subd. 2. **Admission criteria.** For an individual to be admitted to a withdrawal management program, the program must make a determination that the program services are appropriate to the needs of the individual. A program may only admit individuals who meet the admission criteria and who, at the time of admission:

(1) are impaired as the result of intoxication;

(2) are experiencing physical, mental, or emotional problems due to intoxication or withdrawal from alcohol or other drugs;

(3) are being held under apprehend and hold orders under section 253B.07, subdivision 2b;

(4) have been committed under chapter 253B, and need temporary placement;

(5) are held under emergency holds or peace and health officer holds under section 253B.05, subdivision 1 or 2; or

(6) need to stay temporarily in a protective environment because of a crisis related to substance use disorder. Individuals satisfying this clause may be admitted only at the request of the county of fiscal responsibility, as determined according to section 256G.02, subdivision 4. Individuals admitted according to this clause must not be restricted to the facility.

Subd. 3. **Individuals denied admission by program.** (a) A license holder must have a written policy and procedure for addressing the needs of individuals who are denied admission to the program. These individuals include:

(1) individuals whose pregnancy, in combination with their presenting problem, requires services not provided by the program; and

(2) individuals who are in imminent danger of harming self or others if their behavior is beyond the behavior management capabilities of the program and staff.

(b) Programs must document denied admissions, including the date and time of the admission request, reason for the denial of admission, and where the individual was referred. If the individual did not receive a referral, the program must document why a referral was not made. This information must be documented on a form approved by the commissioner and made available to the commissioner upon request.

Subd. 4. **License holder responsibilities; denying admission or terminating services.** (a) If a license holder denies an individual admission to the program or terminates services to a patient and the denial or termination poses an immediate threat to the patient's or individual's health or requires immediate medical intervention, the license

holder must refer the patient or individual to a medical facility capable of admitting the patient or individual.

(b) A license holder must report to a law enforcement agency with proper jurisdiction all denials of admission and terminations of services that involve the commission of a crime against a staff member of the license holder or on the license holder's property, as provided in Code of Federal Regulations, title 42, section 2.12(c)(5), and title 45, parts 160 to 164.

Subd. 5. **Discharge and transfer policies.** A license holder must have a written policy and procedure, approved and signed by the medical director, that specifies conditions under which patients may be discharged or transferred. The policy must include the following:

(1) guidelines for determining when a patient is medically stable and whether a patient is able to be discharged or transferred to a lower level of care;

(2) guidelines for determining when a patient needs a transfer to a higher level of care. Clinically managed program guidelines must include guidelines for transfer to a medically monitored program, hospital, or other acute care facility. Medically monitored program guidelines must include guidelines for transfer to a hospital or other acute care facility;

(3) procedures staff must follow when discharging a patient under each of the following circumstances:

(i) the patient is involved in the commission of a crime against program staff or against a license holder's property. The procedures for a patient discharged under this item must specify how reports must be made to law enforcement agencies with proper jurisdiction as allowed under Code of Federal Regulations, title 42, section 2.12(c)(5), and title 45, parts 160 to 164;

(ii) the patient is in imminent danger of harming self or others and is beyond the license holder's capacity to ensure safety;

(iii) the patient was admitted under chapter 253B; or

(iv) the patient is leaving against staff or medical advice; and

(4) a requirement that staff must document where the patient was referred after discharge or transfer, and if a referral was not made, the reason the patient was not provided a referral.

Sec. 6. **[245F.06] SCREENING AND COMPREHENSIVE ASSESSMENT.**

Subdivision 1. **Screening for substance use disorder.** A nurse or an alcohol and drug counselor must screen each patient upon admission to determine whether a comprehensive assessment is indicated. The license holder must screen patients at

each admission, except that if the patient has already been determined to suffer from a substance use disorder, subdivision 2 applies.

Subd. 2. **Comprehensive assessment.** (a) Prior to a medically stable discharge, but not later than 72 hours following admission, a license holder must provide a comprehensive assessment according to section 245.4863, paragraph (a), and Minnesota Rules, part 9530.6422, for each patient who has a positive screening for a substance use disorder. If a patient's medical condition prevents a comprehensive assessment from being completed within 72 hours, the license holder must document why the assessment was not completed. The comprehensive assessment must include documentation of the appropriateness of an involuntary referral through the civil commitment process.

(b) If available to the program, a patient's previous comprehensive assessment may be used in the patient record. If a previously completed comprehensive assessment is used, its contents must be reviewed to ensure the assessment is accurate and current and complies with the requirements of this chapter. The review must be completed by a staff person qualified according to Minnesota Rules, part 9530.6450, subpart 5. The license holder must document that the review was completed and that the previously completed assessment is accurate and current, or the license holder must complete an updated or new assessment.

Sec. 7. **[245F.07] STABILIZATION PLANNING.**

Subdivision 1. **Stabilization plan.** Within 12 hours of admission, a license holder must develop an individualized stabilization plan for each patient accepted for stabilization services. The plan must be based on the patient's initial health assessment and continually updated based on new information gathered about the patient's condition from the comprehensive assessment, medical evaluation and consultation, and ongoing monitoring and observations of the patient. The patient must have an opportunity to have direct involvement in the development of the plan. The stabilization plan must:

(1) identify medical needs and goals to be achieved while the patient is receiving services;

(2) specify stabilization services to address the identified medical needs and goals, including amount and frequency of services;

(3) specify the participation of others in the stabilization planning process and specific services where appropriated; and

(4) document the patient's participation in developing the content of the stabilization plan and any updates.

Subd. 2. **Progress notes.** Progress notes must be entered in the patient's file at least daily and immediately following any significant event, including any change that impacts the medical, behavioral, or legal status of the patient. Progress notes must:

(1) include documentation of the patient's involvement in the stabilization services, including the type and amount of each stabilization service;

(2) include the monitoring and observations of the patient's medical needs;

(3) include documentation of referrals made to other services or agencies;

(4) specify the participation of others; and

(5) be legible, signed, and dated by the staff person completing the documentation.

Subd. 3. **Discharge plan.** Before a patient leaves the facility, the license holder must conduct discharge planning for the patient, document discharge planning in the patient's record, and provide the patient with a copy of the discharge plan. The discharge plan must include:

(1) referrals made to other services or agencies at the time of transition;

(2) the patient's plan for follow-up, aftercare, or other poststabilization services;

(3) documentation of the patient's participation in the development of the transition plan;

(4) any service that will continue after discharge under the direction of the license holder; and

(5) a stabilization summary and final evaluation of the patient's progress toward treatment objectives.

Sec. 8. **[245F.08] STABILIZATION SERVICES.**

Subdivision 1. **General.** The license holder must encourage patients to remain in care for an appropriate duration as determined by the patient's stabilization plan, and must encourage all patients to enter programs for ongoing recovery as clinically indicated. In addition, the license holder must offer services that are patient-centered, trauma-informed, and culturally appropriate. Culturally appropriate services must include translation services and dietary services that meet a patient's dietary needs. All services provided to the patient must be documented in the patient's medical record. The following services must be offered unless clinically inappropriate and the justifying clinical rational is documented:

(1) individual or group motivational counseling sessions;

(2) individual advocacy and case management services;

(3) medical services as required in section 245F.12;

(4) care coordination provided according to subdivision 2;

(5) peer recovery support services provided according to subdivision 3;

(6) patient education provided according to subdivision 4; and

(7) referrals to mutual aid, self-help, and support groups.

Subd. 2. **Care coordination.** Care coordination services must be initiated for each patient upon admission. The license holder must identify the staff person responsible for the provision of each service. Care coordination services must include:

(1) coordination with significant others to assist in the stabilization planning process whenever possible;

(2) coordination with and follow-up to appropriate medical services as identified by the nurse or licensed practitioner;

(3) referral to substance use disorder services as indicated by the comprehensive assessment;

(4) referral to mental health services as identified in the comprehensive assessment;

(5) referrals to economic assistance, social services, and prenatal care in accordance with the patient's needs;

(6) review and approval of the transition plan prior to discharge, except in an emergency, by a staff member able to provide direct patient contact;

(7) documentation of the provision of care coordination services in the patient's file; and

(8) addressing cultural and socioeconomic factors affecting the patient's access to services.

Subd. 3. **Peer recovery support services.** (a) Peers in recovery serve as mentors or recovery-support partners for individuals in recovery, and may provide encouragement, self-disclosure of recovery experiences, transportation to appointments, assistance with finding resources that will help locate housing, job search resources, and assistance finding and participating in support groups.

(b) Peer recovery support services are provided by a recovery peer and must be supervised by the responsible staff person.

Subd. 4. **Patient education.** A license holder must provide education to each patient on the following:

(1) substance use disorder, including the effects of alcohol and other drugs, specific information about the effects of substance use on unborn children, and the signs and symptoms of fetal alcohol spectrum disorders;

(2) tuberculosis and reporting known cases of tuberculosis disease to health care authorities according to section 144.4804;

(3) Hepatitis C treatment and prevention;

(4) HIV as required in section 245A.19, paragraphs (b) and (c);

(5) nicotine cessation options, if applicable;

(6) opioid tolerance and overdose risks, if applicable; and

(7) long-term withdrawal issues related to use of barbiturates and benzodiazepines, if applicable.

Subd. 5. **Mutual aid, self-help, and support groups.** The license holder must refer patients to mutual aid, self-help, and support groups when clinically indicated and to the extent available in the community.

Sec. 9. **[245F.09] PROTECTIVE PROCEDURES.**

Subdivision 1. **Use of protective procedures.** (a) Programs must incorporate person-centered planning and trauma-informed care into its protective procedure policies. Protective procedures may be used only in cases where a less restrictive alternative will not protect the patient or others from harm and when the patient is in imminent danger of harming self or others. When a program uses a protective procedure, the program must continuously observe the patient until the patient may safely be left for 15-minute intervals. Use of the procedure must end when the patient is no longer in imminent danger of harming self or others.

(b) Protective procedures may not be used:

(1) for disciplinary purposes;

(2) to enforce program rules;

(3) for the convenience of staff;

(4) as a part of any patient's health monitoring plan; or

(5) for any reason except in response to specific, current behaviors which create an imminent danger of harm to the patient or others.

Subd. 2. **Protective procedures plan.** A license holder must have a written policy and procedure that establishes the protective procedures that program staff must follow when a patient is in imminent danger of harming self or others. The policy must be appropriate to the type of facility and the level of staff training. The protective procedures policy must include:

(1) an approval signed and dated by the program director and medical director prior to implementation. Any changes to the policy must also be approved, signed, and dated by the current program director and the medical director prior to implementation;

(2) which protective procedures the license holder will use to prevent patients from imminent danger of harming self or others;

(3) the emergency conditions under which the protective procedures are permitted to be used, if any;

(4) the patient's health conditions that limit the specific procedures that may be used and alternative means of ensuring safety;

(5) emergency resources the program staff must contact when a patient's behavior cannot be controlled by the procedures established in the policy;

(6) the training that staff must have before using any protective procedure;

(7) documentation of approved therapeutic holds;

(8) the use of law enforcement personnel as described in subdivision 4;

(9) standards governing emergency use of seclusion. Seclusion must be used only when less restrictive measures are ineffective or not feasible. The standards in items (i) to (vii) must be met when seclusion is used with a patient:

(i) seclusion must be employed solely for the purpose of preventing a patient from imminent danger of harming self or others;

(ii) seclusion rooms must be equipped in a manner that prevents patients from self-harm using projections, windows, electrical fixtures, or hard objects, and must allow the patient to be readily observed without being interrupted;

(iii) seclusion must be authorized by the program director, a licensed physician, or a registered nurse. If one of these individuals is not present in the facility, the program director or a licensed physician or registered nurse must be contacted and authorization must be obtained within 30 minutes of initiating seclusion, according to written policies;

(iv) patients must not be placed in seclusion for more than 12 hours at any one time;

(v) once the condition of a patient in seclusion has been determined to be safe enough to end continuous observation, a patient in seclusion must be observed at a minimum of every 15 minutes for the duration of seclusion and must always be within hearing range of program staff;

(vi) a process for program staff to use to remove a patient to other resources available to the facility if seclusion does not sufficiently assure patient safety; and

(vii) a seclusion area may be used for other purposes, such as intensive observation, if the room meets normal standards of care for the purpose and if the room is not locked; and

(10) physical holds may only be used when less restrictive measures are not feasible. The standards in items (i) to (iv) must be met when physical holds are used with a patient:

(i) physical holds must be employed solely for preventing a patient from imminent danger of harming self or others;

(ii) physical holds must be authorized by the program director, a licensed physician, or a registered nurse. If one of these individuals is not present in the facility, the program director or a licensed physician or a registered nurse must be contacted and authorization

must be obtained within 30 minutes of initiating a physical hold, according to written policies;

(iii) the patient's health concerns must be considered in deciding whether to use physical holds and which holds are appropriate for the patient; and

(iv) only approved holds may be utilized. Prone holds are not allowed and must not be authorized.

Subd. 3. **Records.** Each use of a protective procedure must be documented in the patient record. The patient record must include:

(1) a description of specific patient behavior precipitating a decision to use a protective procedure, including date, time, and program staff present;

(2) the specific means used to limit the patient's behavior;

(3) the time the protective procedure began, the time the protective procedure ended, and the time of each staff observation of the patient during the procedure;

(4) the names of the program staff authorizing the use of the protective procedure, the time of the authorization, and the program staff directly involved in the protective procedure and the observation process;

(5) a brief description of the purpose for using the protective procedure, including less restrictive interventions used prior to the decision to use the protective procedure and a description of the behavioral results obtained through the use of the procedure. If a less restrictive intervention was not used, the reasons for not using a less restrictive intervention must be documented;

(6) documentation by the responsible staff person on duty of reassessment of the patient at least every 15 minutes to determine if seclusion or the physical hold can be terminated;

(7) a description of the physical holds used in escorting a patient; and

(8) any injury to the patient that occurred during the use of a protective procedure.

Subd. 4. **Use of law enforcement.** The program must maintain a central log documenting each incident involving use of law enforcement, including:

(1) the date and time law enforcement arrived at and left the program;

(2) the reason for the use of law enforcement;

(3) if law enforcement used force or a protective procedure and which protective procedure was used; and

(4) whether any injuries occurred.

Subd. 5. **Administrative review.** (a) The license holder must keep a record of all patient incidents and protective procedures used. An administrative review of each use of protective procedures must be completed within 72 hours by someone other than the

person who used the protective procedure. The record of the administrative review of the use of protective procedures must state whether:

(1) the required documentation was recorded for each use of a protective procedure;

(2) the protective procedure was used according to the policy and procedures;

(3) the staff who implemented the protective procedure was properly trained; and

(4) the behavior met the standards for imminent danger of harming self or others.

(b) The license holder must conduct and document a quarterly review of the use of protective procedures with the goal of reducing the use of protective procedures. The review must include:

(1) any patterns or problems indicated by similarities in the time of day, day of the week, duration of the use of a protective procedure, individuals involved, or other factors associated with the use of protective procedures;

(2) any injuries resulting from the use of protective procedures;

(3) whether law enforcement was involved in the use of a protective procedure;

(4) actions needed to correct deficiencies in the program's implementation of protective procedures;

(5) an assessment of opportunities missed to avoid the use of protective procedures; and

(6) proposed actions to be taken to minimize the use of protective procedures.

Sec. 10. **[245F.10] PATIENT RIGHTS AND GRIEVANCE PROCEDURES.**

Subdivision 1. **Patient rights.** Patients have the rights in sections 144.651, 148F.165, and 253B.03, as applicable. The license holder must give each patient, upon admission, a written statement of patient rights. Program staff must review the statement with the patient.

Subd. 2. **Grievance procedure.** Upon admission, the license holder must explain the grievance procedure to the patient or patient's representative. The grievance procedure must be posted in a place visible to the patient and must be made available to current and former patients upon request. A license holder's written grievance procedure must include:

(1) staff assistance in developing and processing the grievance;

(2) an initial response to the patient who filed the grievance within 24 hours of the program's receipt of the grievance, and timelines for additional steps to be taken to resolve the grievance, including access to the person with the highest level of authority in the program if the grievance cannot be resolved by other staff members; and

(3) the addresses and telephone numbers of the Department of Human Services Licensing Division, Department of Health Office of Health Facilities Complaints, Board

of Behavioral Health and Therapy, Board of Medical Practice, Board of Nursing, and Office of the Ombudsman for Mental Health and Developmental Disabilities.

Sec. 11. **[245F.11] PATIENT PROPERTY MANAGEMENT.**

A license holder must meet the requirements for handling patient funds and property in section 245A.04, subdivision 14, except:

(1) a license holder must establish policies regarding the use of personal property to assure that program activities and the rights of other patients are not infringed, and may take temporary custody of personal property if these policies are violated;

(2) a license holder must retain the patient's property for a minimum of seven days after discharge if the patient does not reclaim the property after discharge; and

(3) the license holder must return to the patient all of the patient's property held in trust at discharge, regardless of discharge status, except that:

(i) drugs, drug paraphernalia, and drug containers that are forfeited under section 609.5316 must be destroyed by staff or given over to the custody of a local law enforcement agency, according to Code of Federal Regulations, title 42, sections 2.1 to 2.67, and title 45, parts 160 to 164; and

(ii) weapons, explosives, and other property that may cause serious harm to self or others must be transferred to a local law enforcement agency. The patient must be notified of the transfer and the right to reclaim the property if the patient has a legal right to possess the item.

Sec. 12. **[245F.12] MEDICAL SERVICES.**

Subdivision 1. **Services provided at all programs.** Withdrawal management programs must have:

(1) a standardized data collection tool for collecting health-related information about each patient. The data collection tool must be developed in collaboration with a registered nurse and approved and signed by the medical director; and

(2) written procedures for a nurse to assess and monitor patient health within the nurse's scope of practice. The procedures must:

(i) be approved by the medical director;

(ii) include a follow-up screening conducted between four and 12 hours after service initiation to collect information relating to acute intoxication, other health complaints, and behavioral risk factors that the patient may not have communicated at service initiation;

(iii) specify the physical signs and symptoms that, when present, require consultation with a registered nurse or a physician and that require transfer to an acute care facility or a higher level of care than that provided by the program;

(iv) specify those staff members responsible for monitoring patient health and provide for hourly observation and for more frequent observation if the initial health assessment or follow-up screening indicates a need for intensive physical or behavioral health monitoring; and

(v) specify the actions to be taken to address specific complicating conditions, including pregnancy or the presence of physical signs or symptoms of any other medical condition.

Subd. 2. **Services provided at clinically managed programs.** In addition to the services listed in subdivision 1, clinically managed programs must:

(1) have a licensed practical nurse on site 24 hours a day and a medical director;

(2) provide an initial health assessment conducted by a nurse upon admission;

(3) provide daily on-site medical evaluation and consultation with a registered nurse and have a registered nurse available by telephone or in person for consultation 24 hours a day;

(4) have an individual who meets the qualification requirements of a medical director available by telephone or in person for consultation 24 hours a day; and

(5) have appropriately licensed staff available to administer medications according to prescriber-approved orders.

Subd. 3. **Services provided at medically monitored programs.** In addition to the services listed in subdivision 1, medically monitored programs must have a registered nurse on site 24 hours a day and a medical director. Medically monitored programs must provide intensive inpatient withdrawal management services which must include:

(1) an initial health assessment conducted by a registered nurse upon admission;

(2) the availability of a medical evaluation and consultation with a registered nurse 24 hours a day;

(3) the availability of a licensed professional who meets the qualification requirements of a medical director by telephone or in person for consultation 24 hours a day;

(4) the ability to be seen within 24 hours or sooner by an individual who meets the qualification requirements of a medical director if the initial health assessment indicates the need to be seen;

(5) the availability of on-site monitoring of patient care seven days a week by an individual who meets the qualification requirements of a medical director; and

(6) appropriately licensed staff available to administer medications according to prescriber-approved orders.

Sec. 13. **[245F.13] MEDICATIONS.**

Subdivision 1. **Administration of medications.** A license holder must employ or contract with a registered nurse to develop the policies and procedures for medication administration. A registered nurse must provide supervision as defined in section 148.171, subdivision 23, for the administration of medications. For clinically managed programs, the registered nurse supervision must include on-site supervision at least monthly or more often as warranted by the health needs of the patient. The medication administration policies and procedures must include:

(1) a provision that patients may carry emergency medication such as nitroglycerin as instructed by their prescriber;

(2) requirements for recording the patient's use of medication, including staff signatures with date and time;

(3) guidelines regarding when to inform a licensed practitioner or a registered nurse of problems with medication administration, including failure to administer, patient refusal of a medication, adverse reactions, or errors; and

(4) procedures for acceptance, documentation, and implementation of prescriptions, whether written, oral, telephonic, or electronic.

Subd. 2. **Control of drugs.** A license holder must have in place and implement written policies and procedures relating to control of drugs. The policies and procedures must be developed by a registered nurse and must contain the following provisions:

(1) a requirement that all drugs must be stored in a locked compartment. Schedule II drugs, as defined in section 152.02, subdivision 3, must be stored in a separately locked compartment that is permanently affixed to the physical plant or a medication cart;

(2) a system for accounting for all scheduled drugs each shift;

(3) a procedure for recording a patient's use of medication, including staff signatures with time and date;

(4) a procedure for destruction of discontinued, outdated, or deteriorated medications;

(5) a statement that only authorized personnel are permitted to have access to the keys to the locked drug compartments; and

(6) a statement that no legend drug supply for one patient may be given to another patient.

Sec. 14. **[245F.14] STAFFING REQUIREMENTS AND DUTIES.**

Subdivision 1. **Program director.** A license holder must employ or contract with a person, on a full-time basis, to serve as program director. The program director must be responsible for all aspects of the facility and the services delivered to the license holder's patients. An individual may serve as program director for more than one program owned by the same license holder.

Subd. 2. **Responsible staff person.** During all hours of operation, a license holder must designate a staff member as the responsible staff person to be present and awake in the facility and be responsible for the program. The responsible staff person must have decision-making authority over the day-to-day operation of the program as well as the authority to direct the activity of or terminate the shift of any staff member who has direct patient contact.

Subd. 3. **Technician required.** A license holder must have one technician awake and on duty at all times for every ten patients in the program. A license holder may assign technicians according to the need for care of the patients, except that the same technician must not be responsible for more than 15 patients at one time. For purposes of establishing this ratio, all staff whose qualifications meet or exceed those for technicians under section 245F.15, subdivision 6, and who are performing the duties of a technician may be counted as technicians. The same individual may not be counted as both a technician and an alcohol and drug counselor.

Subd. 4. **Registered nurse required.** A license holder must employ or contract with a registered nurse, who must be available 24 hours a day by telephone or in person for consultation. The registered nurse is responsible for:

(1) establishing and implementing procedures for the provision of nursing care and delegated medical care, including:

(i) a health monitoring plan;

(ii) a medication control plan;

(iii) training and competency evaluations for staff performing delegated medical and nursing functions;

(iv) handling serious illness, accident, or injury to patients;

(v) an infection control program; and

(vi) a first aid kit;

(2) delegating nursing functions to other staff consistent with their education, competence, and legal authorization;

(3) assigning, supervising, and evaluating the performance of nursing tasks; and

(4) implementing condition-specific protocols in compliance with section 151.37, subdivision 2.

Subd. 5. **Medical director required.** A license holder must have a medical director available for medical supervision. The medical director is responsible for ensuring the accurate and safe provision of all health-related services and procedures. A license holder must obtain and document the medical director's annual approval of the following procedures before the procedures may be used:

(1) admission, discharge, and transfer criteria and procedures;

(2) a health services plan;

(3) physical indicators for a referral to a physician, registered nurse, or hospital, and procedures for referral;

(4) procedures to follow in case of accident, injury, or death of a patient;

(5) formulation of condition-specific protocols regarding the medications that require a withdrawal regimen that will be administered to patients;

(6) an infection control program;

(7) protective procedures; and

(8) a medication control plan.

Subd. 6. **Alcohol and drug counselor.** A withdrawal management program must provide one full-time equivalent alcohol and drug counselor for every 16 patients served by the program.

Subd. 7. **Ensuring staff-to-patient ratio.** The responsible staff person under subdivision 2 must ensure that the program does not exceed the staff-to-patient ratios in subdivisions 3 and 6 and must inform admitting staff of the current staffed capacity of the program for that shift. A license holder must have a written policy for documenting staff-to-patient ratios for each shift and actions to take when staffed capacity is reached.

Sec. 15. **[245F.15] STAFF QUALIFICATIONS.**

Subdivision 1. **Qualifications for all staff who have direct patient contact.** (a) All staff who have direct patient contact must be at least 18 years of age and must, at the time of hiring, document that they meet the requirements in paragraph (b), (c), or (d).

(b) Program directors, supervisors, nurses, and alcohol and drug counselors must be free of substance use problems for at least two years immediately preceding their hiring and must sign a statement attesting to that fact.

(c) Recovery peers must be free of substance use problems for at least one year immediately preceding their hiring and must sign a statement attesting to that fact.

(d) Technicians and other support staff must be free of substance use problems for at least six months immediately preceding their hiring and must sign a statement attesting to that fact.

Subd. 2. **Continuing employment; no substance use problems.** License holders must require staff to be free from substance use problems as a condition of continuing employment. Staff are not required to sign statements attesting to their freedom from substance use problems after the initial statement required by subdivision 1. Staff with substance use problems must be immediately removed from any responsibilities that include direct patient contact.

Subd. 3. **Program director qualifications.** A program director must:

(1) have at least one year of work experience in direct service to individuals with substance use disorders or one year of work experience in the management or administration of direct service to individuals with substance use disorders;

(2) have a baccalaureate degree or three years of work experience in administration or personnel supervision in human services; and

(3) know and understand the implications of this chapter and chapters 245A and 245C, and sections 253B.04, 253B.05, 626.556, 626.557, and 626.5572.

Subd. 4. **Alcohol and drug counselor qualifications.** An alcohol and drug counselor must meet the requirements in Minnesota Rules, part 9530.6450, subpart 5.

Subd. 5. **Responsible staff person qualifications.** Each responsible staff person must know and understand the implications of this chapter and sections 245A.65, 253B.04, 253B.05, 626.556, 626.557, and 626.5572. In a clinically managed program, the responsible staff person must be a licensed practiced nurse employed by or under contract with the license holder. In a medically monitored program, the responsible staff person must be a registered nurse, program director, or physician.

Subd. 6. **Technician qualifications.** A technician employed by a program must demonstrate competency, prior to direct patient contact, in the following areas:

(1) knowledge of the client bill of rights in section 148F.165, and staff responsibilities in sections 144.651 and 253B.03;

(2) knowledge of and the ability to perform basic health screening procedures with intoxicated patients that consist of:

(i) blood pressure, pulse, temperature, and respiration readings;

(ii) interviewing to obtain relevant medical history and current health complaints; and

(iii) visual observation of a patient's health status, including monitoring a patient's behavior as it relates to health status;

(3) a current first aid certificate from the American Red Cross or an equivalent organization; a current cardiopulmonary resuscitation certificate from the American Red Cross, the American Heart Association, a community organization, or an equivalent organization; and knowledge of first aid for seizures, trauma, and loss of consciousness; and

(4) knowledge of and ability to perform basic activities of daily living and personal hygiene.

Subd. 7. **Recovering peer qualifications.** Recovery peers must:

(1) be at least 21 years of age and have a high school diploma or its equivalent;

(2) have a minimum of one year in recovery from substance use disorder;

(3) have completed a curriculum designated by the commissioner that teaches specific skills and training in the domains of ethics and boundaries, advocacy, mentoring and education, and recovery and wellness support; and

(4) receive supervision in areas specific to the domains of their role by qualified supervisory staff.

Subd. 8. **Personal relationships.** A license holder must have a written policy addressing personal relationships between patients and staff who have direct patient contact. The policy must:

(1) prohibit direct patient contact between a patient and a staff member if the staff member has had a personal relationship with the patient within two years prior to the patient's admission to the program;

(2) prohibit access to a patient's clinical records by a staff member who has had a personal relationship with the patient within two years prior to the patient's admission, unless the patient consents in writing; and

(3) prohibit a clinical relationship between a staff member and a patient if the staff member has had a personal relationship with the patient within two years prior to the patient's admission. If a personal relationship exists, the staff member must report the relationship to the staff member's supervisor and recuse the staff member from a clinical relationship with that patient.

Sec. 16. **[245F.16] PERSONNEL POLICIES AND PROCEDURES.**

Subdivision 1. **Policy requirements.** A license holder must have written personnel policies and must make them available to staff members at all times. The personnel policies must:

(1) ensure that staff member's retention, promotion, job assignment, or pay are not affected by a good faith communication between the staff member and the Department of Human Services, Department of Health, Ombudsman for Mental Health and Developmental Disabilities, law enforcement, or local agencies that investigate complaints regarding patient rights, health, or safety;

(2) include a job description for each position that specifies job responsibilities, degree of authority to execute job responsibilities, standards of job performance related to specified job responsibilities, and qualifications;

(3) provide for written job performance evaluations for staff members of the license holder at least annually;

(4) describe behavior that constitutes grounds for disciplinary action, suspension, or dismissal, including policies that address substance use problems and meet the requirements of section 245F.15, subdivisions 1 and 2. The policies and procedures must list behaviors or incidents that are considered substance use problems. The list must include:

(i) receiving treatment for substance use disorder within the period specified for the position in the staff qualification requirements;

(ii) substance use that has a negative impact on the staff member's job performance;

(iii) substance use that affects the credibility of treatment services with patients, referral sources, or other members of the community; and

(iv) symptoms of intoxication or withdrawal on the job;

(5) include policies prohibiting personal involvement with patients and policies prohibiting patient maltreatment as specified under chapter 604 and sections 245A.65, 626.556, 626.557, and 626.5572;

(6) include a chart or description of organizational structure indicating the lines of authority and responsibilities;

(7) include a written plan for new staff member orientation that, at a minimum, includes training related to the specific job functions for which the staff member was hired, program policies and procedures, patient needs, and the areas identified in subdivision 2, paragraphs (b) to (e); and

(8) include a policy on the confidentiality of patient information.

Subd. 2. **Staff development.** (a) A license holder must ensure that each staff member receives orientation training before providing direct patient care and at least 30 hours of continuing education every two years. A written record must be kept to demonstrate completion of training requirements.

(b) Within 72 hours of beginning employment, all staff having direct patient contact must be provided orientation on the following:

(1) specific license holder and staff responsibilities for patient confidentiality;

(2) standards governing the use of protective procedures;

(3) patient ethical boundaries and patient rights, including the rights of patients admitted under chapter 253B;

(4) infection control procedures;

(5) mandatory reporting under sections 245A.65, 626.556, and 626.557, including specific training covering the facility's policies concerning obtaining patient releases of information;

(6) HIV minimum standards as required in section 245A.19;

(7) motivational counseling techniques and identifying stages of change; and

(8) eight hours of training on the program's protective procedures policy required in section 245F.09, including:

(i) approved therapeutic holds;

(ii) protective procedures used to prevent patients from imminent danger of harming self or others;

(iii) the emergency conditions under which the protective procedures may be used, if any;

(iv) documentation standards for using protective procedures;

(v) how to monitor and respond to patient distress; and

(vi) person-centered planning and trauma-informed care.

(c) All staff having direct patient contact must be provided annual training on the following:

(1) infection control procedures;

(2) mandatory reporting under sections 245A.65, 626.556, and 626.557, including specific training covering the facility's policies concerning obtaining patient releases of information;

(3) HIV minimum standards as required in section 245A.19; and

(4) motivational counseling techniques and identifying stages of change.

(d) All staff having direct patient contact must be provided training every two years on the following:

(1) specific license holder and staff responsibilities for patient confidentiality;

(2) standards governing use of protective procedures, including:

(i) approved therapeutic holds;

(ii) protective procedures used to prevent patients from imminent danger of harming self or others;

(iii) the emergency conditions under which the protective procedures may be used, if any;

(iv) documentation standards for using protective procedures;

(v) how to monitor and respond to patient distress; and

(vi) person-centered planning and trauma-informed care; and

(3) patient ethical boundaries and patient rights, including the rights of patients admitted under chapter 253B.

(e) Continuing education that is completed in areas outside of the required topics must provide information to the staff person that is useful to the performance of the individual staff person's duties.

Sec. 17. **[245F.17] PERSONNEL FILES.**

A license holder must maintain a separate personnel file for each staff member. At a minimum, the file must contain:

(1) a completed application for employment signed by the staff member that contains the staff member's qualifications for employment and documentation related to the applicant's background study data, as defined in chapter 245C;

(2) documentation of the staff member's current professional license or registration, if relevant;

(3) documentation of orientation and subsequent training;

(4) documentation of a statement of freedom from substance use problems; and

(5) an annual job performance evaluation.

Sec. 18. **[245F.18] POLICY AND PROCEDURES MANUAL.**

A license holder must develop a written policy and procedures manual that is alphabetically indexed and has a table of contents, so that staff have immediate access to all policies and procedures, and that consumers of the services, and other authorized parties have access to all policies and procedures. The manual must contain the following materials:

(1) a description of patient education services as required in section 245F.06;

(2) personnel policies that comply with section 245F.16;

(3) admission information and referral and discharge policies that comply with section 245F.05;

(4) a health monitoring plan that complies with section 245F.12;

(5) a protective procedures policy that complies with section 245F.09, if the program elects to use protective procedures;

(6) policies and procedures for assuring appropriate patient-to-staff ratios that comply with section 245F.14;

(7) policies and procedures for assessing and documenting the susceptibility for risk of abuse to the patient as the basis for the individual abuse prevention plan required by section 245A.65;

(8) procedures for mandatory reporting as required by sections 245A.65, 626.556, and 626.557;

(9) a medication control plan that complies with section 245F.13; and

(10) policies and procedures regarding HIV that meet the minimum standards under section 245A.19.

Sec. 19. **[245F.19] PATIENT RECORDS.**

Subdivision 1. **Patient records required.** A license holder must maintain a file of current patient records on the program premises where the treatment is provided. Each entry in each patient record must be signed and dated by the staff member making the entry. Patient records must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and section 254A.09; Code of Federal Regulations, title 42, sections 2.1 to 2.67; and title 45, parts 160 to 164.

Subd. 2. **Records retention.** A license holder must retain and store records as required by section 245A.041, subdivisions 3 and 4.

Subd. 3. **Contents of records.** Patient records must include the following:

(1) documentation of the patient's presenting problem, any substance use screening, the most recent assessment, and any updates;

(2) a stabilization plan and progress notes as required by section 245F.07, subdivisions 1 and 2;

(3) a discharge summary as required by section 245F.07, subdivision 3;

(4) an individual abuse prevention plan that complies with section 245A.65, and related rules;

(5) documentation of referrals made; and

(6) documentation of the monitoring and observations of the patient's medical needs.

Sec. 20. **[245F.20] DATA COLLECTION REQUIRED.**

The license holder must participate in the drug and alcohol abuse normative evaluation system (DAANES) by submitting, in a format provided by the commissioner, information concerning each patient admitted to the program. Staff submitting data must be trained by the license holder with the DAANES Web manual.

Sec. 21. **[245F.21] PAYMENT METHODOLOGY.**

The commissioner shall develop a payment methodology for services provided under this chapter or by an Indian Health Services facility or a facility owned and operated by a tribe or tribal organization operating under Public Law 93-638 as a 638 facility. The

commissioner shall seek federal approval for the methodology. Upon federal approval, the commissioner must seek and obtain legislative approval of the funding methodology to support the service.

ARTICLE 4

DIRECT CARE AND TREATMENT

Section 1. Minnesota Statutes 2014, section 246.54, subdivision 1, is amended to read:

Subdivision 1. **County portion for cost of care.** (a) Except for chemical dependency services provided under sections 254B.01 to 254B.09, the client's county shall pay to the state of Minnesota a portion of the cost of care provided in a regional treatment center or a state nursing facility to a client legally settled in that county. A county's payment shall be made from the county's own sources of revenue and payments shall equal a percentage of the cost of care, as determined by the commissioner, for each day, or the portion thereof, that the client spends at a regional treatment center or a state nursing facility according to the following schedule:

(1) zero percent for the first 30 days;

(2) 20 percent for days 31 ~~to 60~~ and over if the stay is determined to be clinically appropriate for the client; and

(3) ~~75 percent for any days over 60~~ 100 percent for each day during the stay, including the day of admission, when the facility determines that it is clinically appropriate for the client to be discharged.

~~(b) The increase in the county portion for cost of care under paragraph (a), clause (3), shall be imposed when the treatment facility has determined that it is clinically appropriate for the client to be discharged.~~

~~(c)~~ (b) If payments received by the state under sections 246.50 to 246.53 exceed 80 percent of the cost of care for days over 31 ~~to 60, or 25 percent for days over 60~~ for clients who meet the criteria in paragraph (a), clause (2), the county shall be responsible for paying the state only the remaining amount. The county shall not be entitled to reimbursement from the client, the client's estate, or from the client's relatives, except as provided in section 246.53.

Sec. 2. Minnesota Statutes 2014, section 246B.01, subdivision 2b, is amended to read:

Subd. 2b. **Cost of care.** "Cost of care" means the commissioner's charge for housing ~~and~~, treatment, aftercare services, and supervision, provided to any person admitted to the Minnesota sex offender program.

For purposes of this subdivision, "charge for housing ~~and~~, treatment, aftercare services, and supervision" means the cost of services, treatment, maintenance, bonds issued for capital improvements, depreciation of buildings and equipment, and indirect costs related to the operation of state facilities. The commissioner may determine the charge for services on an anticipated average per diem basis as an all-inclusive charge per facility.

Sec. 3. Minnesota Statutes 2014, section 246B.10, is amended to read:

246B.10 LIABILITY OF COUNTY; REIMBURSEMENT.

The civilly committed sex offender's county shall pay to the state a portion of the cost of care provided in the Minnesota sex offender program to a civilly committed sex offender who has legally settled in that county. A county's payment must be made from the county's own sources of revenue and payments must equal 25 percent of the cost of care, as determined by the commissioner, for each day or portion of a day, that the civilly committed sex offender ~~spends at the facility~~ receives services, either within a Minnesota sex offender program facility or while on provisional discharge. If payments received by the state under this chapter exceed 75 percent of the cost of care for civilly committed sex offenders admitted to the program on or after August 1, 2011, the county is responsible for paying the state the remaining amount. If payments received by the state under this chapter exceed 90 percent of the cost of care for civilly committed sex offenders admitted to the program prior to August 1, 2011, the county is responsible for paying the state the remaining amount. The county is not entitled to reimbursement from the civilly committed sex offender, the civilly committed sex offender's estate, or from the civilly committed sex offender's relatives, except as provided in section 246B.07.

EFFECTIVE DATE. The amendment to the provision governing county payments for each day or portion of a day that a civilly committed sex offender receives services is effective for civilly committed sex offenders provisionally discharged on or after the day following final enactment.

ARTICLE 5

OPERATIONS

Section 1. Minnesota Statutes 2014, section 144.057, subdivision 1, is amended to read:

Subdivision 1. **Background studies required.** The commissioner of health shall contract with the commissioner of human services to conduct background studies of:

(1) individuals providing services which have direct contact, as defined under section 245C.02, subdivision 11, with patients and residents in hospitals, boarding care

homes, outpatient surgical centers licensed under sections 144.50 to 144.58; nursing homes and home care agencies licensed under chapter 144A; residential care homes licensed under chapter 144B, and board and lodging establishments that are registered to provide supportive or health supervision services under section 157.17;

(2) individuals specified in section 245C.03, subdivision 1, who perform direct contact services in a nursing home or a home care agency licensed under chapter 144A or a boarding care home licensed under sections 144.50 to 144.58~~, and~~. If the individual under study resides outside Minnesota, the study must ~~be at least as comprehensive as that of a Minnesota resident and include a search of information from the criminal justice data communications network in the state where the subject of the study resides~~ include a check for substantiated findings of maltreatment of adults and children in the individual's state of residence when the information is made available by that state, and must include a check of the National Crime Information Center database;

(3) beginning July 1, 1999, all other employees in nursing homes licensed under chapter 144A, and boarding care homes licensed under sections 144.50 to 144.58. A disqualification of an individual in this section shall disqualify the individual from positions allowing direct contact or access to patients or residents receiving services. "Access" means physical access to a client or the client's personal property without continuous, direct supervision as defined in section 245C.02, subdivision 8, when the employee's employment responsibilities do not include providing direct contact services;

(4) individuals employed by a supplemental nursing services agency, as defined under section 144A.70, who are providing services in health care facilities; and

(5) controlling persons of a supplemental nursing services agency, as defined under section 144A.70.

If a facility or program is licensed by the Department of Human Services and subject to the background study provisions of chapter 245C and is also licensed by the Department of Health, the Department of Human Services is solely responsible for the background studies of individuals in the jointly licensed programs.

Sec. 2. Minnesota Statutes 2014, section 174.30, is amended by adding a subdivision to read:

Subd. 10. **Background studies.** (a) Providers of special transportation service regulated under this section must initiate background studies in accordance with chapter 245C on the following individuals:

(1) each person with a direct or indirect ownership interest of five percent or higher in the transportation service provider;

(2) each controlling individual as defined under section 245A.02;

(3) managerial officials as defined in section 245A.02;

(4) each driver employed by the transportation service provider;

(5) each individual employed by the transportation service provider to assist a passenger during transport; and

(6) all employees of the transportation service agency who provide administrative support, including those who:

(i) may have face-to-face contact with or access to passengers, their personal property, or their private data;

(ii) perform any scheduling or dispatching tasks; or

(iii) perform any billing activities.

(b) The transportation service provider must initiate the background studies required under paragraph (a) using the online NETStudy system operated by the commissioner of human services.

(c) The transportation service provider shall not permit any individual to provide any service listed in paragraph (a) until the transportation service provider has received notification from the commissioner of human services indicating that the individual:

(1) is not disqualified under chapter 245C; or

(2) is disqualified, but has received a set-aside of that disqualification according to section 245C.23 related to that transportation service provider.

(d) When a local or contracted agency is authorizing a ride under section 256B.0625, subdivision 17, by a volunteer driver, and the agency authorizing the ride has reason to believe the volunteer driver has a history that would disqualify the individual or that may pose a risk to the health or safety of passengers, the agency may initiate a background study to be completed according to chapter 245C using the commissioner of human services' online NETStudy system, or through contacting the Department of Human Services background study division for assistance. The agency that initiates the background study under this paragraph shall be responsible for providing the volunteer driver with the privacy notice required under section 245C.05, subdivision 2c, and payment for the background study required under section 245C.10, subdivision 11, before the background study is completed.

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

Sec. 3. Minnesota Statutes 2014, section 245C.03, is amended by adding a subdivision to read:

Subd. 10. **Providers of special transportation service.** The commissioner shall conduct background studies on any individual required under section 174.30 to have a background study completed under this chapter.

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

Sec. 4. Minnesota Statutes 2014, section 245C.03, is amended by adding a subdivision to read:

Subd. 11. **MNsure consumer assistance partners.** The commissioner shall conduct background studies on any individual required under section 256.962, subdivision 9, to have a background study completed under this chapter.

Sec. 5. Minnesota Statutes 2014, section 245C.08, subdivision 1, is amended to read:

Subdivision 1. **Background studies conducted by Department of Human Services.** (a) For a background study conducted by the Department of Human Services, the commissioner shall review:

(1) information related to names of substantiated perpetrators of maltreatment of vulnerable adults that has been received by the commissioner as required under section 626.557, subdivision 9c, paragraph (j);

(2) the commissioner's records relating to the maltreatment of minors in licensed programs, and from findings of maltreatment of minors as indicated through the social service information system;

(3) information from juvenile courts as required in subdivision 4 for individuals listed in section 245C.03, subdivision 1, paragraph (a), when there is reasonable cause;

(4) information from the Bureau of Criminal Apprehension, including information regarding a background study subject's registration in Minnesota as a predatory offender under section 243.166;

(5) except as provided in clause (6), information from the national crime information system when the commissioner has reasonable cause as defined under section 245C.05, subdivision 5, or as required under section 144.057, subdivision 1, clause (2); and

(6) for a background study related to a child foster care application for licensure, a transfer of permanent legal and physical custody of a child under sections 260C.503 to 260C.515, or adoptions, the commissioner shall also review:

(i) information from the child abuse and neglect registry for any state in which the background study subject has resided for the past five years; and

(ii) information from national crime information databases, when the background study subject is 18 years of age or older.

(b) Notwithstanding expungement by a court, the commissioner may consider information obtained under paragraph (a), clauses (3) and (4), unless the commissioner received notice of the petition for expungement and the court order for expungement is directed specifically to the commissioner.

(c) The commissioner shall also review criminal case information received according to section 245C.04, subdivision 4a, from the Minnesota court information system that relates to individuals who have already been studied under this chapter and who remain affiliated with the agency that initiated the background study.

(d) When the commissioner has reasonable cause to believe that the identity of a background study subject is uncertain, the commissioner may require the subject to provide a set of classifiable fingerprints for purposes of completing a fingerprint-based record check with the Bureau of Criminal Apprehension. Fingerprints collected under this paragraph shall not be saved by the commissioner after they have been used to verify the identity of the background study subject against the particular criminal record in question.

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

Subd. 11. **Providers of special transportation service.** The commissioner shall recover the cost of background studies initiated by providers of special transportation service under section 174.30 through a fee of no more than $20 per study. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

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

Sec. 7. Minnesota Statutes 2014, section 245C.10, is amended by adding a subdivision to read:

Subd. 12. **MNsure consumer assistance partners.** The commissioner shall recover the cost of background studies required under section 256.962, subdivision 9, through a fee of no more than $20 per study. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 8. Minnesota Statutes 2014, section 245C.12, is amended to read:

245C.12 BACKGROUND STUDY; TRIBAL ORGANIZATIONS.

(a) For the purposes of background studies completed by tribal organizations performing licensing activities otherwise required of the commissioner under this chapter,

after obtaining consent from the background study subject, tribal licensing agencies shall have access to criminal history data in the same manner as county licensing agencies and private licensing agencies under this chapter.

(b) Tribal organizations may contract with the commissioner to obtain background study data on individuals under tribal jurisdiction related to adoptions according to section 245C.34. Tribal organizations may also contract with the commissioner to obtain background study data on individuals under tribal jurisdiction related to child foster care according to section 245C.34.

(c) For the purposes of background studies completed to comply with a tribal organization's licensing requirements for individuals affiliated with nursing facilities licensed under section 144.057, the commissioner shall obtain criminal history data from the National Criminal Records Repository in accordance with section 245C.32.

Sec. 9. Minnesota Statutes 2014, section 256.962, is amended by adding a subdivision to read:

Subd. 9. **Background studies for consumer assistance partners.** All consumer assistance partners, as defined in Minnesota Rules, part 7700.0020, subpart 7, are required to undergo a background study according to the requirements of chapter 245C.

Sec. 10. **REPEALER.**

Minnesota Rules, part 8840.5900, subparts 12 and 14, are repealed.

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

ARTICLE 6

HEALTH CARE

Section 1. Minnesota Statutes 2014, section 62A.045, is amended to read:

62A.045 PAYMENTS ON BEHALF OF ENROLLEES IN GOVERNMENT HEALTH PROGRAMS.

(a) As a condition of doing business in Minnesota or providing coverage to residents of Minnesota covered by this section, each health insurer shall comply with the requirements of the federal Deficit Reduction Act of 2005, Public Law 109-171, including any federal regulations adopted under that act, to the extent that it imposes a requirement that applies in this state and that is not also required by the laws of this state. This section does not require compliance with any provision of the federal act prior to the effective date provided for that provision in the federal act. The commissioner shall enforce this section.

For the purpose of this section, "health insurer" includes self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are by contract legally responsible to pay a claim for a health-care item or service for an individual receiving benefits under paragraph (b).

(b) No plan offered by a health insurer issued or renewed to provide coverage to a Minnesota resident shall contain any provision denying or reducing benefits because services are rendered to a person who is eligible for or receiving medical benefits pursuant to title XIX of the Social Security Act (Medicaid) in this or any other state; chapter 256; 256B; or 256D or services pursuant to section 252.27; 256L.01 to 256L.10; 260B.331, subdivision 2; 260C.331, subdivision 2; or 393.07, subdivision 1 or 2. No health insurer providing benefits under plans covered by this section shall use eligibility for medical programs named in this section as an underwriting guideline or reason for nonacceptance of the risk.

(c) If payment for covered expenses has been made under state medical programs for health care items or services provided to an individual, and a third party has a legal liability to make payments, the rights of payment and appeal of an adverse coverage decision for the individual, or in the case of a child their responsible relative or caretaker, will be subrogated to the state agency. The state agency may assert its rights under this section within three years of the date the service was rendered. For purposes of this section, "state agency" includes prepaid health plans under contract with the commissioner according to sections 256B.69, 256D.03, subdivision 4, paragraph (c), and 256L.12; children's mental health collaboratives under section 245.493; demonstration projects for persons with disabilities under section 256B.77; nursing homes under the alternative payment demonstration project under section 256B.434; and county-based purchasing entities under section 256B.692.

(d) Notwithstanding any law to the contrary, when a person covered by a plan offered by a health insurer receives medical benefits according to any statute listed in this section, payment for covered services or notice of denial for services billed by the provider must be issued directly to the provider. If a person was receiving medical benefits through the Department of Human Services at the time a service was provided, the provider must indicate this benefit coverage on any claim forms submitted by the provider to the health insurer for those services. If the commissioner of human services notifies the health insurer that the commissioner has made payments to the provider, payment for benefits or notices of denials issued by the health insurer must be issued directly to the commissioner. Submission by the department to the health insurer of the claim on a Department of Human Services claim form is proper notice and shall be considered proof of payment of

the claim to the provider and supersedes any contract requirements of the health insurer relating to the form of submission. Liability to the insured for coverage is satisfied to the extent that payments for those benefits are made by the health insurer to the provider or the commissioner as required by this section.

(e) When a state agency has acquired the rights of an individual eligible for medical programs named in this section and has health benefits coverage through a health insurer, the health insurer shall not impose requirements that are different from requirements applicable to an agent or assignee of any other individual covered.

(f) A health insurer must process a claim made by a state agency for covered expenses paid under state medical programs within 90 business days of the claim's submission. If the health insurer needs additional information to process the claim, the health insurer may be granted an additional 30 business days to process the claim, provided the health insurer submits the request for additional information to the state agency within 30 business days after the health insurer received the claim.

(g) A health insurer may request a refund of a claim paid in error to the Department of Human Services within two years of the date the payment was made to the department. A request for a refund shall not be honored by the department if the health insurer makes the request after the time period has lapsed.

Sec. 2. Minnesota Statutes 2014, section 256.015, subdivision 7, is amended to read:

Subd. 7. **Cooperation with information requests required.** (a) Upon the request of the commissioner of human services:

(1) any state agency or third-party payer shall cooperate by furnishing information to help establish a third-party liability, as required by the federal Deficit Reduction Act of 2005, Public Law 109-171;

(2) any employer or third-party payer shall cooperate by furnishing a data file containing information about group health insurance plan or medical benefit plan coverage of its employees or insureds within 60 days of the request. The information in the data file must include at least the following: full name, date of birth, Social Security number if collected by the employer or third-party payer, employer name, policy identification number, group identification number, and plan or coverage type.

(b) For purposes of section 176.191, subdivision 4, the commissioner of labor and industry may allow the commissioner of human services and county agencies direct access and data matching on information relating to workers' compensation claims in order to determine whether the claimant has reported the fact of a pending claim and the amount paid to or on behalf of the claimant to the commissioner of human services.

(c) For the purpose of compliance with section 169.09, subdivision 13, and federal requirements under Code of Federal Regulations, title 42, section 433.138 (d)(4), the commissioner of public safety shall provide accident data as requested by the commissioner of human services. The disclosure shall not violate section 169.09, subdivision 13, paragraph (d).

(d) The commissioner of human services and county agencies shall limit its use of information gained from agencies, third-party payers, and employers to purposes directly connected with the administration of its public assistance and child support programs. The provision of information by agencies, third-party payers, and employers to the department under this subdivision is not a violation of any right of confidentiality or data privacy.

Sec. 3. Minnesota Statutes 2014, section 256.969, subdivision 1, is amended to read:

Subdivision 1. **Hospital cost index.** (a) The hospital cost index shall be the change in the Consumer Price Index-All Items (United States city average) (CPI-U) forecasted by Data Resources, Inc. The commissioner shall use the indices as forecasted in the third quarter of the calendar year prior to the rate year. The hospital cost index may be used to adjust the base year operating payment rate through the rate year on an annually compounded basis.

(b) For fiscal years beginning on or after July 1, 1993, the commissioner of human services shall not provide automatic annual inflation adjustments for hospital payment rates under medical assistance. ~~The commissioner of management and budget shall include as a budget change request in each biennial detailed expenditure budget submitted to the legislature under section 16A.11 annual adjustments in hospital payment rates under medical assistance based upon the hospital cost index.~~

Sec. 4. Minnesota Statutes 2014, section 256.969, subdivision 2b, is amended to read:

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

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

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

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

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

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

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

(d) For discharges occurring on or after November 1, 2014, through June 30, 2016, the rebased rates under paragraph (c) shall include adjustments to the projected rates that result in no greater than a five percent increase or decrease from the base year payments for any hospital. Any adjustments to the rates made by the commissioner under this paragraph and paragraph (e) shall maintain budget neutrality as described in paragraph (c).

(e) For discharges occurring on or after November 1, 2014, through June 30, 2016, the commissioner may make additional adjustments to the rebased rates, and when evaluating whether additional adjustments should be made, the commissioner shall consider the impact of the rates on the following:

(1) pediatric services;

(2) behavioral health services;

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

(4) transplant services;

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

(6) outlier admissions;

(7) low-volume providers; and

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

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

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

(2) for critical access hospitals, interim per diem payment rates shall be based on the ratio of cost and charges reported on the base year Medicare cost report or reports and applied to medical assistance utilization data. Final settlement payments for a state fiscal year must be determined based on a review of the medical assistance cost report required under subdivision 4b for the applicable state fiscal year;

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

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

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

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

(i) Effective for discharges occurring on or after July 1, 2015, payment rates for critical access hospitals located in Minnesota or the local trade area shall be determined using a new cost-based methodology. The commissioner shall establish within the methodology tiers of payment designed to promote efficiency and cost-effectiveness.

Annual payments to hospitals under this paragraph shall equal the total cost for critical access hospitals as reflected in base year cost reports. The new cost-based rate shall be the final rate and shall not be settled to actual incurred costs. The factors used to develop the new methodology may include but are not limited to:

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

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

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

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

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

(6) geographic location.

Sec. 5. Minnesota Statutes 2014, section 256.969, subdivision 9, is amended to read:

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

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

(2) for a hospital with a medical assistance inpatient utilization rate above one standard deviation above the mean, the adjustment must be determined by multiplying the adjustment that would be determined under clause (1) for that hospital by 1.1.

The commissioner may establish a separate disproportionate population payment rate adjustment for critical access hospitals. The commissioner shall report annually on the

number of hospitals likely to receive the adjustment authorized by this paragraph. The commissioner shall specifically report on the adjustments received by public hospitals and public hospital corporations located in cities of the first class.

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

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

(d) Effective July 1, 2015, disproportionate share hospital (DSH) payments shall be paid in accordance with a new methodology. Annual DSH payments made under this paragraph shall equal the total amount of DSH payments made for 2012. The new methodology shall take into account a variety of factors, including but not limited to:

(1) the medical assistance utilization rate of the hospitals that receive payments under this subdivision;

(2) whether the hospital is located within Minnesota;

(3) the difference between a hospital's costs for treating medical assistance patients and the total amount of payments received from medical assistance;

(4) the percentage of uninsured patient days at each qualifying hospital in relation to the total number of uninsured patient days statewide;

(5) the hospital's status as a hospital authorized to make presumptive eligibility determinations for medical assistance in accordance with section 256B.057, subdivision 12;

(6) the hospital's status as a safety net, critical access, children's, rehabilitation, or long-term hospital;

(7) whether the hospital's administrative cost of compiling the necessary DSH reports exceeds the anticipated value of any calculated DSH payment; and

(8) whether the hospital provides specific services designated by the commissioner to be of particular importance to the medical assistance program.

(e) Any payments or portion of payments made to a hospital under this subdivision that are subsequently returned to the commissioner because the payments are found to exceed the hospital-specific DSH limit for that hospital shall be redistributed to other DSH-eligible hospitals in a manner established by the commissioner.

Sec. 6. Minnesota Statutes 2014, section 256B.059, subdivision 5, is amended to read:

Subd. 5. **Asset availability.** (a) At the time of initial determination of eligibility for medical assistance benefits following the first continuous period of institutionalization on or after October 1, 1989, assets considered available to the institutionalized spouse shall be the total value of all assets in which either spouse has an ownership interest, reduced by the following amount for the community spouse:

(1) prior to July 1, 1994, the greater of:

(i) $14,148;

(ii) the lesser of the spousal share or $70,740; or

(iii) the amount required by court order to be paid to the community spouse;

(2) for persons whose date of initial determination of eligibility for medical assistance following their first continuous period of institutionalization occurs on or after July 1, 1994, the greater of:

(i) $20,000;

(ii) the lesser of the spousal share or $70,740; or

(iii) the amount required by court order to be paid to the community spouse.

The value of assets transferred for the sole benefit of the community spouse under section 256B.0595, subdivision 4, in combination with other assets available to the community spouse under this section, cannot exceed the limit for the community spouse asset allowance determined under subdivision 3 or 4. Assets that exceed this allowance shall be considered available to the institutionalized spouse ~~whether or not~~ unless converted to income. If the community spouse asset allowance has been increased under subdivision 4, then the assets considered available to the institutionalized spouse under this subdivision shall be further reduced by the value of additional amounts allowed under subdivision 4.

(b) An institutionalized spouse may be found eligible for medical assistance even though assets in excess of the allowable amount are found to be available under paragraph (a) if the assets are owned jointly or individually by the community spouse, and the institutionalized spouse cannot use those assets to pay for the cost of care without the consent of the community spouse, and if: (i) the institutionalized spouse assigns to the commissioner the right to support from the community spouse under section 256B.14, subdivision 3; (ii) the institutionalized spouse lacks the ability to execute an assignment due to a physical or mental impairment; or (iii) the denial of eligibility would cause an imminent threat to the institutionalized spouse's health and well-being.

(c) After the month in which the institutionalized spouse is determined eligible for medical assistance, during the continuous period of institutionalization, no assets of the

community spouse are considered available to the institutionalized spouse, unless the institutionalized spouse has been found eligible under paragraph (b).

(d) Assets determined to be available to the institutionalized spouse under this section must be used for the health care or personal needs of the institutionalized spouse.

(e) For purposes of this section, assets do not include assets excluded under the Supplemental Security Income program.

Sec. 7. Minnesota Statutes 2014, section 256B.0625, subdivision 9, is amended to read:

Subd. 9. **Dental services.** (a) Medical assistance covers dental services.

(b) Medical assistance dental coverage for nonpregnant adults is limited to the following services:

(1) comprehensive exams, limited to once every five years;

(2) periodic exams, limited to one per year;

(3) limited exams;

(4) bitewing x-rays, limited to one per year;

(5) periapical x-rays;

(6) panoramic x-rays, limited to one every five years except (1) when medically necessary for the diagnosis and follow-up of oral and maxillofacial pathology and trauma or (2) once every two years for patients who cannot cooperate for intraoral film due to a developmental disability or medical condition that does not allow for intraoral film placement;

(7) prophylaxis, limited to one per year;

(8) application of fluoride varnish, limited to one per year;

(9) posterior fillings, all at the amalgam rate;

(10) anterior fillings;

(11) endodontics, limited to root canals on the anterior and premolars only;

(12) removable prostheses, each dental arch limited to one every six years;

(13) oral surgery, limited to extractions, biopsies, and incision and drainage of abscesses;

(14) palliative treatment and sedative fillings for relief of pain; ~~and~~

(15) full-mouth debridement, limited to one every five years~~.~~; and

(16) nonsurgical treatment for periodontal disease, including scaling, root planing, and routine periodontal maintenance procedures, limited to once per quadrant per year.

(c) In addition to the services specified in paragraph (b), medical assistance covers the following services for adults, if provided in an outpatient hospital setting or freestanding ambulatory surgical center as part of outpatient dental surgery:

(1) periodontics, limited to periodontal scaling and root planing once every two years;

(2) general anesthesia; and

(3) full-mouth survey once every five years.

(d) Medical assistance covers medically necessary dental services for children and pregnant women. The following guidelines apply:

(1) posterior fillings are paid at the amalgam rate;

(2) application of sealants are covered once every five years per permanent molar for children only;

(3) application of fluoride varnish is covered once every six months; and

(4) orthodontia is eligible for coverage for children only.

(e) In addition to the services specified in paragraphs (b) and (c), medical assistance covers the following services for adults:

(1) house calls or extended care facility calls for on-site delivery of covered services;

(2) behavioral management when additional staff time is required to accommodate behavioral challenges and sedation is not used;

(3) oral or IV sedation, if the covered dental service cannot be performed safely without it or would otherwise require the service to be performed under general anesthesia in a hospital or surgical center; and

(4) prophylaxis, in accordance with an appropriate individualized treatment plan, but no more than four times per year.

(f) The commissioner shall not require prior authorization for the services included in paragraph (e), clauses (1) to (3), and shall prohibit managed care and county-based purchasing plans from requiring prior authorization for the services included in paragraph (e), clauses (1) to (3), when provided under sections 256B.69, 256B.692, and 256L.12.

Sec. 8. Minnesota Statutes 2014, section 256B.0625, subdivision 13h, is amended to read:

Subd. 13h. **Medication therapy management services.** (a) Medical assistance ~~and general assistance medical care cover~~ covers medication therapy management services for a recipient taking ~~three or more~~ prescriptions to treat or prevent one or more chronic medical conditions~~; a recipient with a drug therapy problem that is identified by the commissioner or identified by a pharmacist and approved by the commissioner; or prior authorized by the commissioner that has resulted or is likely to result in significant nondrug program costs. The commissioner may cover medical therapy management services under MinnesotaCare if the commissioner determines this is cost-effective~~. For purposes of this subdivision, "medication therapy management" means the provision

of the following pharmaceutical care services by a licensed pharmacist to optimize the therapeutic outcomes of the patient's medications:

(1) performing or obtaining necessary assessments of the patient's health status;

(2) formulating a medication treatment plan;

(3) monitoring and evaluating the patient's response to therapy, including safety and effectiveness;

(4) performing a comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events;

(5) documenting the care delivered and communicating essential information to the patient's other primary care providers;

(6) providing verbal education and training designed to enhance patient understanding and appropriate use of the patient's medications;

(7) providing information, support services, and resources designed to enhance patient adherence with the patient's therapeutic regimens; and

(8) coordinating and integrating medication therapy management services within the broader health care management services being provided to the patient.

Nothing in this subdivision shall be construed to expand or modify the scope of practice of the pharmacist as defined in section 151.01, subdivision 27.

(b) To be eligible for reimbursement for services under this subdivision, a pharmacist must meet the following requirements:

(1) have a valid license issued by the Board of Pharmacy of the state in which the medication therapy management service is being performed;

(2) have graduated from an accredited college of pharmacy on or after May 1996, or completed a structured and comprehensive education program approved by the Board of Pharmacy and the American Council of Pharmaceutical Education for the provision and documentation of pharmaceutical care management services that has both clinical and didactic elements;

(3) be practicing in an ambulatory care setting as part of a multidisciplinary team or have developed a structured patient care process that is offered in a private or semiprivate patient care area that is separate from the commercial business that also occurs in the setting, or in home settings, including long-term care settings, group homes, and facilities providing assisted living services, but excluding skilled nursing facilities; and

(4) make use of an electronic patient record system that meets state standards.

(c) For purposes of reimbursement for medication therapy management services, the commissioner may enroll individual pharmacists as medical assistance ~~and general assistance medical care~~ providers. The commissioner may also establish contact

requirements between the pharmacist and recipient, including limiting the number of reimbursable consultations per recipient.

(d) If there are no pharmacists who meet the requirements of paragraph (b) practicing within a reasonable geographic distance of the patient, a pharmacist who meets the requirements may provide the services via two-way interactive video. Reimbursement shall be at the same rates and under the same conditions that would otherwise apply to the services provided. To qualify for reimbursement under this paragraph, the pharmacist providing the services must meet the requirements of paragraph (b), and must be located within an ambulatory care setting ~~approved by the commissioner~~ that meets the requirements of paragraph (b), clause (3). The patient must also be located within an ambulatory care setting ~~approved by the commissioner~~ that meets the requirements of paragraph (b), clause (3). Services provided under this paragraph may not be transmitted into the patient's residence.

~~(e) The commissioner shall establish a pilot project for an intensive medication therapy management program for patients identified by the commissioner with multiple chronic conditions and a high number of medications who are at high risk of preventable hospitalizations, emergency room use, medication complications, and suboptimal treatment outcomes due to medication-related problems. For purposes of the pilot project, medication therapy management services may be provided in a patient's home or community setting, in addition to other authorized settings. The commissioner may waive existing payment policies and establish special payment rates for the pilot project. The pilot project must be designed to produce a net savings to the state compared to the estimated costs that would otherwise be incurred for similar patients without the program. The pilot project must begin by January 1, 2010, and end June 30, 2012.~~

(e) Medication therapy management services may be delivered into a patient's residence via secure interactive video if the medication therapy management services are performed electronically during a covered home care visit by an enrolled provider. Reimbursement shall be at the same rates and under the same conditions that would otherwise apply to the services provided. To qualify for reimbursement under this paragraph, the pharmacist providing the services must meet the requirements of paragraph (b) and must be located within an ambulatory care setting that meets the requirements of paragraph (b), clause (3).

Sec. 9. Minnesota Statutes 2014, section 256B.0625, subdivision 58, is amended to read:

Subd. 58. **Early and periodic screening, diagnosis, and treatment services.** Medical assistance covers early and periodic screening, diagnosis, and treatment services

(EPSDT). The payment amount for a complete EPSDT screening shall not include charges for ~~vaccines~~ health care services and products that are available at no cost to the provider and shall not exceed the rate established per Minnesota Rules, part 9505.0445, item M, effective October 1, 2010.

Sec. 10. Minnesota Statutes 2014, section 256B.0631, is amended to read:

256B.0631 MEDICAL ASSISTANCE CO-PAYMENTS.

Subdivision 1. **Cost-sharing.** (a) Except as provided in subdivision 2, the medical assistance benefit plan shall include the following cost-sharing for all recipients, effective for services provided on or after September 1, 2011:

(1) $3 per nonpreventive visit, except as provided in paragraph (b). For purposes of this subdivision, a visit means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist;

(2) $3.50 for nonemergency visits to a hospital-based emergency room, except that this co-payment shall be increased to $20 upon federal approval;

(3) $3 per brand-name drug prescription and $1 per generic drug prescription, subject to a $12 per month maximum for prescription drug co-payments. No co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness;

(4) ~~effective January 1, 2012,~~ a family deductible equal to ~~the maximum amount allowed under Code of Federal Regulations, title 42, part 447.54~~ $2.75 per month per family and adjusted annually by the percentage increase in the medical care component of the CPI-U for the period of September to September of the preceding calendar year, rounded to the next higher five-cent increment; and

(5) ~~for individuals identified by the commissioner with income at or below 100 percent of the federal poverty guidelines,~~ total monthly cost-sharing must not exceed five percent of family income. For purposes of this paragraph, family income is the total earned and unearned income of the individual and the individual's spouse, if the spouse is enrolled in medical assistance and also subject to the five percent limit on cost-sharing. This paragraph does not apply to premiums charged to individuals described under section 256B.057, subdivision 9.

(b) Recipients of medical assistance are responsible for all co-payments and deductibles in this subdivision.

(c) Notwithstanding paragraph (b), the commissioner, through the contracting process under sections 256B.69 and 256B.692, may allow managed care plans and

county-based purchasing plans to waive the family deductible under paragraph (a), clause (4). The value of the family deductible shall not be included in the capitation payment to managed care plans and county-based purchasing plans. Managed care plans and county-based purchasing plans shall certify annually to the commissioner the dollar value of the family deductible.

(d) Notwithstanding paragraph (b), the commissioner may waive the collection of the family deductible described under paragraph (a), clause (4), from individuals and allow long-term care and waivered service providers to assume responsibility for payment.

(e) Notwithstanding paragraph (b), the commissioner, through the contracting process under section 256B.0756 shall allow the pilot program in Hennepin County to waive co-payments. The value of the co-payments shall not be included in the capitation payment amount to the integrated health care delivery networks under the pilot program.

Subd. 2. **Exceptions.** Co-payments and deductibles shall be subject to the following exceptions:

(1) children under the age of 21;

(2) pregnant women for services that relate to the pregnancy or any other medical condition that may complicate the pregnancy;

(3) recipients expected to reside for at least 30 days in a hospital, nursing home, or intermediate care facility for the developmentally disabled;

(4) recipients receiving hospice care;

(5) 100 percent federally funded services provided by an Indian health service;

(6) emergency services;

(7) family planning services;

(8) services that are paid by Medicare, resulting in the medical assistance program paying for the coinsurance and deductible;

(9) co-payments that exceed one per day per provider for nonpreventive visits, eyeglasses, and nonemergency visits to a hospital-based emergency room; ~~and~~

(10) services, fee-for-service payments subject to volume purchase through competitive bidding.~~;~~

(11) American Indians who meet the requirements in Code of Federal Regulations, title 42, section 447.51;

(12) persons needing treatment for breast or cervical cancer as described under section 256B.057, subdivision 10; and

(13) services that currently have a rating of A or B from the United States Preventive Services Task Force (USPSTF), immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and

preventive services and screenings provided to women as described in Code of Federal Regulations, title 45, section 147.130.

Subd. 3. **Collection.** (a) The medical assistance reimbursement to the provider shall be reduced by the amount of the co-payment or deductible, except that reimbursements shall not be reduced:

(1) once a recipient has reached the $12 per month maximum for prescription drug co-payments; or

(2) for a recipient ~~identified by the commissioner under 100 percent of the federal poverty guidelines~~ who has met their monthly five percent cost-sharing limit.

(b) The provider collects the co-payment or deductible from the recipient. Providers may not deny services to recipients who are unable to pay the co-payment or deductible.

(c) Medical assistance reimbursement to fee-for-service providers and payments to managed care plans shall not be increased as a result of the removal of co-payments or deductibles effective on or after January 1, 2009.

EFFECTIVE DATE. The amendment to subdivision 1, paragraph (a), clause (4), is effective retroactively from January 1, 2014.

Sec. 11. **[256B.0638] OPIOID PRESCRIBING IMPROVEMENT PROGRAM.**

Subdivision 1. **Program established.** The commissioner of human services, in conjunction with the commissioner of health, shall coordinate and implement an opioid prescribing improvement program to reduce opioid dependency and substance use by Minnesotans due to the prescribing of opioid analgesics by health care providers.

Subd. 2. **Definitions.** (a) For purposes of this section, the terms defined in this subdivision have the meanings given them.

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

(c) "Commissioners" means the commissioner of human services and the commissioner of health.

(d) "DEA" means the United States Drug Enforcement Administration.

(e) "Opioid disenrollment standards" means parameters of opioid prescribing practices that fall outside community standard thresholds for prescribing to such a degree that a provider must be disenrolled as a medical assistance provider.

(f) "Opioid prescriber" means a licensed health care provider who prescribes opioids to medical assistance and MinnesotaCare enrollees under the fee-for-service system or under a managed care or county-based purchasing plan.

(g) "Program" means the statewide opioid prescribing improvement program established under this section.

(h) "Provider group" means a clinic, hospital, or primary or specialty practice group that employs, contracts with, or is affiliated with an opioid prescriber. Provider group does not include a professional association supported by dues-paying members.

(i) "Opioid quality improvement standard thresholds" means parameters of opioid prescribing practices that fall outside community standards for prescribing to such a degree that quality improvement is required.

(j) "Sentinel measures" means measures of opioid use that identify variations in prescribing practices during the prescribing intervals.

Subd. 3. **Opioid prescribing work group.** (a) The commissioner of human services, in consultation with the commissioner of health, shall appoint the following voting members to an opioid prescribing work group:

(1) two consumer members who have been impacted by an opioid abuse disorder or opioid dependence disorder, either personally or with family members;

(2) one member who is a licensed physician actively practicing in Minnesota and registered as a practitioner with the DEA;

(3) one member who is a licensed pharmacist actively practicing in Minnesota and registered as a practitioner with the DEA;

(4) one member who is a licensed nurse practitioner actively practicing in Minnesota and registered as a practitioner with the DEA;

(5) one member who is a licensed dentist actively practicing in Minnesota and registered as a practitioner with the DEA;

(6) two members who are nonphysician licensed health care professionals actively engaged in the practice of their profession in Minnesota, and their practice includes treating pain;

(7) one member who is a mental health professional who is licensed or registered in a mental health profession, who is actively engaged in the practice of that profession in Minnesota, and whose practice includes treating patients with chemical dependency or substance abuse;

(8) one member who is a medical examiner for a Minnesota county;

(9) one member of the Health Services Policy Committee established under section 256B.0625, subdivisions 3c to 3e;

(10) one member who is a medical director of a health plan company doing business in Minnesota;

(11) one member who is a pharmacy director of a health plan company doing business in Minnesota; and

(12) one member representing Minnesota law enforcement.

(b) In addition, the work group shall include the following nonvoting members:

(1) the medical director for the medical assistance program;

(2) the Department of Human Services pharmacy program manager; and

(3) the medical director for the Department of Labor and Industry.

(c) An honorarium of $200 per meeting and reimbursement for mileage and parking shall be paid to each voting member in attendance.

Subd. 4. **Program components.** (a) The working group shall recommend to the commissioners the components of the statewide opioid prescribing improvement program, including, but not limited to, the following:

(1) developing criteria for opioid prescribing protocols, including:

(i) prescribing for the interval of up to four days immediately after an acute painful event;

(ii) prescribing for the interval of up to 45 days after an acute painful event; and

(iii) prescribing for chronic pain, which means pain lasting longer than 45 days after an acute painful event;

(2) developing sentinel measures;

(3) developing educational resources for opioid prescribers about communicating with patients about pain management and the use of opioids to treat pain;

(4) developing opioid quality improvement standard thresholds and opioid disenrollment standards for opioid prescribers and provider groups. In developing opioid disenrollment standards, the standards may be described in terms of the length of time in which prescribing practices fall outside community standards and the nature and amount of opioid prescribing that fall outside community standards; and

(5) addressing other program issues as determined by the commissioners.

(b) The opioid prescribing protocols shall not apply to opioids prescribed for patients who are experiencing pain caused by a malignant condition or who are receiving hospice care, or to opioids prescribed as medication-assisted therapy to treat opioid dependency.

(c) All opioid prescribers who prescribe opioids to medical assistance or MinnesotaCare enrollees must participate in the program in accordance with subdivision 5. Any other prescriber who prescribed opioids may comply with the components of this program described in paragraph (a) on a voluntary basis.

Subd. 5. **Program implementation.** (a) The commissioner shall implement the program within the medical assistance and MinnesotaCare programs to improve the health of and quality of care provided to medical assistance and MinnesotaCare enrollees. The commissioner shall annually collect and report to opioid prescribers data showing the sentinel measures of their opioid prescribing patterns compared to their anonymized peers.

(b) The commissioner shall notify an opioid prescriber and all provider groups with which the opioid prescriber is employed or affiliated when the opioid prescriber's prescribing pattern exceeds the opioid quality improvement standard thresholds. An opioid prescriber and any provider group that receives a notice under this paragraph shall submit to the commissioner a quality improvement plan for review and approval by the commissioner with the goal of bringing the opioid prescriber's prescribing practices into alignment with community standards. A quality improvement plan must include:

(1) components of the program described in subdivision 4, paragraph (a);

(2) internal practice-based measures to review the prescribing practice of the opioid prescriber and, where appropriate, any other opioid prescribers employed by or affiliated with any of the provider groups with which the opioid prescriber is employed or affiliated; and

(3) appropriate use of the prescription monitoring program under section 152.126.

(c) If, after a year from the commissioner's notice under paragraph (b), the opioid prescriber's prescribing practices do not improve so that they are consistent with community standards, the commissioner shall take one or more of the following steps:

(1) monitor prescribing practices more frequently than annually;

(2) monitor more aspects of the opioid prescriber's prescribing practices than the sentinel measures; or

(3) require the opioid prescriber to participate in additional quality improvement efforts, including but not limited to mandatory use of the prescription monitoring program established under section 152.126.

(d) The commissioner shall disenroll from the medical assistance and MinnesotaCare programs all opioid prescribers and provider groups whose prescribing practices fall within the applicable opioid disenrollment standards.

Subd. 6. **Data practices.** (a) Reports and data identifying an opioid prescriber are private data on individuals as defined under section 13.02, subdivision 12, until an opioid prescriber is subject to disenrollment as a medical assistance provider under this section. Notwithstanding this data classification, the commissioner shall share with all of the provider groups with which an opioid prescriber is employed or affiliated, a report identifying an opioid prescriber who is subject to quality improvement activities under subdivision 5, paragraph (b) or (c).

(b) Reports and data identifying a provider group are nonpublic data as defined under section 13.02, subdivision 9, until the provider group is subject to disenrollment as a medical assistance provider under this section.

(c) Upon disenrollment under this section, reports and data identifying an opioid prescriber or provider group are public, except that any identifying information of medical assistance or MinnesotaCare enrollees must be redacted by the commissioner.

Subd. 7. **Annual report to legislature.** By September 15, 2016, and annually thereafter, the commissioner of human services shall report to the legislature on the implementation of the opioid prescribing improvement program in the medical assistance and MinnesotaCare programs. The report must include data on the utilization of opioids within the medical assistance and MinnesotaCare programs.

Sec. 12. Minnesota Statutes 2014, section 256B.0757, is amended to read:

256B.0757 COORDINATED CARE THROUGH A HEALTH HOME.

Subdivision 1. **Provision of coverage.** (a) The commissioner shall provide medical assistance coverage of health home services for eligible individuals with chronic conditions who select a designated provider~~, a team of health care professionals, or a health team~~ as the individual's health home.

(b) The commissioner shall implement this section in compliance with the requirements of the state option to provide health homes for enrollees with chronic conditions, as provided under the Patient Protection and Affordable Care Act, Public Law 111-148, sections 2703 and 3502. Terms used in this section have the meaning provided in that act.

(c) The commissioner shall establish behavioral health homes to serve populations with serious mental illness. The health home services provided by behavioral health homes shall focus on both the behavioral and the physical health of these populations.

Subd. 2. **Eligible individual.** (a) An individual is eligible for health home services under this section if the individual is eligible for medical assistance under this chapter and has at least:

(1) two chronic conditions;

(2) one chronic condition and is at risk of having a second chronic condition; or

(3) one serious and persistent mental health condition.

(b) An individual is eligible for health home services under this section if the individual is eligible for medical assistance under this chapter; meets the definition in section 245.462, subdivision 20, paragraph (a), or 245.4871, subdivision 15, clause (2); and has a current diagnostic assessment as defined in Minnesota Rules, part 9505.0372, subpart 1, item B or C, as performed or reviewed by a mental health professional employed by or under contract with the behavioral health home. The commissioner shall establish criteria for determining continued eligibility.

Subd. 3. **Health home services.** (a) Health home services means comprehensive and timely high-quality services that are provided by a health home. These services include:

(1) comprehensive care management;

(2) care coordination and health promotion;

(3) comprehensive transitional care, including appropriate follow-up, from inpatient to other settings;

(4) patient and family support, including authorized representatives;

(5) referral to community and social support services, if relevant; and

(6) use of health information technology to link services, as feasible and appropriate.

(b) The commissioner shall maximize the number and type of services included in this subdivision to the extent permissible under federal law, including physician, outpatient, mental health treatment, and rehabilitation services necessary for comprehensive transitional care following hospitalization.

Subd. 4. ~~**Health teams**~~ **Designated provider.** (a) Health home services are voluntary and an eligible individual may choose any designated provider. The commissioner shall establish ~~health teams to support the patient-centered~~ designated providers to serve as health ~~home~~ homes and provide the services described in subdivision 3 to individuals eligible under subdivision 2. The commissioner shall apply for grants ~~or contracts~~ as provided under section 3502 of the Patient Protection and Affordable Care Act to establish health ~~teams~~ homes and provide capitated payments to ~~primary care~~ designated providers. For purposes of this section, ~~"health teams"~~ "designated provider" means ~~community-based, interdisciplinary, interprofessional teams of health care providers that support primary care practices. These providers may include medical specialists, nurses, advanced practice registered nurses, pharmacists, nutritionists, social workers, behavioral and mental health providers, doctors of chiropractic, licensed complementary and alternative medicine practitioners, and physician assistants.~~ a physician, clinical practice or clinical group practice, rural clinic, community health center, community mental health center, or any other entity or provider that is determined by the commissioner to be qualified to be a health home for eligible individuals. This determination must be based on documentation evidencing that the designated provider has the systems and infrastructure in place to provide health home services and satisfies the qualification standards established by the commissioner in consultation with stakeholders and approved by the Centers for Medicare and Medicaid Services.

(b) The commissioner shall develop and implement certification standards for designated providers under this subdivision.

Subd. 5. **Payments.** The commissioner shall make payments to each ~~health home and each health team~~ designated provider for the provision of health home services described in subdivision 3 to each eligible individual ~~with chronic conditions~~ under subdivision 2 that selects the health home as a provider.

Subd. 6. **Coordination.** The commissioner, to the extent feasible, shall ensure that the requirements and payment methods for ~~health homes and health teams~~ designated providers developed under this section are consistent with the requirements and payment methods for health care homes established under sections 256B.0751 and 256B.0753. The commissioner may modify requirements and payment methods under sections 256B.0751 and 256B.0753 in order to be consistent with federal health home requirements and payment methods.

Subd. 8. **Evaluation and continued development.** (a) For continued certification under this section, health homes must meet process, outcome, and quality standards developed and specified by the commissioner. The commissioner shall collect data from health homes as necessary to monitor compliance with certification standards.

(b) The commissioner may contract with a private entity to evaluate patient and family experiences, health care utilization, and costs.

(c) The commissioner shall utilize findings from the implementation of behavioral health homes to determine populations to serve under subsequent health home models for individuals with chronic conditions.

EFFECTIVE DATE. This section is effective upon federal approval. The services under subdivision 3 are effective January 1, 2016, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 13. Minnesota Statutes 2014, section 256B.75, is amended to read:

256B.75 HOSPITAL OUTPATIENT REIMBURSEMENT.

(a) For outpatient hospital facility fee payments for services rendered on or after October 1, 1992, the commissioner of human services shall pay the lower of (1) submitted charge, or (2) 32 percent above the rate in effect on June 30, 1992, except for those services for which there is a federal maximum allowable payment. Effective for services rendered on or after January 1, 2000, payment rates for nonsurgical outpatient hospital facility fees and emergency room facility fees shall be increased by eight percent over the rates in effect on December 31, 1999, except for those services for which there is a federal maximum allowable payment. Services for which there is a federal maximum allowable

payment shall be paid at the lower of (1) submitted charge, or (2) the federal maximum allowable payment. Total aggregate payment for outpatient hospital facility fee services shall not exceed the Medicare upper limit. If it is determined that a provision of this section conflicts with existing or future requirements of the United States government with respect to federal financial participation in medical assistance, the federal requirements prevail. The commissioner may, in the aggregate, prospectively reduce payment rates to avoid reduced federal financial participation resulting from rates that are in excess of the Medicare upper limitations.

(b) Notwithstanding paragraph (a), payment for outpatient, emergency, and ambulatory surgery hospital facility fee services for critical access hospitals designated under section 144.1483, clause (9), shall be paid on a cost-based payment system that is based on the cost-finding methods and allowable costs of the Medicare program. Effective for services provided on or after July 1, 2015, rates established for critical access hospitals under this paragraph for the applicable payment year shall be the final payment and shall not be settled to actual costs.

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

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

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

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

Sec. 14. Minnesota Statutes 2014, section 256B.76, subdivision 2, is amended to read:

Subd. 2. **Dental reimbursement.** (a) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for dental services as follows:

(1) dental services shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992; and

(2) dental rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases.

(b) Beginning October 1, 1999, the payment for tooth sealants and fluoride treatments shall be the lower of (1) submitted charge, or (2) 80 percent of median 1997 charges.

(c) Effective for services rendered on or after January 1, 2000, payment rates for dental services shall be increased by three percent over the rates in effect on December 31, 1999.

(d) Effective for services provided on or after January 1, 2002, payment for diagnostic examinations and dental x-rays provided to children under age 21 shall be the lower of (1) the submitted charge, or (2) 85 percent of median 1999 charges.

(e) The increases listed in paragraphs (b) and (c) shall be implemented January 1, 2000, for managed care.

(f) Effective for dental services rendered on or after October 1, 2010, by a state-operated dental clinic, payment shall be paid on a reasonable cost basis that is based on the Medicare principles of reimbursement. This payment shall be effective for services rendered on or after January 1, 2011, to recipients enrolled in managed care plans or county-based purchasing plans.

(g) Beginning in fiscal year 2011, if the payments to state-operated dental clinics in paragraph (f), including state and federal shares, are less than $1,850,000 per fiscal year, a supplemental state payment equal to the difference between the total payments in paragraph (f) and $1,850,000 shall be paid from the general fund to state-operated services for the operation of the dental clinics.

~~(h) If the cost-based payment system for state-operated dental clinics described in paragraph (f) does not receive federal approval, then state-operated dental clinics shall be designated as critical access dental providers under subdivision 4, paragraph (b), and shall receive the critical access dental reimbursement rate as described under subdivision 4, paragraph (a).~~

~~(i)~~ (h) Effective for services rendered on or after September 1, 2011, through June 30, 2013, payment rates for dental services shall be reduced by three percent. This reduction does not apply to state-operated dental clinics in paragraph (f).

~~(j)~~ (i) Effective for services rendered on or after January 1, 2014, payment rates for dental services shall be increased by five percent from the rates in effect on December

31, 2013. This increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, and Indian health services. Effective January 1, 2014, payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment increase described in this paragraph.

(j) Effective for services rendered on or after January 1, 2016, payment rates for dental services shall be set to the percentage of 2012 fee-for-service submitted charges that results in a 15 percent increase in the aggregate payment for dental services from the rates in effect on December 31, 2015.

Sec. 15. Minnesota Statutes 2014, section 256B.76, subdivision 4, is amended to read:

Subd. 4. **Critical access dental providers.** (a) Effective for dental services rendered on or after January 1, 2002, the commissioner shall increase reimbursements to dentists and dental clinics deemed by the commissioner to be critical access dental providers. ~~For dental services rendered on or after July 1, 2007, the commissioner shall increase reimbursement by 35 percent above the reimbursement rate that would otherwise be paid to the critical access dental provider.~~ The commissioner shall pay the managed care plans and county-based purchasing plans in amounts sufficient to reflect increased reimbursements to critical access dental providers as approved by the commissioner.

(b) For dental services rendered on or after January 1, 2016, the commissioner shall reimburse a critical access dental provider that is not a community health clinic an additional 20 percent above the payment rate specified in subdivision 2.

(c) For dental services rendered on or after January 1, 2016, the commissioner shall reimburse a critical access dental provider that is also a community health clinic an additional 17.4 percent above the payment rate specified in subdivision 2.

~~(b)~~ (d) The commissioner shall designate the following dentists and dental clinics as critical access dental providers:

(1) nonprofit community clinics that:

(i) have nonprofit status in accordance with chapter 317A;

(ii) have tax exempt status in accordance with the Internal Revenue Code, section 501(c)(3);

(iii) are established to provide oral health services to patients who are low income, uninsured, have special needs, and are underserved;

(iv) have professional staff familiar with the cultural background of the clinic's patients;

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

(vi) do not restrict access or services because of a patient's financial limitations or public assistance status; and

(vii) have free care available as needed;

(2) federally qualified health centers, rural health clinics, and public health clinics;

(3) city or county owned and operated hospital-based dental clinics;

(4) a dental clinic or dental group owned and operated by a nonprofit corporation in accordance with chapter 317A with more than 10,000 patient encounters per year with patients who are uninsured or covered by medical assistance or MinnesotaCare;

(5) a dental clinic owned and operated by the University of Minnesota or the Minnesota State Colleges and Universities system; and

(6) private practicing dentists if:

(i) the dentist's office is located within a health professional shortage area as defined under Code of Federal Regulations, title 42, part 5, and United States Code, title 42, section 254E;

(ii) more than 50 percent of the dentist's patient encounters per year are with patients who are uninsured or covered by medical assistance or MinnesotaCare;

(iii) the dentist does not restrict access or services because of a patient's financial limitations or public assistance status; and

(iv) the level of service provided by the dentist is critical to maintaining adequate levels of patient access within the service area in which the dentist operates.

~~(e)~~ (e) A designated critical access clinic shall receive the reimbursement rate specified in paragraph (a) for dental services provided off site at a private dental office if the following requirements are met:

(1) the designated critical access dental clinic is located within a health professional shortage area as defined under Code of Federal Regulations, title 42, part 5, and United States Code, title 42, section 254E, and is located outside the seven-county metropolitan area;

(2) the designated critical access dental clinic is not able to provide the service and refers the patient to the off-site dentist;

(3) the service, if provided at the critical access dental clinic, would be reimbursed at the critical access reimbursement rate;

(4) the dentist and allied dental professionals providing the services off site are licensed and in good standing under chapter 150A;

(5) the dentist providing the services is enrolled as a medical assistance provider;

(6) the critical access dental clinic submits the claim for services provided off site and receives the payment for the services; and

(7) the critical access dental clinic maintains dental records for each claim submitted under this paragraph, including the name of the dentist, the off-site location, and the license number of the dentist and allied dental professionals providing the services.

Sec. 16. **[256B.79] INTEGRATED CARE FOR HIGH-RISK PREGNANT WOMEN.**

Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have the meanings given them.

(b) "Adverse outcomes" means maternal opiate addiction, other reportable prenatal substance abuse, low birth weight, or preterm birth.

(c) "Qualified integrated perinatal care collaborative" or "collaborative" means a combination of (1) members of community-based organizations that represent communities within the identified targeted populations, and (2) local or tribally based service entities, including health care, public health, social services, mental health, chemical dependency treatment, and community-based providers, determined by the commissioner to meet the criteria for the provision of integrated care and enhanced services for enrollees within targeted populations.

(d) "Targeted populations" means pregnant medical assistance enrollees residing in geographic areas identified by the commissioner as being at above-average risk for adverse outcomes.

Subd. 2. **Pilot program established.** The commissioner shall implement a pilot program to improve birth outcomes and strengthen early parental resilience for pregnant women who are medical assistance enrollees, are at significantly elevated risk for adverse outcomes of pregnancy, and are in targeted populations. The program must promote the provision of integrated care and enhanced services to these pregnant women, including postpartum coordination to ensure ongoing continuity of care, by qualified integrated perinatal care collaboratives.

Subd. 3. **Grant awards.** The commissioner shall award grants to qualifying applicants to support interdisciplinary, integrated perinatal care. Grants must be awarded beginning July 1, 2016. Grant funds must be distributed through a request for proposals process to a designated lead agency within an entity that has been determined to be a qualified integrated perinatal care collaborative or within an entity in the process of meeting the qualifications to become a qualified integrated perinatal care collaborative. Grant awards must be used to support interdisciplinary, team-based needs assessments,

planning, and implementation of integrated care and enhanced services for targeted populations. In determining grant award amounts, the commissioner shall consider the identified health and social risks linked to adverse outcomes and attributed to enrollees within the identified targeted population.

Subd. 4. **Eligibility for grants.** To be eligible for a grant under this section, an entity must show that the entity meets or is in the process of meeting qualifications established by the commissioner to be a qualified integrated perinatal care collaborative. These qualifications must include evidence that the entity has or is in the process of developing policies, services, and partnerships to support interdisciplinary, integrated care. The policies, services, and partnerships must meet specific criteria and be approved by the commissioner. The commissioner shall establish a process to review the collaborative's capacity for interdisciplinary, integrated care, to be reviewed at the commissioner's discretion. In determining whether the entity meets the qualifications for a qualified integrated perinatal care collaborative, the commissioner shall verify and review whether the entity's policies, services, and partnerships:

(1) optimize early identification of drug and alcohol dependency and abuse during pregnancy, effectively coordinate referrals and follow-up of identified patients to evidence-based or evidence-informed treatment, and integrate perinatal care services with behavioral health and substance abuse services;

(2) enhance access to, and effective use of, needed health care or tribal health care services, public health or tribal public health services, social services, mental health services, chemical dependency services, or services provided by community-based providers by bridging cultural gaps within systems of care and by integrating community-based paraprofessionals such as doulas and community health workers as routinely available service components;

(3) encourage patient education about prenatal care, birthing, and postpartum care, and document how patient education is provided. Patient education may include information on nutrition, reproductive life planning, breastfeeding, and parenting;

(4) integrate child welfare case planning with substance abuse treatment planning and monitoring, as appropriate;

(5) effectively systematize screening, collaborative care planning, referrals, and follow up for behavioral and social risks know to be associated with adverse outcomes and known to be prevalent within the targeted populations;

(6) facilitate ongoing continuity of care to include postpartum coordination and referrals for interconception care, continued treatment for substance abuse, identification and referrals for maternal depression and other chronic mental health conditions,

continued medication management for chronic diseases, and appropriate referrals to tribal or county-based social services agencies and tribal or county-based public health nursing services; and

(7) implement ongoing quality improvement activities as determined by the commissioner, including collection and use of data from qualified providers on metrics of quality such as health outcomes and processes of care, and the use of other data that has been collected by the commissioner.

Subd. 5. **Gaps in communication, support, and care.** A collaborative receiving a grant under this section must develop means of identifying and reporting gaps in the collaborative's communication, administrative support, and direct care that must be remedied for the collaborative to effectively provide integrated care and enhanced services to targeted populations.

Subd. 6. **Report.** By January 31, 2019, the commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance on the status and progress of the pilot program. The report must:

(1) describe the capacity of collaboratives receiving grants under this section;

(2) contain aggregate information about enrollees served within targeted populations;

(3) describe the utilization of enhanced prenatal services;

(4) for enrollees identified with maternal substance use disorders, describe the utilization of substance use treatment and dispositions of any child protection cases;

(5) contain data on outcomes within targeted populations and compare these outcomes to outcomes statewide, using standard categories of race and ethnicity; and

(6) include recommendations for continuing the program or sustaining improvements through other means beyond June 30, 2019.

Subd. 7. **Expiration.** This section expires June 30, 2019.

Sec. 17. Minnesota Statutes 2014, section 256L.01, subdivision 3a, is amended to read:

Subd. 3a. **Family.** (a) Except as provided in paragraphs (c) and (d), "family" has the meaning given for family and family size as defined in Code of Federal Regulations, title 26, section 1.36B-1.

(b) The term includes children who are temporarily absent from the household in settings such as schools, camps, or parenting time with noncustodial parents.

(c) For an individual who does not expect to file a federal tax return and does not expect to be claimed as a dependent for the applicable tax year, "family" has the meaning given in Code of Federal Regulations, title 42, section 435.603(f)(3).

(d) For a married couple, "family" has the meaning given in Code of Federal Regulations, title 42, section 435.603(f)(4).

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

Sec. 18. Minnesota Statutes 2014, section 256L.01, subdivision 5, is amended to read:

Subd. 5. **Income.** "Income" has the meaning given for modified adjusted gross income, as defined in Code of Federal Regulations, title 26, section 1.36B-1~~.~~, and means a household's projected annual income for the applicable tax year

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

Sec. 19. Minnesota Statutes 2014, section 256L.03, subdivision 5, is amended to read:

Subd. 5. **Cost-sharing.** (a) Except as otherwise provided in this subdivision, the MinnesotaCare benefit plan shall include the following cost-sharing requirements for all enrollees:

(1) $3 per prescription for adult enrollees;

(2) $25 for eyeglasses for adult enrollees;

(3) $3 per nonpreventive visit. For purposes of this subdivision, a "visit" means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist;

(4) $6 for nonemergency visits to a hospital-based emergency room for services provided through December 31, 2010, and $3.50 effective January 1, 2011; and

(5) a family deductible equal to ~~the maximum amount allowed under Code of Federal Regulations, title 42, part 447.54~~. $2.75 per month per family and adjusted annually by the percentage increase in the medical care component of the CPI-U for the period of September to September of the preceding calendar year, rounded to the next-higher five cent increment.

(b) Paragraph (a) does not apply to children under the age of 21 and to American Indians as defined in Code of Federal Regulations, title 42, section 447.51.

(c) Paragraph (a), clause (3), does not apply to mental health services.

(d) MinnesotaCare reimbursements to fee-for-service providers and payments to managed care plans or county-based purchasing plans shall not be increased as a result of the reduction of the co-payments in paragraph (a), clause (4), effective January 1, 2011.

(e) The commissioner, through the contracting process under section 256L.12, may allow managed care plans and county-based purchasing plans to waive the family deductible under paragraph (a), clause (5). The value of the family deductible shall not be included in the capitation payment to managed care plans and county-based purchasing plans. Managed care plans and county-based purchasing plans shall certify annually to the commissioner the dollar value of the family deductible.

(f) The commissioner shall increase co-payments for covered services in a manner sufficient to reduce the actuarial value of the benefit to 94 percent. The cost-sharing charges described in this paragraph do not apply to eligible recipients or services exempt from cost-sharing under state law. The cost-sharing changes described in this paragraph shall not be implemented prior to January 1, 2016.

(g) The cost-sharing changes authorized under paragraph (f) must satisfy the requirements for cost-sharing under the Basic Health Program as set forth in Code of Federal Regulations, title 42, sections 600.510 and 600.520.

EFFECTIVE DATE. The amendment to paragraph (a), clause (5), is effective retroactively from January 1, 2014. The amendment to paragraph (b) is effective the day following final enactment.

Sec. 20. Minnesota Statutes 2014, section 256L.04, subdivision 1a, is amended to read:

Subd. 1a. **Social Security number ~~required~~.** ~~(a)~~ Individuals and families applying for MinnesotaCare coverage must provide a Social Security number if required in Code of Federal Regulations, title 45, section 155.310(a)(3).

~~(b) The commissioner shall not deny eligibility to an otherwise eligible applicant who has applied for a Social Security number and is awaiting issuance of that Social Security number.~~

~~(c) Newborns enrolled under section 256L.05, subdivision 3, are exempt from the requirements of this subdivision.~~

~~(d) Individuals who refuse to provide a Social Security number because of well-established religious objections are exempt from the requirements of this subdivision. The term "well-established religious objections" has the meaning given in Code of Federal Regulations, title 42, section 435.910.~~

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

Sec. 21. Minnesota Statutes 2014, section 256L.04, subdivision 1c, is amended to read:

Subd. 1c. **General requirements.** To be eligible for ~~coverage under~~ MinnesotaCare, a person must meet the eligibility requirements of this section. A person eligible for MinnesotaCare shall not be considered a qualified individual under section 1312 of the Affordable Care Act, and is not eligible for enrollment in a qualified health plan offered through MNsure under chapter 62V.

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

Sec. 22. Minnesota Statutes 2014, section 256L.04, subdivision 7b, is amended to read:

Subd. 7b. **Annual income limits adjustment.** The commissioner shall adjust the income limits under this section ~~each July 1 by the annual update of the federal poverty guidelines following publication by the United States Department of Health and Human Services except that the income standards shall not go below those in effect on July 1, 2009~~ annually on January 1 as provided in Code of Federal Regulations, title 26, section 1.36B-1(h).

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

Sec. 23. Minnesota Statutes 2014, section 256L.04, subdivision 10, is amended to read:

Subd. 10. **Citizenship requirements.** (a) Eligibility for MinnesotaCare is limited to citizens or nationals of the United States and lawfully present noncitizens as defined in Code of Federal Regulations, title ~~8~~ 45, section ~~103.12~~ 152.2. Undocumented noncitizens are ineligible for MinnesotaCare. For purposes of this subdivision, an undocumented noncitizen is an individual who resides in the United States without the approval or acquiescence of the United States Citizenship and Immigration Services. Families with children who are citizens or nationals of the United States must cooperate in obtaining satisfactory documentary evidence of citizenship or nationality according to the requirements of the federal Deficit Reduction Act of 2005, Public Law 109-171.

(b) Notwithstanding subdivisions 1 and 7, eligible persons include families and individuals who are lawfully present and ineligible for medical assistance by reason of immigration status and who have incomes equal to or less than 200 percent of federal poverty guidelines.

Sec. 24. Minnesota Statutes 2014, section 256L.05, is amended by adding a subdivision to read:

Subd. 2a. **Eligibility and coverage.** For purposes of this chapter, an individual is eligible for MinnesotaCare following a determination by the commissioner that the

individual meets the eligibility criteria for the applicable period of eligibility. For an individual required to pay a premium, coverage is only available in each month of the applicable period of eligibility for which a premium is paid.

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

Sec. 25. Minnesota Statutes 2014, section 256L.05, subdivision 3, is amended to read:

Subd. 3. **Effective date of coverage.** (a) The effective date of coverage is the first day of the month following the month in which eligibility is approved and the first premium payment has been received. The effective date of coverage for new members added to the family is the first day of the month following the month in which the change is reported. All eligibility criteria must be met by the family at the time the new family member is added. The income of the new family member is included with the family's modified adjusted gross income and the adjusted premium begins in the month the new family member is added.

(b) The initial premium must be received by the last working day of the month for coverage to begin the first day of the following month.

(c) Notwithstanding any other law to the contrary, benefits under sections 256L.01 to 256L.18 are secondary to a plan of insurance or benefit program under which an eligible person may have coverage and the commissioner shall use cost avoidance techniques to ensure coordination of any other health coverage for eligible persons. The commissioner shall identify eligible persons who may have coverage or benefits under other plans of insurance or who become eligible for medical assistance.

(d) The effective date of coverage for individuals or families who are exempt from paying premiums under section 256L.15, subdivision 1, paragraph (c), is the first day of the month following the month in which ~~verification of American Indian status is received or~~ eligibility is approved~~, whichever is later~~.

Sec. 26. Minnesota Statutes 2014, section 256L.05, subdivision 3a, is amended to read:

Subd. 3a. **~~Renewal~~ Redetermination of eligibility.** (a) ~~Beginning July 1, 2007,~~ An enrollee's eligibility must be ~~renewed every 12 months~~ redetermined on an annual basis. ~~The 12-month period begins in the month after the month the application is approved.~~ The period of eligibility is the entire calendar year following the year in which eligibility is redetermined. Beginning in calendar year 2015, eligibility redeterminations shall occur during the open enrollment period for qualified health plans as specified in Code of Federal Regulations, title 45, section 155.410.

(b) Each new period of eligibility must take into account any changes in circumstances that impact eligibility and premium amount. ~~An enrollee must provide all~~

~~the information needed to redetermine eligibility by the first day of the month that ends the eligibility period. The premium for the new period of eligibility must be received~~ Coverage begins as provided in section 256L.06 ~~in order for eligibility to continue~~.

~~(c) For children enrolled in MinnesotaCare, the first period of renewal begins the month the enrollee turns 21 years of age.~~

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

Sec. 27. Minnesota Statutes 2014, section 256L.05, subdivision 4, is amended to read:

Subd. 4. **Application processing.** The commissioner of human services shall determine an applicant's eligibility for MinnesotaCare no more than ~~30~~ 45 days from the date that the application is received by the Department of Human Services as set forth in Code of Federal Regulations, title 42, section 435.912. ~~Beginning January 1, 2000, this requirement also applies to local county human services agencies that determine eligibility for MinnesotaCare.~~

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

Sec. 28. Minnesota Statutes 2014, section 256L.06, subdivision 3, is amended to read:

Subd. 3. **Commissioner's duties and payment.** (a) Premiums are dedicated to the commissioner for MinnesotaCare.

(b) The commissioner shall develop and implement procedures to: (1) require enrollees to report changes in income; (2) adjust sliding scale premium payments, based upon both increases and decreases in enrollee income, at the time the change in income is reported; and (3) disenroll enrollees from MinnesotaCare for failure to pay required premiums. Failure to pay includes payment with a dishonored check, a returned automatic bank withdrawal, or a refused credit card or debit card payment. The commissioner may demand a guaranteed form of payment, including a cashier's check or a money order, as the only means to replace a dishonored, returned, or refused payment.

(c) Premiums are calculated on a calendar month basis and may be paid on a monthly, quarterly, or semiannual basis, with the first payment due upon notice from the commissioner of the premium amount required. The commissioner shall inform applicants and enrollees of these premium payment options. Premium payment is required before enrollment is complete and to maintain eligibility in MinnesotaCare. Premium payments received before noon are credited the same day. Premium payments received after noon are credited on the next working day.

(d) Nonpayment of the premium will result in disenrollment from the plan effective for the calendar month following the month for which the premium was due. Persons disenrolled for nonpayment ~~who pay all past due premiums as well as current premiums due, including premiums due for the period of disenrollment, within 20 days of disenrollment, shall be reenrolled retroactively to the first day of disenrollment~~ may not reenroll prior to the first day of the month following the payment of an amount equal to two months' premiums.

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

Sec. 29. Minnesota Statutes 2014, section 256L.11, subdivision 7, is amended to read:

Subd. 7. **Critical access dental providers.** (a) Effective for dental services provided to MinnesotaCare enrollees on or after January 1, 2007, through August 31, 2011, the commissioner shall increase payment rates to dentists and dental clinics deemed by the commissioner to be critical access providers under section 256B.76, subdivision 4, by 50 percent above the payment rate that would otherwise be paid to the provider. Effective for dental services provided on or after September 1, 2011, the commissioner shall increase the payment rate by 30 percent above the payment rate that would otherwise be paid to the provider. The commissioner shall pay the prepaid health plans under contract with the commissioner amounts sufficient to reflect this rate increase. The prepaid health plan must pass this rate increase to providers who have been identified by the commissioner as critical access dental providers under section 256B.76, subdivision 4.

(b) Effective for services provided on or after January 1, 2016, the commissioner shall no longer provide a critical access dental add-on in the MinnesotaCare program.

Sec. 30. Minnesota Statutes 2014, section 256L.121, subdivision 1, is amended to read:

Subdivision 1. **Competitive process.** The commissioner of human services shall establish a competitive process for entering into contracts with participating entities for the offering of standard health plans through MinnesotaCare. Coverage through standard health plans must be available to enrollees beginning January 1, 2015. Each standard health plan must cover the health services listed in and meet the requirements of section 256L.03. The competitive process must meet the requirements of section 1331 of the Affordable Care Act and be designed to ensure enrollee access to high-quality health care coverage options. The commissioner, to the extent feasible, shall seek to ensure that enrollees have a choice of coverage from more than one participating entity within a geographic area. In counties that were part of a county-based purchasing plan on January 1, 2013, the commissioner shall use the medical assistance competitive procurement

process under section 256B.69, ~~subdivisions 1 to 32,~~ under which selection of entities is based on criteria related to provider network access, coordination of health care with other local services, alignment with local public health goals, and other factors.

Sec. 31. Minnesota Statutes 2014, section 256L.15, subdivision 2, is amended to read:

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

(b) ~~Beginning~~ Between January 1, 2014, and December 31, 2015, MinnesotaCare enrollees shall pay premiums according to the premium scale specified in paragraph ~~(c) with the exception that children 20 years of age and younger in families with income at or below 200 percent of the federal poverty guidelines shall pay no premiums~~ (d). Beginning January 1, 2016, MinnesotaCare enrollees shall pay premiums according to the premium scale specified in paragraph (e).

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

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

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

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

Federal Poverty Guideline		**Individual Premium**
Greater than or Equal to	**Less than**	**Amount**
~~0%~~ 35%	55%	$4
55%	80%	$6
80%	90%	$8
90%	100%	$10
100%	110%	$12
110%	120%	~~$15~~ $14
120%	130%	~~$18~~ $15
130%	140%	~~$21~~ $16
140%	150%	$25
150%	160%	$29
160%	170%	$33
170%	180%	$38
180%	190%	$43
190%		$50

(e) Beginning January 1, 2016, the following premium scale is established for each individual in the household who is 21 years of age or older and enrolled in MinnesotaCare:

Federal Poverty Guideline		**Individual Premium**
Greater than or Equal to	**Less than**	**Amount**
35%	55%	$4
55%	80%	$6
80%	90%	$8
90%	100%	$10
100%	110%	$12
110%	120%	$14
120%	130%	$15
130%	140%	$16
140%	150%	$25
150%	160%	$36
160%	170%	$42
170%	180%	$51
180%	190%	$58
190%		$68

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

Sec. 32. Minnesota Statutes 2014, section 282.241, subdivision 1, is amended to read:

Subdivision 1. **Repurchase requirements.** The owner at the time of forfeiture, or the owner's heirs, devisees, or representatives, or any person to whom the right to pay taxes was given by statute, mortgage, or other agreement, may repurchase any parcel of land claimed by the state to be forfeited to the state for taxes unless before the time repurchase is made the parcel is sold under installment payments, or otherwise, by the state as provided by law, or is under mineral prospecting permit or lease, or proceedings have been commenced by the state or any of its political subdivisions or by the United States to condemn the parcel of land. The parcel of land may be repurchased for the sum of all delinquent taxes and assessments computed under section 282.251, together with penalties, interest, and costs, that accrued or would have accrued if the parcel of land had not forfeited to the state. Except for property which was homesteaded on the date of forfeiture, repurchase is permitted during one year only from the date of forfeiture, and in any case only after the adoption of a resolution by the board of county commissioners determining that by repurchase undue hardship or injustice resulting from the forfeiture will be corrected, or that permitting the repurchase will promote the use of the lands that will best serve the public interest. If the county board has good cause to believe that a repurchase installment payment plan for a particular parcel is unnecessary and not

in the public interest, the county board may require as a condition of repurchase that the entire repurchase price be paid at the time of repurchase. A repurchase is subject to any easement, lease, or other encumbrance granted by the state before the repurchase, including an encumbrance allowed under sections 256B.15 and 514.981, and if the land is located within a restricted area established by any county under Laws 1939, chapter 340, the repurchase must not be permitted unless the resolution approving the repurchase is adopted by the unanimous vote of the board of county commissioners.

The person seeking to repurchase under this section shall pay all maintenance costs incurred by the county auditor during the time the property was tax-forfeited.

Sec. 33. Minnesota Statutes 2014, section 297A.70, subdivision 7, is amended to read:

Subd. 7. **Hospitals, outpatient surgical centers, and critical access dental providers.** (a) Sales, except for those listed in paragraph (d), to a hospital are exempt, if the items purchased are used in providing hospital services. For purposes of this subdivision, "hospital" means a hospital organized and operated for charitable purposes within the meaning of section 501(c)(3) of the Internal Revenue Code, and licensed under chapter 144 or by any other jurisdiction, and "hospital services" are services authorized or required to be performed by a "hospital" under chapter 144.

(b) Sales, except for those listed in paragraph (d), to an outpatient surgical center are exempt, if the items purchased are used in providing outpatient surgical services. For purposes of this subdivision, "outpatient surgical center" means an outpatient surgical center organized and operated for charitable purposes within the meaning of section 501(c)(3) of the Internal Revenue Code, and licensed under chapter 144 or by any other jurisdiction. For the purposes of this subdivision, "outpatient surgical services" means: (1) services authorized or required to be performed by an outpatient surgical center under chapter 144; and (2) urgent care. For purposes of this subdivision, "urgent care" means health services furnished to a person whose medical condition is sufficiently acute to require treatment unavailable through, or inappropriate to be provided by, a clinic or physician's office, but not so acute as to require treatment in a hospital emergency room.

(c) Sales, except for those listed in paragraph (d), to a critical access dental provider are exempt, if the items purchased are used in providing critical access dental care services. For the purposes of this subdivision, "critical access dental provider" means a dentist or dental clinic that qualifies under section 256B.76, subdivision 4, paragraph ~~(b)~~ (d), and, in the previous calendar year, had no more than 15 percent of its patients covered by private dental insurance.

(d) This exemption does not apply to the following products and services:

(1) purchases made by a clinic, physician's office, or any other medical facility not operating as a hospital, outpatient surgical center, or critical access dental provider, even though the clinic, office, or facility may be owned and operated by a hospital, outpatient surgical center, or critical access dental provider;

(2) sales under section 297A.61, subdivision 3, paragraph (g), clause (2), and prepared food, candy, and soft drinks;

(3) building and construction materials used in constructing buildings or facilities that will not be used principally by the hospital, outpatient surgical center, or critical access dental provider;

(4) building, construction, or reconstruction materials purchased by a contractor or a subcontractor as a part of a lump-sum contract or similar type of contract with a guaranteed maximum price covering both labor and materials for use in the construction, alteration, or repair of a hospital, outpatient surgical center, or critical access dental provider; or

(5) the leasing of a motor vehicle as defined in section 297B.01, subdivision 11.

(e) A limited liability company also qualifies for exemption under this subdivision if (1) it consists of a sole member that would qualify for the exemption, and (2) the items purchased qualify for the exemption.

(f) An entity that contains both a hospital and a nonprofit unit may claim this exemption on purchases made for both the hospital and nonprofit unit provided that:

(1) the nonprofit unit would have qualified for exemption under subdivision 4; and

(2) the items purchased would have qualified for the exemption.

Sec. 34. Minnesota Statutes 2014, section 514.73, is amended to read:

514.73 LIENS ASSIGNABLE.

Subdivision 1. **Assignment.** All liens given by this chapter and section 256B.15 are assignable and may be asserted and enforced by the assignee, or by the personal representative of any holder thereof in case of the holder's death.

Subd. 2. **Redemption.** The redemption rights of all liens given by section 256B.15 and sections 514.980 to 514.985 are assignable and may be asserted and enforced by the assignee, or by the personal representative of any holder thereof in case of the holder's death.

Subd. 3. **Lien payoff information.** The commissioner of human services may disclose the outstanding obligation secured by a lien filed under this chapter and section 256B.15 when assigning a lien or assigning the redemption rights of the lien.

Sec. 35. Minnesota Statutes 2014, section 514.981, subdivision 2, is amended to read:

Subd. 2. **Attachment.** (a) A medical assistance lien attaches and becomes enforceable against specific real property as of the date when the following conditions are met:

(1) payments have been made by an agency for a medical assistance benefit;

(2) notice and an opportunity for a hearing have been provided under paragraph (b);

(3) a lien notice has been filed as provided in section 514.982;

(4) if the property is registered property, the lien notice has been memorialized on the certificate of title of the property affected by the lien notice; and

(5) all restrictions against enforcement have ceased to apply.

(b) An agency may not file a medical assistance lien notice until the medical assistance recipient or the recipient's legal representative has been sent, by certified or registered mail, written notice of the agency's lien rights and there has been an opportunity for a hearing under section 256.045. In addition, the agency may not file a lien notice unless the agency determines as medically verified by the recipient's attending physician that the medical assistance recipient cannot reasonably be expected to be discharged from a medical institution and return home or the medical assistance recipient has resided in a medical institution for six months or longer.

(c) An agency may not file a medical assistance lien notice against real property while it is the home of the recipient's spouse.

(d) An agency may not file a medical assistance lien notice against real property that was the homestead of the medical assistance recipient or the recipient's spouse when the medical assistance recipient received medical institution services if any of the following persons are lawfully residing in the property:

(1) a child of the medical assistance recipient if the child is under age 21 or is blind or permanently and totally disabled according to the Supplemental Security Income criteria;

(2) a child of the medical assistance recipient if the child resided in the homestead for at least two years immediately before the date the medical assistance recipient received medical institution services, and the child provided care to the medical assistance recipient that permitted the recipient to live without medical institution services; or

(3) a sibling of the medical assistance recipient if the sibling has an equity interest in the property and has resided in the property for at least one year immediately before the date the medical assistance recipient began receiving medical institution services.

(e) A medical assistance lien applies only to the specific real property described in the lien notice.

Sec. 36. Minnesota Statutes 2014, section 580.032, subdivision 1, is amended to read:

Subdivision 1. **Recording request for notice.** A person having a redeemable interest in real property under section 580.23 or 580.24, may record a request for notice of a mortgage foreclosure by advertisement with the county recorder or registrar of titles of the county where the property is located. To be effective for purposes of this section, a request for notice must be recorded as a separate and distinct document, except a mechanic's lien statement recorded pursuant to section 514.08 and a lien recorded pursuant to sections 256B.15 and 514.981 also ~~constitutes~~ constitute a request for notice if the ~~mechanic's~~ lien statement includes a legal description of the real property and the name and mailing address of the mechanic's lien claimant.

Sec. 37. **STATEWIDE OPIOID PRESCRIBING IMPROVEMENT PROGRAM.**

The commissioner of human services, in collaboration with the commissioner of health, shall report to the legislature by December 1, 2015, on recommendations made by the opioid prescribing work group under Minnesota Statutes, section 256B.0638, subdivision 4, and steps taken by the commissioner of human services to implement the opioid prescribing improvement program under Minnesota Statutes, section 256B.0638, subdivision 6.

Sec. 38. **PAYMENT SYSTEM FOR CRITICAL ACCESS DENTAL PROVIDERS.**

The commissioner of human services, in collaboration with the Dental Services Advisory Committee, shall make recommendations on modifications to the current Critical Access Dental Program so that the payment system for critical access dental providers is based at least 50 percent on measures of quality and outcome measures. These measures may include but are not limited to provider ability to meet both preventative and restorative needs of their patients, patient risk and risk reduction over time, or other dental outcome measures. The commissioner shall submit recommendations to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over health and human services and finance by January 15, 2017.

Sec. 39. **REPEALER.**

(a) Minnesota Statutes 2014, sections 256.969, subdivision 30; and 256B.69, subdivision 32, are repealed.

(b) Minnesota Statutes 2014, sections 256L.02, subdivision 3; and 256L.05, subdivisions 1b, 1c, 3c, and 5, are repealed effective the day following final enactment.

ARTICLE 7

CONTINUING CARE

Section 1. Minnesota Statutes 2014, section 256.478, is amended to read:

256.478 HOME AND COMMUNITY-BASED SERVICES TRANSITIONS GRANTS.

~~(a)~~ The commissioner shall make available home and community-based services transition grants to serve individuals who do not meet eligibility criteria for the medical assistance program under section 256B.056 or 256B.057, but who otherwise meet the criteria under section 256B.092, subdivision 13, or 256B.49, subdivision 24.

~~(b) For the purposes of this section, the commissioner has the authority to transfer funds between the medical assistance account and the home and community-based services transitions grants account.~~

Sec. 2. Minnesota Statutes 2014, section 256.975, subdivision 8, is amended to read:

Subd. 8. **~~Promotion of~~ Establish long-term care ~~insurance~~ benefits call center.** Within the limits of appropriations specifically for this purpose, the Minnesota Board on Aging, ~~either directly or~~ through ~~contract,~~ its Senior LinkAge Line established under section 256.975, subdivision 7, shall ~~promote the provision of employer-sponsored,~~ establish a long-term care benefits call center that promotes planning for long-term care, information about long-term care insurance, and other benefits that support Minnesotans as they age or have more long-term chronic care needs. The board shall ~~encourage private and public sector employers to make long-term care insurance available to employees, provide interested employers with information on the long-term care insurance product offered to state employees, and provide~~ work with a variety of stakeholders, including employers, insurance providers, brokers, or other sellers of products and consumers to develop the call center. The board shall seek technical assistance ~~to employers~~ from the commissioner in designing long-term care insurance products and contacting companies offering long-term care insurance products for implementation of the call center.

Sec. 3. Minnesota Statutes 2014, section 256B.092, subdivision 13, is amended to read:

Subd. 13. **Waiver allocations for transition populations.** (a) The commissioner shall make available additional waiver allocations and additional necessary resources to assure timely discharges from the Anoka Metro Regional Treatment Center and the Minnesota Security Hospital in St. Peter for individuals who meet the following criteria:

(1) are otherwise eligible for the developmental disabilities waiver under this section;

(2) who would otherwise remain at the Anoka Metro Regional Treatment Center or the Minnesota Security Hospital;

(3) whose discharge would be significantly delayed without the available waiver allocation; and

(4) who have met treatment objectives and no longer meet hospital level of care.

(b) Additional waiver allocations and resources under this subdivision must meet cost-effectiveness requirements of the federal approved waiver plan.

(c) Any corporate foster care home developed under this subdivision must be considered an exception under section 245A.03, subdivision 7, paragraph (a).

Sec. 4. Minnesota Statutes 2014, section 256B.49, subdivision 24, is amended to read:

Subd. 24. **Waiver allocations for transition populations.** (a) The commissioner shall make available additional waiver allocations and additional necessary resources to assure timely discharges from the Anoka Metro Regional Treatment Center and the Minnesota Security Hospital in St. Peter for individuals who meet the following criteria:

(1) are otherwise eligible for the brain injury, community alternatives for disabled individuals, or community alternative care waivers under this section;

(2) who would otherwise remain at the Anoka Metro Regional Treatment Center or the Minnesota Security Hospital;

(3) whose discharge would be significantly delayed without the available waiver allocation or resources; and

(4) who have met treatment objectives and no longer meet hospital level of care.

(b) Additional waiver allocations and resources under this subdivision must meet cost-effectiveness requirements of the federal approved waiver plan.

(c) Any corporate foster care home developed under this subdivision must be considered an exception under section 245A.03, subdivision 7, paragraph (a).

Sec. 5. **DEVELOPMENT OF LONG-TERM CARE; LIFE STAGE PLANNING INSURANCE PRODUCT.**

The commissioner of human services, in consultation with members of the Own Your Future Advisory Council, the commissioner of commerce, and other stakeholders, shall conduct research on the feasibility of creating a life stage planning insurance product that merges term life insurance with long-term care insurance coverage. The commissioner shall:

(1) conduct project evaluation research with consumers;

(2) conduct an actuarial analysis to create pricing for the product;

(3) meet with interested insurance carriers to determine interest in pursuing the product;

(4) identify specific state laws and regulations that may need to be amended to make the product available; and

(5) develop one or more pilot programs to market test the product.

Sec. 6. **RATE INCREASE FOR SELF-DIRECTED WORKFORCE NEGOTIATIONS.**

(a) If the labor agreement between the state of Minnesota and SEIU Healthcare Minnesota according to Laws 2013, chapter 128, article 2, is ratified by the legislature, the commissioner of human services shall increase reimbursement rates, grants, individual budgets, or allocations by 1.53 percent for services provided on or after July 1, 2015, and by an additional 0.2 percent for services provided on or after July 1, 2016, as necessary, to implement and assure compliance with the provisions of the agreement.

(b) The rate changes described in this section apply to direct support services provided through a covered program, as defined in Minnesota Statutes, section 256B.0711, subdivision 1.

Sec. 7. **HOME AND COMMUNITY-BASED SERVICES INCENTIVE POOL.**

The commissioner of human services shall develop an initiative to provide incentives for innovation in achieving integrated competitive employment, living in the most integrated setting, and other outcomes determined by the commissioner. The commissioner shall seek requests for proposals and shall contract with one or more entities to provide incentive payments for meeting identified outcomes. The initial requests for proposals must be issued by October 1, 2015. The commissioner of human services shall submit a report by January 31, 2017, to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services finance on the outcomes of these projects. The report must include:

(1) the request for proposals funds;

(2) the amount of incentive payments authorized;

(3) the outcomes achieved by each project; and

(4) recommendations for further action based on the outcomes achieved.

ARTICLE 8

HEALTH DEPARTMENT

Section 1. **[15.445] RETAIL FOOD ESTABLISHMENT FEES.**

Subdivision 1. **Fees.** The fees in this section are required for retail food handler and food and beverage service establishments, licensed under chapters 28A and 157. Permanent retail food handler and food and beverage service establishments must pay the applicable fee under subdivision 2, paragraph (a), (b), (c), or (d), and all applicable fees under subdivision 4. Temporary food establishments and special events must pay the applicable fee under subdivision 3.

Subd. 2. **Permanent food establishments.** (a) The Category 1 establishment license fee is $210 annually. "Category 1 establishment" means an establishment that does one or more of the following:

(1) sells only prepackaged nonpotentially hazardous foods as defined in Minnesota Rules, chapter 4626;

(2) provides cleaning for eating, drinking, or cooking utensils, when the only food served is prepared off-site;

(3) operates a childcare facility licensed under section 245A.03 and Minnesota Rules, chapter 9503; or

(4) operates as a retail food handler classified in section 28A.05 and has gross annual sales of $250,000 or less.

(b) The Category 2 establishment license fee is $270 annually. "Category 2 establishment" means an establishment that is not a Category 1 establishment and is either:

(1) a food establishment where the method of food preparation meets the definition of a low-risk establishment in section 157.20; or

(2) an elementary or secondary school as defined in section 120A.05.

(c) The Category 3 establishment license fee is $460 annually. "Category 3 establishment" means an establishment that is not a Category 1 or 2 establishment and the method of food preparation meets the definition of a medium-risk establishment in section 157.20.

(d) The Category 4 establishment license fee is $690 annually. "Category 4 establishment" means an establishment that is not a Category 1, 2, or 3 establishment and is either:

(1) a food establishment where the method of food preparation meets the definition of a high-risk establishment in section 157.20; or

(2) an establishment where 500 or more meals per day are prepared at one location and served at one or more separate locations.

Subd. 3. **Temporary food establishments and special events.** (a) The special event food stand license fee is $50 annually. Special event food stand is where food is

prepared or served in conjunction with celebrations, county fairs, or special events from a special event food stand as defined in section 157.15.

(b) The temporary food and beverage service license fee is $210 annually. A temporary food and beverage service includes food carts, mobile food units, seasonal temporary food stands, retail food vehicles, portable structures, and seasonal permanent food stands.

Subd. 4. **Additional applicable fees.** (a) The individual private sewer or individual private water license fee is $60 annually. Individual private water is a water supply other than a community public water supply as covered in Minnesota Rules, chapter 4720. Individual private sewer is an individual sewage treatment system which uses subsurface treatment and disposal.

(b) The additional food or beverage service license fee is $165 annually. Additional food or beverage service is a location at a food service establishment, other than the primary food preparation and service area, used to prepare or serve food or beverages to the public. Additional food service does not apply to school concession stands.

(c) The large retail food handler license fee is .02 percent of gross sales or service including food service with a maximum fee of $5,000 annually. Large retail food handler is a fee category added to a license for retail food handlers as classified in section 28A.05 with gross annual sales over $10,000,000.

(d) The specialized processing license fee is $400 annually. Specialized processing is a business that performs one or more specialized processes that require a HACCP as required in Minnesota Rules, chapter 4626.

Sec. 2. Minnesota Statutes 2014, section 62J.498, is amended to read:

62J.498 HEALTH INFORMATION EXCHANGE.

Subdivision 1. **Definitions.** The following definitions apply to sections 62J.498 to 62J.4982:

(a) "Clinical data repository" means a real time database that consolidates data from a variety of clinical sources to present a unified view of a single patient.

~~(a)~~ (b) "Clinical transaction" means any meaningful use transaction or other health information exchange transaction that is not covered by section 62J.536.

~~(b)~~ (c) "Commissioner" means the commissioner of health.

~~(c) "Direct health information exchange" means the electronic transmission of health-related information through a direct connection between the electronic health record systems of health care providers without the use of a health data intermediary.~~

(d) "Health care provider" or "provider" means a health care provider or provider as defined in section 62J.03, subdivision 8.

(e) "Health data intermediary" means an entity that provides the ~~infrastructure~~ technical capabilities or related products and services to ~~connect computer systems or other electronic devices used by health care providers, laboratories, pharmacies, health plans, third-party administrators, or pharmacy benefit managers to facilitate the secure transmission of health information, including~~ enable health information exchange among health care providers that are not related health care entities as defined in section 144.291, subdivision 2, paragraph (j). This includes but is not limited to: health information service providers (HISP), electronic health record vendors, and pharmaceutical electronic data intermediaries as defined in section 62J.495. ~~This does not include health care providers engaged in direct health information exchange.~~

(f) "Health information exchange" means the electronic transmission of health-related information between organizations according to nationally recognized standards.

(g) "Health information exchange service provider" means a health data intermediary or health information organization ~~that has been issued a certificate of authority by the commissioner under section 62J.4981~~.

(h) "Health information organization" means an organization that oversees, governs, and facilitates ~~the~~ health information exchange ~~of health-related information~~ among ~~organizations according to nationally recognized standards~~ health care providers that are not related health care entities as defined in section 144.291, subdivision 2, paragraph (j), to improve coordination of patient care and the efficiency of health care delivery.

(i) "HITECH Act" means the Health Information Technology for Economic and Clinical Health Act as defined in section 62J.495.

(j) "Major participating entity" means:

(1) a participating entity that receives compensation for services that is greater than 30 percent of the health information organization's gross annual revenues from the health information exchange service provider;

(2) a participating entity providing administrative, financial, or management services to the health information organization, if the total payment for all services provided by the participating entity exceeds three percent of the gross revenue of the health information organization; and

(3) a participating entity that nominates or appoints 30 percent or more of the board of directors or equivalent governing body of the health information organization.

(k) "Meaningful use" means use of certified electronic health record technology ~~that includes e-prescribing, and is connected in a manner that provides for the electronic~~

~~exchange of health information and used for the submission of clinical quality measures~~ to improve quality, safety, and efficiency and reduce health disparities; engage patients and families; improve care coordination and population and public health; and maintain privacy and security of patient health information as established by the Center for Medicare and Medicaid Services and the Minnesota Department of Human Services pursuant to sections 4101, 4102, and 4201 of the HITECH Act.

(l) "Meaningful use transaction" means an electronic transaction that a health care provider must exchange to receive Medicare or Medicaid incentives or avoid Medicare penalties pursuant to sections 4101, 4102, and 4201 of the HITECH Act.

(m) "Participating entity" means any of the following persons, health care providers, companies, or other organizations with which a health information organization or health data intermediary has contracts or other agreements for the provision of health information exchange ~~service providers~~ services:

(1) a health care facility licensed under sections 144.50 to 144.56, a nursing home licensed under sections 144A.02 to 144A.10, and any other health care facility otherwise licensed under the laws of this state or registered with the commissioner;

(2) a health care provider, and any other health care professional otherwise licensed under the laws of this state or registered with the commissioner;

(3) a group, professional corporation, or other organization that provides the services of individuals or entities identified in clause (2), including but not limited to a medical clinic, a medical group, a home health care agency, an urgent care center, and an emergent care center;

(4) a health plan as defined in section 62A.011, subdivision 3; and

(5) a state agency as defined in section 13.02, subdivision 17.

(n) "Reciprocal agreement" means an arrangement in which two or more health information exchange service providers agree to share in-kind services and resources to allow for the pass-through of ~~meaningful use~~ clinical transactions.

(o) "State-certified health data intermediary" means a health data intermediary that~~:~~ has been issued a certificate of authority to operate in Minnesota.

~~(1) provides a subset of the meaningful use transaction capabilities necessary for hospitals and providers to achieve meaningful use of electronic health records;~~

~~(2) is not exclusively engaged in the exchange of meaningful use transactions covered by section 62J.536; and~~

~~(3) has been issued a certificate of authority to operate in Minnesota.~~

(p) "State-certified health information organization" means a ~~nonprofit~~ health information organization that ~~provides transaction capabilities necessary to fully support~~

~~clinical transactions required for meaningful use of electronic health records that~~ has been issued a certificate of authority to operate in Minnesota.

Subd. 2. **Health information exchange oversight.** (a) The commissioner shall protect the public interest on matters pertaining to health information exchange. The commissioner shall:

(1) review and act on applications from health data intermediaries and health information organizations for certificates of authority to operate in Minnesota;

(2) provide ongoing monitoring to ensure compliance with criteria established under sections 62J.498 to 62J.4982;

(3) respond to public complaints related to health information exchange services;

(4) take enforcement actions as necessary, including the imposition of fines, suspension, or revocation of certificates of authority as outlined in section 62J.4982;

(5) provide a biennial report on the status of health information exchange services that includes but is not limited to:

(i) recommendations on actions necessary to ensure that health information exchange services are adequate to meet the needs of Minnesota citizens and providers statewide;

(ii) recommendations on enforcement actions to ensure that health information exchange service providers act in the public interest without causing disruption in health information exchange services;

(iii) recommendations on updates to criteria for obtaining certificates of authority under this section; and

(iv) recommendations on standard operating procedures for health information exchange, including but not limited to the management of consumer preferences; and

(6) other duties necessary to protect the public interest.

(b) As part of the application review process for certification under paragraph (a), prior to issuing a certificate of authority, the commissioner shall:

(1) ~~hold public hearings that provide an adequate opportunity for participating entities and consumers to provide feedback and recommendations on the application under consideration. The commissioner shall~~ make all portions of the application classified as public data available to the public for at least ten days ~~in advance of the hearing~~ while an application is under consideration. At the request of the commissioner, the applicant shall participate in ~~the~~ a public hearing by presenting an overview of their application and responding to questions from interested parties; and

(2) ~~make available all feedback and recommendations gathered at the hearing available to the public prior to issuing a certificate of authority; and~~

~~(3)~~ consult with hospitals, physicians, and other ~~professionals eligible to receive meaningful use incentive payments or subject to penalties as established in the HITECH Act, and their respective statewide associations,~~ providers prior to issuing a certificate of authority.

(c) When the commissioner is actively considering a suspension or revocation of a certificate of authority as described in section 62J.4982, subdivision 3, all investigatory data that are collected, created, or maintained related to the suspension or revocation are classified as confidential data on individuals and as protected nonpublic data in the case of data not on individuals.

(d) The commissioner may disclose data classified as protected nonpublic or confidential under paragraph (c) if disclosing the data will protect the health or safety of patients.

(e) After the commissioner makes a final determination regarding a suspension or revocation of a certificate of authority, all minutes, orders for hearing, findings of fact, conclusions of law, and the specification of the final disciplinary action, are classified as public data.

Sec. 3. Minnesota Statutes 2014, section 62J.4981, is amended to read:

62J.4981 CERTIFICATE OF AUTHORITY TO PROVIDE HEALTH INFORMATION EXCHANGE SERVICES.

Subdivision 1. **Authority to require organizations to apply.** The commissioner shall require ~~an entity providing health information exchange services~~ a health data intermediary or a health information organization to apply for a certificate of authority under this section. An applicant may continue to operate until the commissioner acts on the application. If the application is denied, the applicant is considered a health information ~~organization~~ exchange service provider whose certificate of authority has been revoked under section 62J.4982, subdivision 2, paragraph (d).

Subd. 2. **Certificate of authority for health data intermediaries.** (a) A health data intermediary ~~that provides health information exchange services for the transmission of one or more clinical transactions necessary for hospitals, providers, or eligible professionals to achieve meaningful use~~ must be ~~registered with~~ certified by the state and comply with requirements established in this section.

(b) Notwithstanding any law to the contrary, any corporation organized to do so may apply to the commissioner for a certificate of authority to establish and operate as a health data intermediary in compliance with this section. No person shall establish or operate a health data intermediary in this state, nor sell or offer to sell, or solicit offers

to purchase or receive advance or periodic consideration in conjunction with a health data intermediary contract unless the organization has a certificate of authority or has an application under active consideration under this section.

(c) In issuing the certificate of authority, the commissioner shall determine whether the applicant for the certificate of authority has demonstrated that the applicant meets the following minimum criteria:

~~(1) interoperate with at least one state-certified health information organization;~~

~~(2) provide an option for Minnesota entities to connect to their services through at least one state-certified health information organization;~~

~~(3) have a record locator service as defined in section 144.291, subdivision 2, paragraph (i), that is compliant with the requirements of section 144.293, subdivision 8, when conducting meaningful use transactions; and~~

~~(4)~~ (1) hold reciprocal agreements with at least one state-certified health information organization to ~~enable~~ access ~~to record locator services to find~~ patient data, and for the transmission and receipt of ~~meaningful use~~ clinical transactions ~~consistent with the format and content required by national standards established by Centers for Medicare and Medicaid Services~~. Reciprocal agreements must meet the requirements established in subdivision 5~~.~~; and

(2) participate in statewide shared health information exchange services as defined by the commissioner to support interoperability between state-certified health information organizations and state-certified health data intermediaries.

Subd. 3. **Certificate of authority for health information organizations.** (a) A health information organization ~~that provides all electronic capabilities for the transmission of clinical transactions necessary for meaningful use of electronic health records~~ must obtain a certificate of authority from the commissioner and demonstrate compliance with the criteria in paragraph (c).

(b) Notwithstanding any law to the contrary, ~~a nonprofit corporation organized to do so~~ an organization may apply for a certificate of authority to establish and operate a health information organization under this section. No person shall establish or operate a health information organization in this state, nor sell or offer to sell, or solicit offers to purchase or receive advance or periodic consideration in conjunction with a health information organization or health information contract unless the organization has a certificate of authority under this section.

(c) In issuing the certificate of authority, the commissioner shall determine whether the applicant for the certificate of authority has demonstrated that the applicant meets the following minimum criteria:

(1) the entity is a legally established~~, nonprofit~~ organization;

(2) appropriate insurance, including liability insurance, for the operation of the health information organization is in place and sufficient to protect the interest of the public and participating entities;

(3) strategic and operational plans ~~clearly~~ address governance, technical infrastructure, legal and policy issues, finance, and business operations in regard to how the organization will expand ~~technical capacity of the health information organization~~ to support providers in achieving ~~meaningful use of electronic health records~~ health information exchange goals over time;

(4) the entity addresses the parameters to be used with participating entities and other health information ~~organizations~~ exchange service providers for ~~meaningful use~~ clinical transactions, compliance with Minnesota law, and interstate health information exchange ~~in~~ trust agreements;

(5) the entity's board of directors or equivalent governing body is composed of members that broadly represent the health information organization's participating entities and consumers;

(6) the entity maintains a professional staff responsible to the board of directors or equivalent governing body with the capacity to ensure accountability to the organization's mission;

(7) the organization is compliant with ~~criteria established under the Health Information Exchange Accreditation Program of the Electronic Healthcare Network Accreditation Commission (EHNAC) or equivalent criteria established~~ national certification and accreditation programs designated by the commissioner;

(8) the entity maintains ~~a~~ the capability to query for patient information based on national standards. The query capability may utilize a master patient index, clinical data repository, or record locator service as defined in section 144.291, subdivision 2, paragraph (i)~~, that is~~. If the entity maintains a record locator service, it must be compliant with the requirements of section 144.293, subdivision 8, when conducting ~~meaningful use~~ clinical transactions;

(9) the organization demonstrates interoperability with all other state-certified health information organizations using nationally recognized standards;

(10) the organization demonstrates compliance with all privacy and security requirements required by state and federal law; and

(11) the organization uses financial policies and procedures consistent with generally accepted accounting principles and has an independent audit of the organization's financials on an annual basis.

(d) Health information organizations that have obtained a certificate of authority must:

(1) meet the requirements established for connecting to the ~~Nationwide Health Information Network (NHIN) within the federally mandated timeline or within a time frame established by the commissioner and published in the State Register. If the state timeline for implementation varies from the federal timeline, the State Register notice shall include an explanation for the variation~~ National eHealth Exchange;

(2) annually submit strategic and operational plans for review by the commissioner that address:

~~(i) increasing adoption rates to include a sufficient number of participating entities to achieve financial sustainability; and~~

~~(ii)~~ (i) progress in achieving objectives included in previously submitted strategic and operational plans across the following domains: business and technical operations, technical infrastructure, legal and policy issues, finance, and organizational governance;

~~(3) develop and maintain a business plan that addresses:~~

~~(i)~~ (ii) plans for ensuring the necessary capacity to support ~~meaningful use~~ clinical transactions;

~~(ii)~~ (iii) approach for attaining financial sustainability, including public and private financing strategies, and rate structures;

~~(iii)~~ (iv) rates of adoption, utilization, and transaction volume, and mechanisms to support health information exchange; and

~~(iv)~~ (v) an explanation of methods employed to address the needs of community clinics, critical access hospitals, and free clinics in accessing health information exchange services;

~~(4) annually submit a rate plan to the commissioner outlining fee structures for health information exchange services for approval by the commissioner. The commissioner shall approve the rate plan if it:~~

~~(i) distributes costs equitably among users of health information services;~~

~~(ii) provides predictable costs for participating entities;~~

~~(iii) covers all costs associated with conducting the full range of meaningful use clinical transactions, including access to health information retrieved through other state-certified health information exchange service providers; and~~

~~(iv) provides for a predictable revenue stream for the health information organization and generates sufficient resources to maintain operating costs and develop technical infrastructure necessary to serve the public interest;~~

~~(5)~~ (3) enter into reciprocal agreements with all other state-certified health information organizations and state-certified health data intermediaries to enable access

to ~~record locator services to find~~ patient data, and for the transmission and receipt of ~~meaningful use~~ clinical transactions ~~consistent with the format and content required by national standards established by Centers for Medicare and Medicaid Services~~. Reciprocal agreements must meet the requirements in subdivision 5; ~~and~~

(4) participate in statewide shared health information exchange services as defined by the commissioner to support interoperability between state-certified health information organizations and state-certified health data intermediaries; and

~~(6)~~ (5) comply with additional requirements for the certification or recertification of health information organizations that may be established by the commissioner.

Subd. 4. **Application for certificate of authority for health information exchange service providers.** (a) Each application for a certificate of authority shall be in a form prescribed by the commissioner and verified by an officer or authorized representative of the applicant. Each application shall include the following in addition to information described in the criteria in subdivisions 2 and 3:

(1) for health information organizations only, a copy of the basic organizational document, if any, of the applicant and of each major participating entity, such as the articles of incorporation, or other applicable documents, and all amendments to it;

(2) for health information organizations only, a list of the names, addresses, and official positions of the following:

(i) all members of the board of directors or equivalent governing body, and the principal officers and, if applicable, shareholders of the applicant organization; and

(ii) all members of the board of directors or equivalent governing body, and the principal officers of each major participating entity and, if applicable, each shareholder beneficially owning more than ten percent of any voting stock of the major participating entity;

(3) for health information organizations only, the name and address of each participating entity and the agreed-upon duration of each contract or agreement if applicable;

(4) a copy of each standard agreement or contract intended to bind the participating entities and the health information ~~organization~~ exchange service provider. Contractual provisions shall be consistent with the purposes of this section, in regard to the services to be performed under the standard agreement or contract, the manner in which payment for services is determined, the nature and extent of responsibilities to be retained by the health information organization, and contractual termination provisions;

~~(5) a copy of each contract intended to bind major participating entities and the health information organization. Contract information filed with the commissioner under this section shall be nonpublic as defined in section 13.02, subdivision 9;~~

~~(6)~~ (5) a statement generally describing the health information ~~organization~~ exchange service provider, its health information exchange contracts, facilities, and personnel, including a statement describing the manner in which the applicant proposes to provide participants with comprehensive health information exchange services;

~~(7) financial statements showing the applicant's assets, liabilities, and sources of financial support, including a copy of the applicant's most recent certified financial statement;~~

~~(8) strategic and operational plans that specifically address how the organization will expand technical capacity of the health information organization to support providers in achieving meaningful use of electronic health records over time, a description of the proposed method of marketing the services, a schedule of proposed charges, and a financial plan that includes a three-year projection of the expenses and income and other sources of future capital;~~

~~(9)~~ (6) a statement reasonably describing the geographic area or areas to be served and the type or types of participants to be served;

~~(10)~~ (7) a description of the complaint procedures to be used as required under this section;

~~(11)~~ (8) a description of the mechanism by which participating entities will have an opportunity to participate in matters of policy and operation;

~~(12)~~ (9) a copy of any pertinent agreements between the health information organization and insurers, including liability insurers, demonstrating coverage is in place;

~~(13)~~ (10) a copy of the conflict of interest policy that applies to all members of the board of directors or equivalent governing body and the principal officers of the health information organization; and

~~(14)~~ (11) other information as the commissioner may reasonably require to be provided.

(b) Within ~~30~~ 45 days after the receipt of the application for a certificate of authority, the commissioner shall determine whether or not the application submitted meets the requirements for completion in paragraph (a), and notify the applicant of any further information required for the application to be processed.

(c) Within 90 days after the receipt of a complete application for a certificate of authority, the commissioner shall issue a certificate of authority to the applicant if the commissioner determines that the applicant meets the minimum criteria requirements

of subdivision 2 for health data intermediaries or subdivision 3 for health information organizations. If the commissioner determines that the applicant is not qualified, the commissioner shall notify the applicant and specify the reasons for disqualification.

(d) Upon being granted a certificate of authority to operate as a state-certified health information organization or state-certified health data intermediary, the organization must operate in compliance with the provisions of this section. Noncompliance may result in the imposition of a fine or the suspension or revocation of the certificate of authority according to section 62J.4982.

Subd. 5. **Reciprocal agreements between health information exchange entities.** (a) Reciprocal agreements between two health information organizations or between a health information organization and a health data intermediary must include a fair and equitable model for charges between the entities that:

(1) does not impede the secure transmission of clinical transactions ~~necessary to achieve meaningful use~~;

(2) does not charge a fee for the exchange of meaningful use transactions transmitted according to nationally recognized standards where no additional value-added service is rendered to the sending or receiving health information organization or health data intermediary either directly or on behalf of the client;

(3) is consistent with fair market value and proportionately reflects the value-added services accessed as a result of the agreement; and

(4) prevents health care stakeholders from being charged multiple times for the same service.

(b) Reciprocal agreements must include comparable quality of service standards that ensure equitable levels of services.

(c) Reciprocal agreements are subject to review and approval by the commissioner.

(d) Nothing in this section precludes a state-certified health information organization or state-certified health data intermediary from entering into contractual agreements for the provision of value-added services beyond meaningful use transactions.

~~(e) The commissioner of human services or health, when providing access to data or services through a certified health information organization, must offer the same data or services directly through any certified health information organization at the same pricing, if the health information organization pays for all connection costs to the state data or service. For all external connectivity to the respective agencies through existing or future information exchange implementations, the respective agency shall establish the required connectivity methods as well as protocol standards to be utilized.~~

~~Subd. 6. **State participation in health information exchange.** A state agency that connects to a health information exchange service provider for the purpose of exchanging meaningful use transactions must ensure that the contracted health information exchange service provider has reciprocal agreements in place as required by this section. The reciprocal agreements must provide equal access to information supplied by the agency as necessary for meaningful use by the participating entities of the other health information service providers.~~

Sec. 4. Minnesota Statutes 2014, section 62J.4982, subdivision 4, is amended to read:

Subd. 4. **Coordination.** ~~(a)~~ The commissioner shall, to the extent possible, seek the advice of the Minnesota e-Health Advisory Committee, in the review and update of criteria for the certification and recertification of health information exchange service providers when implementing sections 62J.498 to 62J.4982.

~~(b) By January 1, 2011, the commissioner shall report to the governor and the chairs of the senate and house of representatives committees having jurisdiction over health information policy issues on the status of health information exchange in Minnesota, and provide recommendations on further action necessary to facilitate the secure electronic movement of health information among health providers that will enable Minnesota providers and hospitals to meet meaningful use exchange requirements.~~

Sec. 5. Minnesota Statutes 2014, section 62J.4982, subdivision 5, is amended to read:

Subd. 5. **Fees and monetary penalties.** (a) The commissioner shall assess fees on every health information exchange service provider subject to sections 62J.4981 and 62J.4982 as follows:

(1) filing an application for certificate of authority to operate as a health information organization, ~~$10,500~~ $7,000;

(2) filing an application for certificate of authority to operate as a health data intermediary, $7,000;

(3) annual health information organization certificate fee, ~~$14,000~~ $7,000; and

(4) annual health data intermediary certificate fee, $7,000~~; and~~

~~(5) fees for other filings, as specified by rule~~.

(b) Fees collected under this section shall be deposited in the state treasury and credited to the state government special revenue fund.

~~(b)~~ (c) Administrative monetary penalties imposed under this subdivision shall be credited to an account in the special revenue fund and are appropriated to the commissioner for the purposes of sections 62J.498 to 62J.4982.

Sec. 6. Minnesota Statutes 2014, section 144.3831, subdivision 1, is amended to read:

Subdivision 1. **Fee setting.** The commissioner of health may assess an annual fee of ~~$6.36~~ $8.28 for every service connection to a public water supply that is owned or operated by a home rule charter city, a statutory city, a city of the first class, or a town. The commissioner of health may also assess an annual fee for every service connection served by a water user district defined in section 110A.02. Fees collected under this section shall be deposited in the state treasury and credited to the state government special revenue fund.

Sec. 7. **[144.4961] MINNESOTA RADON LICENSING ACT.**

Subdivision 1. **Citation.** This section may be cited as the "Minnesota Radon Licensing Act."

Subd. 2. **Definitions.** (a) As used in this section, the following terms have the meanings given them.

(b) "Mitigation" means the act of repairing or altering a building or building design for the purpose in whole or in part of reducing the concentration of radon in the indoor atmosphere.

(c) "Radon" means both the radioactive, gaseous element produced by the disintegration of radium, and the short-lived radionuclides that are decay products of radon.

Subd. 3. **Rulemaking.** The commissioner of health shall adoptrules for licensure and enforcement of applicable laws and rules relating to indoor radon in dwellings and other buildings, with the exception of newly constructed Minnesota homes according to section 326B.106, subdivision 6. The commissioner shall coordinate, oversee, and implementall state functions in matters concerning the presence, effects, measurement, and mitigation of risks of radon in dwellings and other buildings.

Subd. 4. **System tag.** All radon mitigation systems installed in Minnesota on or after July 1, 2016, must have a radon mitigation system tag provided by the commissioner. A radon mitigation professional must attach the tag to the radon mitigation system in a visible location.

Subd. 5. **License required annually.** A license is required annually for every person, firm, or corporation that sells a device or performs a service for compensation to detect the presence of radon in the indoor atmosphere, performs laboratory analysis, or performs a service to mitigate radon in the indoor atmosphere. This section does not apply to retail stores that only sell or distribute radon sampling but are not engaged in the manufacture of radon sampling devices.

Subd. 6. **Exemptions.** Radon systems installed in newly constructed Minnesota homes according to section 326B.106, subdivision 6, prior to the issuance of a certificate of occupancy are not required to follow the requirements of this section.

Subd. 7. **License applications and other reports.** The professionals, companies, laboratories, and examinees listed in subdivision 8 must submit applications for licenses, system tags, and any other reporting required under this section and Minnesota Rules on forms prescribed by the commissioner.

Subd. 8. **Licensing fees.** (a) All radon license applications submitted to the commissioner of health must be accompanied by the required fees. If the commissioner determines that insufficient fees were paid, the necessary additional fees must be paid before the commissioner approves the application. The commissioner shall charge the following fees for each radon license:

(1) Each measurement professional license, $600 per year. "Measurement professional" means any person who does not require supervision and performs a test to determine the presence and concentration of radon; provides professional or expert advice on radon testing, radon exposure, or health risks related to radon exposure; provides direct supervision of a measurement technician; or makes representations of doing any of these activities.

(2) Each measurement technician license, $300 per year. "Measurement technician" means any person who is under the direct supervision of a measurement professional, and who performs a test to determine the presence and concentration of radon; provides professional or expert advice on radon testing, radon exposure, or health risks related to radon exposure; or makes representations of doing any of these activities.

(3) Each mitigation professional license, $600 per year. "Mitigation professional" means an individual who does not require supervision and performs radon mitigation; provides professional or expert advice on radon mitigation or radon entry routes; or provides on-site supervision of radon mitigation and mitigation technicians; or makes representations of doing any of these activities.

(4) Each mitigation technician license, $300 per year. "Mitigation technician" means any person who is under the direct supervision of a mitigation professional and who performs radon mitigation; provides professional or expert advice on radon mitigation or radon entry routes; or makes representations of doing any of these activities.

(5) Each mitigation company license, $800 per year. "Mitigation company" means any business or government entity that performs or authorizes employees to perform radon mitigation. This fee is waived if the company is a sole proprietorship.

(6) Each radon analysis laboratory license, $500 per year. "Radon analysis laboratory" means a business entity or government entity that analyzes passive radon detection devices to determine the presence and concentration of radon in the devices.

(7) Each Minnesota Department of Health radon measurement exam, $125 per exam. "Minnesota Department of Health radon measurement exam" means a radon measurement exam administered by the commissioner of health.

(8) Each Minnesota Department of Health radon mitigation exam, $125 per exam. "Minnesota Department of Health radon mitigation exam" means a radon mitigation exam administered by the commissioner of health.

(9) Each Minnesota Department of Health radon mitigation system tag, $50 per tag. "Minnesota Department of Health radon mitigation system tag" or "system tag" means a unique identifiable radon system label provided by the commissioner of health.

(b) Fees collected under this section shall be deposited in the state treasury and credited to the state government special revenue fund.

Subd. 9. **Enforcement.** The commissioner shall enforce this section under the provisions of sections 144.989 to 144.993.

EFFECTIVE DATE. This section is effective July 1, 2015, except subdivisions 4 and 5, which are effective July 1, 2016.

Sec. 8. Minnesota Statutes 2014, section 144.9501, subdivision 22b, is amended to read:

Subd. 22b. **Lead sampling technician.** "Lead sampling technician" means an individual who performs clearance inspections for renovation sites and lead dust sampling for nonabatement sites~~, and who is registered with the commissioner under section 144.9505~~.

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

Sec. 9. Minnesota Statutes 2014, section 144.9501, subdivision 26b, is amended to read:

Subd. 26b. **Renovation.** "Renovation" means the modification of any pre-1978 affected property that results in the disturbance of known or presumed lead-containing painted and coated surfaces defined under section 144.9508, unless that activity is performed as ~~an abatement~~ lead hazard reduction. A renovation performed for the purpose of converting a building or part of a building into an affected property is a renovation under this subdivision.

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

Sec. 10. Minnesota Statutes 2014, section 144.9501, is amended by adding a subdivision to read:

Subd. 26c. **Lead renovator.** "Lead renovator" means an individual who directs individuals who perform renovations. A lead renovator also performs renovation, surface coating testing, and cleaning verification.

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

Sec. 11. Minnesota Statutes 2014, section 144.9505, is amended to read:

144.9505 ~~LICENSING~~ CREDENTIALING OF LEAD FIRMS AND PROFESSIONALS.

Subdivision 1. **Licensing ~~and~~, certification; ~~generally~~, and permitting.** (a) ~~All~~ Fees ~~received shall be paid~~ collected under this section shall be deposited into the state treasury and credited to ~~the lead abatement licensing and certification account and are appropriated to the commissioner to cover costs incurred under this section and section 144.9508~~ state government special revenue fund.

(b) Persons shall not advertise or otherwise present themselves as lead supervisors, lead workers, lead inspectors, lead risk assessors, lead sampling technicians, lead project designers, ~~or~~ renovation firms, lead firms unless they have licenses or certificates issued by ~~or are registered with~~ the commissioner under this section.

(c) The fees required in this section for inspectors, risk assessors, and certified lead firms are waived for state or local government employees performing services for or as an assessing agency.

(d) An individual who is the owner of property on which regulated lead work is to be performed or an adult individual who is related to the property owner, as defined under section 245A.02, subdivision 13, is exempt from the requirements to obtain a license and pay a fee according to this section.

(e) A person that employs individuals to perform regulated lead work outside of the person's property must obtain certification as a certified lead firm or a certified renovation firm. An individual who performs ~~regulated lead work~~ lead hazard reduction, lead hazard screens, lead inspections, lead risk assessments, lead project designer services, lead sampling technician services, swab team services, and activities performed to comply with lead orders must be employed by a certified lead firm, unless the individual is a sole proprietor and does not employ any other ~~individual who performs regulated lead work~~ individuals, the individual is employed by a person that does not perform regulated lead work outside of the person's property, or the individual is employed by an assessing agency.

Subd. 1a. **Lead worker license.** Before an individual performs regulated lead work as a worker, the individual shall first obtain a license from the commissioner. No license shall be issued unless the individual shows evidence of successfully completing a training course in lead hazard control. The commissioner shall specify the course of training and testing requirements and shall charge a $50 fee annually for the license. License fees are nonrefundable and must be submitted with each application. The license must be carried by the individual and be readily available for review by the commissioner and other public health officials charged with the health, safety, and welfare of the state's citizens.

Subd. 1b. **Lead supervisor license.** Before an individual performs regulated lead work as a supervisor, the individual shall first obtain a license from the commissioner. No license shall be issued unless the individual shows evidence of experience and successful completion of a training course in lead hazard control. The commissioner shall specify the course of training, experience, and testing requirements and shall charge a $50 fee annually for the license. License fees are nonrefundable and must be submitted with each application. The license must be carried by the individual and be readily available for review by the commissioner and other public health officials charged with the health, safety, and welfare of the state's citizens.

Subd. 1c. **Lead inspector license.** Before an individual performs lead inspection services, the individual shall first obtain a license from the commissioner. No license shall be issued unless the individual shows evidence of successfully completing a training course in lead inspection. The commissioner shall specify the course of training and testing requirements and shall charge a $50 fee annually for the license. License fees are nonrefundable and must be submitted with each application. The license must be carried by the individual and be readily available for review by the commissioner and other public health officials charged with the health, safety, and welfare of the state's citizens.

Subd. 1d. **Lead risk assessor license.** Before an individual performs lead risk assessor services, the individual shall first obtain a license from the commissioner. No license shall be issued unless the individual shows evidence of experience and successful completion of a training course in lead risk assessment. The commissioner shall specify the course of training, experience, and testing requirements and shall charge a $100 fee annually for the license. License fees are nonrefundable and must be submitted with each application. The license must be carried by the individual and be readily available for review by the commissioner and other public health officials charged with the health, safety, and welfare of the state's citizens.

Subd. 1e. **Lead project designer license.** Before an individual performs lead project designer services, the individual shall first obtain a license from the commissioner.

No license shall be issued unless the individual shows evidence of experience and successful completion of a training course in lead project design. The commissioner shall specify the course of training, experience, and testing requirements and shall charge a $100 fee annually for the license. License fees are nonrefundable and must be submitted with each application. The license must be carried by the individual and be readily available for review by the commissioner and other public health officials charged with the health, safety, and welfare of the state's citizens.

~~Subd. 1f. **Lead sampling technician.** An individual performing lead sampling technician services shall first register with the commissioner. The commissioner shall not register an individual unless the individual shows evidence of successfully completing a training course in lead sampling. The commissioner shall specify the course of training and testing requirements. Proof of registration must be carried by the individual and be readily available for review by the commissioner and other public health officials charged with the health, safety, and welfare of the state's citizens.~~

Subd. 1g. **Certified lead firm.** A person who employs individuals to perform regulated lead work, with the exception of renovation, outside of the person's property must obtain certification as a lead firm. The certificate must be in writing, contain an expiration date, be signed by the commissioner, and give the name and address of the person to whom it is issued. A lead firm certificate is valid for one year. The certification fee is $100, is nonrefundable, and must be submitted with each application. The lead firm certificate or a copy of the certificate must be readily available at the worksite for review by the contracting entity, the commissioner, and other public health officials charged with the health, safety, and welfare of the state's citizens.

Subd. 1h. **Certified renovation firm.** A person who employs individuals to perform renovation activities outside of the person's property must obtain certification as a renovation firm. The certificate must be in writing, contain an expiration date, be signed by the commissioner, and give the name and address of the person to whom it is issued. A renovation firm certificate is valid for two years. The certification fee is $100, is nonrefundable, and must be submitted with each application. The renovation firm certificate or a copy of the certificate must be readily available at the worksite for review by the contracting entity, the commissioner, and other public health officials charged with the health, safety, and welfare of the state's citizens.

Subd. 1i. **Lead training course.** Before a person provides training to lead workers, lead supervisors, lead inspectors, lead risk assessors, lead project designers, lead sampling technicians, and lead renovators, the person shall first obtain a permit from the commissioner. The permit must be in writing, contain an expiration date, be signed by

the commissioner, and give the name and address of the person to whom it is issued. A training course permit is valid for two years. Training course permit fees shall be nonrefundable and must be submitted with each application in the amount of $500 for an initial training course, $250 for renewal of a permit for an initial training course, $250 for a refresher training course, and $125 for renewal of a permit of a refresher training course.

Subd. 3. **Licensed building contractor; information.** The commissioner shall provide health and safety information on lead abatement and lead hazard reduction to all residential building contractors licensed under section 326B.805. The information must include the lead-safe practices and any other materials describing ways to protect the health and safety of both employees and residents.

Subd. 4. **Notice of regulated lead work.** (a) At least five working days before starting work at each regulated lead worksite, the person performing the regulated lead work shall give written notice to the commissioner and the appropriate board of health.

(b) This provision does not apply to lead hazard screen, lead inspection, lead risk assessment, lead sampling technician, renovation, or lead project design activities.

Subd. 6. **Duties of contracting entity.** A contracting entity intending to have regulated lead work performed for its benefit shall include in the specifications and contracts for the work a requirement that the work be performed by contractors and subcontractors licensed by the commissioner under sections 144.9501 to 144.9512 and according to rules adopted by the commissioner related to regulated lead work. No contracting entity shall allow regulated lead work to be performed for its benefit unless the contracting entity has seen that the person has a valid license or certificate. A contracting entity's failure to comply with this subdivision does not relieve a person from any responsibility under sections 144.9501 to 144.9512.

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

Sec. 12. Minnesota Statutes 2014, section 144.9508, is amended to read:

144.9508 RULES.

Subdivision 1. **Sampling and analysis.** The commissioner shall adopt, by rule, methods for:

(1) lead inspections, lead hazard screens, lead risk assessments, and clearance inspections;

(2) environmental surveys of lead in paint, soil, dust, and drinking water to determine areas at high risk for toxic lead exposure;

(3) soil sampling for soil used as replacement soil;

(4) drinking water sampling, which shall be done in accordance with lab certification requirements and analytical techniques specified by Code of Federal Regulations, title 40, section 141.89; and

(5) sampling to determine whether at least 25 percent of the soil samples collected from a census tract within a standard metropolitan statistical area contain lead in concentrations that exceed 100 parts per million.

Subd. 2. **Regulated lead work standards and methods.** (a) The commissioner shall adopt rules establishing regulated lead work standards and methods in accordance with the provisions of this section, for lead in paint, dust, drinking water, and soil in a manner that protects public health and the environment for all residences, including residences also used for a commercial purpose, child care facilities, playgrounds, and schools.

(b) In the rules required by this section, the commissioner shall require lead hazard reduction of intact paint only if the commissioner finds that the intact paint is on a chewable or lead-dust producing surface that is a known source of actual lead exposure to a specific individual. The commissioner shall prohibit methods that disperse lead dust into the air that could accumulate to a level that would exceed the lead dust standard specified under this section. The commissioner shall work cooperatively with the commissioner of administration to determine which lead hazard reduction methods adopted under this section may be used for lead-safe practices including prohibited practices, preparation, disposal, and cleanup. The commissioner shall work cooperatively with the commissioner of the Pollution Control Agency to develop disposal procedures. In adopting rules under this section, the commissioner shall require the best available technology for regulated lead work methods, paint stabilization, and repainting.

(c) The commissioner of health shall adopt regulated lead work standards and methods for lead in bare soil in a manner to protect public health and the environment. The commissioner shall adopt a maximum standard of 100 parts of lead per million in bare soil. The commissioner shall set a soil replacement standard not to exceed 25 parts of lead per million. Soil lead hazard reduction methods shall focus on erosion control and covering of bare soil.

(d) The commissioner shall adopt regulated lead work standards and methods for lead in dust in a manner to protect the public health and environment. Dust standards shall use a weight of lead per area measure and include dust on the floor, on the window sills, and on window wells. Lead hazard reduction methods for dust shall focus on dust removal and other practices which minimize the formation of lead dust from paint, soil, or other sources.

(e) The commissioner shall adopt lead hazard reduction standards and methods for lead in drinking water both at the tap and public water supply system or private well

in a manner to protect the public health and the environment. The commissioner may adopt the rules for controlling lead in drinking water as contained in Code of Federal Regulations, title 40, part 141. Drinking water lead hazard reduction methods may include an educational approach of minimizing lead exposure from lead in drinking water.

(f) The commissioner of the Pollution Control Agency shall adopt rules to ensure that removal of exterior lead-based coatings from residences and steel structures by abrasive blasting methods is conducted in a manner that protects health and the environment.

(g) All regulated lead work standards shall provide reasonable margins of safety that are consistent with more than a summary review of scientific evidence and an emphasis on overprotection rather than underprotection when the scientific evidence is ambiguous.

(h) No unit of local government shall have an ordinance or regulation governing regulated lead work standards or methods for lead in paint, dust, drinking water, or soil that require a different regulated lead work standard or method than the standards or methods established under this section.

(i) Notwithstanding paragraph (h), the commissioner may approve the use by a unit of local government of an innovative lead hazard reduction method which is consistent in approach with methods established under this section.

(j) The commissioner shall adopt rules for issuing lead orders required under section 144.9504, rules for notification of abatement or interim control activities requirements, and other rules necessary to implement sections 144.9501 to 144.9512.

(k) The commissioner shall adopt rules consistent with section 402(c)(3) of the Toxic Substances Control Act to ensure that renovation in a pre-1978 affected property where a child or pregnant female resides is conducted in a manner that protects health and the environment. Notwithstanding sections 14.125 and 14.128, the authority to adopt these rules does not expire.

(l) The commissioner shall adopt rules consistent with sections 406(a) and 406(b) of the Toxic Substances Control Act. Notwithstanding sections 14.125 and 14.128, the authority to adopt these rules does not expire.

Subd. 2a. **Lead standards for exterior surfaces and street dust.** The commissioner may, by rule, establish lead standards for exterior horizontal surfaces, concrete or other impervious surfaces, and street dust on residential property to protect the public health and the environment.

Subd. 3. **Licensure and certification.** The commissioner shall adopt rules to license lead supervisors, lead workers, lead project designers, lead inspectors, lead risk assessors, and lead sampling technicians. The commissioner shall also adopt rules requiring

certification of firms that perform regulated lead work. The commissioner shall require periodic renewal of licenses and certificates and shall establish the renewal periods.

Subd. 4. **Lead training course.** The commissioner shall establish by rule requirements for training course providers and the renewal period for each lead-related training course required for certification or licensure. The commissioner shall establish criteria in rules for the content and presentation of training courses intended to qualify trainees for licensure under subdivision 3. The commissioner shall establish criteria in rules for the content and presentation of training courses for lead renovation and lead sampling technicians. ~~Training course permit fees shall be nonrefundable and must be submitted with each application in the amount of $500 for an initial training course, $250 for renewal of a permit for an initial training course, $250 for a refresher training course, and $125 for renewal of a permit of a refresher training course.~~

Subd. 5. **Variances.** In adopting the rules required under this section, the commissioner shall provide variance procedures for any provision in rules adopted under this section, except for the numerical standards for the concentrations of lead in paint, dust, bare soil, and drinking water. A variance shall be considered only according to the procedures and criteria in Minnesota Rules, parts 4717.7000 to 4717.7050.

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

Sec. 13. Minnesota Statutes 2014, section 144A.70, subdivision 6, is amended to read:

Subd. 6. **Supplemental nursing services agency.** "Supplemental nursing services agency" means a person, firm, corporation, partnership, or association engaged for hire in the business of providing or procuring temporary employment in health care facilities for nurses, nursing assistants, nurse aides, ~~and~~ orderlies, and other licensed health professionals. Supplemental nursing services agency does not include an individual who only engages in providing the individual's services on a temporary basis to health care facilities. Supplemental nursing services agency does not include a professional home care agency licensed ~~as a Class A provider~~ under section 144A.46 ~~and rules adopted thereunder~~ that only provides staff to other home care providers.

Sec. 14. Minnesota Statutes 2014, section 144A.70, is amended by adding a subdivision to read:

Subd. 7. **Oversight.** The commissioner is responsible for the oversight of supplemental nursing services agencies through annual unannounced surveys, complaint investigations under sections 144A.51 to 144A.53, and other actions necessary to ensure compliance with sections 144A.70 to 144A.74.

Sec. 15. Minnesota Statutes 2014, section 144A.71, is amended to read:

144A.71 SUPPLEMENTAL NURSING SERVICES AGENCY REGISTRATION.

Subdivision 1. **Duty to register.** A person who operates a supplemental nursing services agency shall register ~~the agency~~ annually with the commissioner. Each separate location of the business of a supplemental nursing services agency shall register the agency with the commissioner. Each separate location of the business of a supplemental nursing services agency shall have a separate registration. Fees collected under this section shall be deposited in the state treasury and credited to the state government special revenue fund.

Subd. 2. **Application information and fee.** The commissioner shall establish forms and procedures for processing each supplemental nursing services agency registration application. An application for a supplemental nursing services agency registration must include at least the following:

(1) the names and addresses of the owner or owners of the supplemental nursing services agency;

(2) if the owner is a corporation, copies of its articles of incorporation and current bylaws, together with the names and addresses of its officers and directors;

(3) satisfactory proof of compliance with section 144A.72, subdivision 1, clauses (5) to (7);

(4) any other relevant information that the commissioner determines is necessary to properly evaluate an application for registration; ~~and~~

(5) ~~the annual registration fee for a supplemental nursing services agency, which is $891.~~ a policy and procedure that describes how the supplemental nursing services agency's records will be immediately available at all times to the commissioner; and

(6) a registration fee of $2,035.

If a supplemental nursing services agency fails to provide the items in this subdivision to the department, the commissioner shall immediately suspend or refuse to issue the supplemental nursing services agency registration. The supplemental nursing services agency may appeal the commissioner's findings according to section 144A.475, subdivisions 3a and 7, except that the hearing must be conducted by an administrative law judge within 60 calendar days of the request for hearing assignment.

Subd. 3. **Registration not transferable.** A registration issued by the commissioner according to this section is effective for a period of one year from the date of its issuance unless the registration is revoked or suspended under section 144A.72, subdivision 2, or unless the supplemental nursing services agency is sold or ownership or management is transferred. When a supplemental nursing services agency is sold or ownership or

management is transferred, the registration of the agency must be voided and the new owner or operator may apply for a new registration.

Sec. 16. Minnesota Statutes 2014, section 144A.72, is amended to read:

144A.72 REGISTRATION REQUIREMENTS; PENALTIES.

Subdivision 1. **Minimum criteria.** (a) The commissioner shall require that, as a condition of registration:

(1) the supplemental nursing services agency shall document that each temporary employee provided to health care facilities currently meets the minimum licensing, training, and continuing education standards for the position in which the employee will be working;

(2) the supplemental nursing services agency shall comply with all pertinent requirements relating to the health and other qualifications of personnel employed in health care facilities;

(3) the supplemental nursing services agency must not restrict in any manner the employment opportunities of its employees;

(4) the supplemental nursing services agency shall carry medical malpractice insurance to insure against the loss, damage, or expense incident to a claim arising out of the death or injury of any person as the result of negligence or malpractice in the provision of health care services by the supplemental nursing services agency or by any employee of the agency;

(5) the supplemental nursing services agency shall carry an employee dishonesty bond in the amount of $10,000;

(6) the supplemental nursing services agency shall maintain insurance coverage for workers' compensation for all nurses, nursing assistants, nurse aides, and orderlies provided or procured by the agency;

(7) the supplemental nursing services agency shall file with the commissioner of revenue: (i) the name and address of the bank, savings bank, or savings association in which the supplemental nursing services agency deposits all employee income tax withholdings; and (ii) the name and address of any nurse, nursing assistant, nurse aide, or orderly whose income is derived from placement by the agency, if the agency purports the income is not subject to withholding;

(8) the supplemental nursing services agency must not, in any contract with any employee or health care facility, require the payment of liquidated damages, employment fees, or other compensation should the employee be hired as a permanent employee of a health care facility; ~~and~~

(9) the supplemental nursing services agency shall document that each temporary employee provided to health care facilities is an employee of the agency and is not an independent contractor.; and

(10) the supplemental nursing services agency shall retain all records for five calendar years. All records of the supplemental nursing services agency must be immediately available to the department.

(b) In order to retain registration, the supplemental nursing services agency must provide services to a health care facility during the year preceding the supplemental nursing services agency's registration renewal date.

Subd. 2. **Penalties.** A pattern of Failure to comply with this section shall subject the supplemental nursing services agency to revocation or nonrenewal of its registration. Violations of section 144A.74 are subject to a fine equal to 200 percent of the amount billed or received in excess of the maximum permitted under that section.

Subd. 3. **Revocation.** Notwithstanding subdivision 2, the registration of a supplemental nursing services agency that knowingly supplies to a health care facility a person with an illegally or fraudulently obtained or issued diploma, registration, license, certificate, or background study shall be revoked by the commissioner. The commissioner shall notify the supplemental nursing services agency 15 days in advance of the date of revocation.

Subd. 4. **Hearing.** (a) No supplemental nursing services agency's registration may be revoked without a hearing held as a contested case in accordance with chapter 14. The hearing must commence within 60 days after the proceedings are initiated section 144A.475, subdivisions 3a and 7, except the hearing must be conducted by an administrative law judge within 60 calendar days of the request for assignment.

(b) If a controlling person has been notified by the commissioner of health that the supplemental nursing services agency will not receive an initial registration or that a renewal of the registration has been denied, the controlling person or a legal representative on behalf of the supplemental nursing services agency may request and receive a hearing on the denial. This The hearing shall be held as a contested case in accordance with chapter 14 a contested case in accordance with section 144A.475, subdivisions 3a and 7, except the hearing must be conducted by an administrative law judge within 60 calendar days of the request for assignment.

Subd. 5. **Period of ineligibility.** (a) The controlling person of a supplemental nursing services agency whose registration has not been renewed or has been revoked because of noncompliance with the provisions of sections 144A.70 to 144A.74 shall not

be eligible to apply for nor will be granted a registration for five years following the effective date of the nonrenewal or revocation.

(b) The commissioner shall not issue or renew a registration to a supplemental nursing services agency if a controlling person includes any individual or entity who was a controlling person of a supplemental nursing services agency whose registration was not renewed or was revoked as described in paragraph (a) for five years following the effective date of nonrenewal or revocation.

Sec. 17. Minnesota Statutes 2014, section 144A.73, is amended to read:

144A.73 COMPLAINT SYSTEM.

The commissioner shall establish a system for reporting complaints against a supplemental nursing services agency or its employees. Complaints may be made by any member of the public. ~~Written complaints must be forwarded to the employer of each person against whom a complaint is made. The employer shall promptly report to the commissioner any corrective action taken~~ Complaints against a supplemental nursing services agency shall be investigated by the Office of Health Facility Complaints under Minnesota Statutes, sections 144A.51 to 144A.53.

Sec. 18. Minnesota Statutes 2014, section 144D.01, is amended by adding a subdivision to read:

Subd. 3a. **Direct-care staff.** "Direct-care staff" means staff and employees who provide home care services listed in section 144A.471, subdivisions 6 and 7.

Sec. 19. **[144D.066] ENFORCEMENT OF DEMENTIA CARE TRAINING REQUIREMENTS.**

Subdivision 1. **Enforcement.** (a) The commissioner shall enforce the dementia care training standards for staff working in housing with services settings and for housing managers according to clauses (1) to (3):

(1) for dementia care training requirements in section 144D.065, the commissioner shall review training records as part of the home care provider survey process for direct care staff and supervisors of direct care staff, in accordance with section 144A.474. The commissioner may also request and review training records at any time during the year;

(2) for dementia care training standards in section 144D.065, the commissioner shall review training records for maintenance, housekeeping, and food service staff and other staff not providing direct care working in housing with services settings as part of the housing with services registration application and renewal application process in

accordance with section 144D.03. The commissioner may also request and review training records at any time during the year; and

(3) for housing managers, the commissioner shall review the statement verifying compliance with the required training described in section 144D.10, paragraph (d), through the housing with services registration application and renewal application process in accordance with section 144D.03. The commissioner may also request and review training records at any time during the year.

(b) The commissioner shall specify the required forms and what constitutes sufficient training records for the items listed in paragraph (a), clauses (1) to (3).

Subd. 2. **Fines for noncompliance.** (a) Beginning January 1, 2017, the commissioner may impose a $200 fine for every staff person required to obtain dementia care training who does not have training records to show compliance. For violations of subdivision 1, paragraph (a), clause (1), the fine will be imposed upon the home care provider, and may be appealed under the contested case procedure in section 144A.475, subdivisions 3a, 4, and 7. For violations of subdivision 1, paragraph (a), clauses (2) and (3), the fine will be imposed on the housing with services registrant and may be appealed under the contested case procedure in section 144A.475, subdivisions 3a, 4, and 7. Prior to imposing the fine, the commissioner must allow two weeks for staff to complete the required training. Fines collected under this section shall be deposited in the state treasury and credited to the state government special revenue fund.

(b) The housing with services registrant and home care provider must allow for the required training as part of employee and staff duties. Imposition of a fine by the commissioner does not negate the need for the required training. Continued noncompliance with the requirements of sections 144D.065 and 144D.10 may result in revocation or nonrenewal of the housing with services registration or home care license. The commissioner shall make public the list of all housing with services establishments that have complied with the training requirements.

Subd. 3. **Technical assistance.** From January 1, 2016, to December 31, 2016, the commissioner shall provide technical assistance instead of imposing fines for noncompliance with the training requirements. During the year of technical assistance, the commissioner shall review the training records to determine if the records meet the requirements and inform the home care provider. The commissioner shall also provide information about available training resources.

Sec. 20. Minnesota Statutes 2014, section 145A.131, subdivision 1, is amended to read:

Subdivision 1. **Funding formula for community health boards.** (a) Base funding for each community health board eligible for a local public health grant under section 145A.03, subdivision 7, shall be determined by each community health board's fiscal year 2003 allocations, prior to unallotment, for the following grant programs: community health services subsidy; state and federal maternal and child health special projects grants; family home visiting grants; TANF MN ENABL grants; TANF youth risk behavior grants; and available women, infants, and children grant funds in fiscal year 2003, prior to unallotment, distributed based on the proportion of WIC participants served in fiscal year 2003 within the CHS service area.

(b) Base funding for a community health board eligible for a local public health grant under section 145A.03, subdivision 7, as determined in paragraph (a), shall be adjusted by the percentage difference between the base, as calculated in paragraph (a), and the funding available for the local public health grant.

(c) Multicounty or multicity community health boards shall receive a local partnership base of up to $5,000 per year for each county or city in the case of a multicity community health board included in the community health board.

(d) The State Community Health Advisory Committee may recommend a formula to the commissioner to use in distributing ~~state and federal~~ funds to community health boards ~~organized and operating under sections 145A.03 to 145A.131 to achieve locally identified priorities under section 145A.04, subdivision 1a, for use in distributing funds to community health boards beginning January 1, 2006, and thereafter~~.

(e) Notwithstanding any adjustment in paragraph (b), community health boards, all or a portion of which are located outside of the counties of Anoka, Chisago, Carver, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, and Wright, are eligible to receive an increase equal to ten percent of the grant award to the community health board under paragraph (a) starting July 1, 2015. The increase in calendar year 2015 shall be prorated for the last six months of the year. For calendar years beginning on or after January 1, 2016, the amount distributed under this paragraph shall be adjusted each year based on available funding and the number of eligible community health boards.

Sec. 21. Minnesota Statutes 2014, section 149A.20, subdivision 5, is amended to read:

Subd. 5. **Examinations.** After having met the educational requirements of subdivision 4, a person must attain a passing score on the National Board Examination administered by the Conference of Funeral Service Examining Boards of the United States, Inc. or any other examination that, in the determination of the commissioner, adequately and accurately assesses the knowledge and skills required to practice

mortuary science. In addition, a person must attain a passing score on the state licensing examination administered by or on behalf of the commissioner. The state examination shall encompass the laws and rules of Minnesota that pertain to the practice of mortuary science. The commissioner shall make available copies of all pertinent laws and rules prior to administration of the state licensing examination. If a passing score is not attained on the state examination, the individual must wait two weeks before they can retake the examination.

Sec. 22. Minnesota Statutes 2014, section 149A.20, subdivision 6, is amended to read:

Subd. 6. **Internship.** (a) A person who attains a passing score on both examinations in subdivision 5 must complete a registered internship under the direct supervision of an individual currently licensed to practice mortuary science in Minnesota. Interns must file with the commissioner:

(1) the appropriate fee; and

(2) a registration form indicating the name and home address of the intern, the date the internship begins, and the name, license number, and business address of the supervising mortuary science licensee.

(b) Any changes in information provided in the registration must be immediately reported to the commissioner. The internship shall be a minimum of ~~one calendar year and a maximum of three calendar years in duration;~~ 2,080 hours to be completed within a three-year period, however, the commissioner may waive up to ~~three months~~ 520 hours of the internship time requirement upon satisfactory completion of a clinical or practicum in mortuary science administered through the program of mortuary science of the University of Minnesota or a substantially similar program approved by the commissioner. Registrations must be renewed on an annual basis if they exceed one calendar year. During the internship period, the intern must be under the direct supervision of a person holding a current license to practice mortuary science in Minnesota. An intern may be registered under only one licensee at any given time and may be directed and supervised only by the registered licensee. The registered licensee shall have only one intern registered at any given time. The commissioner shall issue to each registered intern a registration permit that must be displayed with the other establishment and practice licenses. While under the direct supervision of the licensee, the intern must ~~actively participate in the embalming of at least 25 dead human bodies and in the arrangements for and direction of at least 25 funerals~~ complete 25 case reports in each of the following areas: embalming, funeral arrangements, and services. Case reports, on forms provided by the commissioner, shall be completed by the intern~~, signed by the supervising licensee,~~ and filed with the

commissioner ~~for at least 25 embalmings and funerals in which the intern participates~~ prior to the completion of the internship. Information contained in these reports that identifies the subject or the family of the subject embalmed or the subject or the family of the subject of the funeral shall be classified as licensing data under section 13.41, subdivision 2.

Sec. 23. Minnesota Statutes 2014, section 149A.40, subdivision 11, is amended to read:

Subd. 11. **Continuing education.** The commissioner ~~may~~ shall require 15 continuing education hours for renewal of a license to practice mortuary science. Nine of the hours must be in the following areas: body preparation, care, or handling, 3 CE hours; professional practices, 3 CE hours; regulation and ethics, 3 CE hours. Continuing education hours shall be reported to the commissioner every other year based on the licensee's license number. Licensees whose license ends in an odd number must report CE hours at renewal time every odd year. If a licensee's license ends in an even number, the licensee must report the licensee's CE hours at renewal time every even year.

Sec. 24. Minnesota Statutes 2014, section 149A.65, is amended to read:

149A.65 FEES.

Subdivision 1. **Generally.** This section establishes the fees for registrations, examinations, initial and renewal licenses, and late fees authorized under the provisions of this chapter.

Subd. 2. **Mortuary science fees.** Fees for mortuary science are:

(1) ~~$50~~ $75 for the initial and renewal registration of a mortuary science intern;

(2) ~~$100~~ $125 for the mortuary science examination;

(3) ~~$125~~ $200 for issuance of initial and renewal mortuary science licenses;

(4) ~~$25~~ $100 late fee charge for a license renewal; and

(5) ~~$200~~ $250 for issuing a mortuary science license by endorsement.

Subd. 3. **Funeral directors.** The license renewal fee for funeral directors is ~~$125~~ $200. The late fee charge for a license renewal is ~~$25~~ $100.

Subd. 4. **Funeral establishments.** The initial and renewal fee for funeral establishments is ~~$300~~ $425. The late fee charge for a license renewal is ~~$25~~ $100.

Subd. 5. **Crematories.** The initial and renewal fee for a crematory is ~~$300~~ $425. The late fee charge for a license renewal is ~~$25~~ $100.

Subd. 6. **Alkaline hydrolysis facilities.** The initial and renewal fee for an alkaline hydrolysis facility is ~~$300~~ $425. The late fee charge for a license renewal is ~~$25~~ $100.

Subd. 7. **State government special revenue fund.** Fees collected by the commissioner under this section must be deposited in the state treasury and credited to the state government special revenue fund.

Sec. 25. Minnesota Statutes 2014, section 149A.92, subdivision 1, is amended to read:

Subdivision 1. **~~Exemption~~ Establishment update.** ~~All funeral establishments having a preparation and embalming room that has not been used for the preparation or embalming of a dead human body in the 12 calendar months prior to July 1, 1997, are exempt from the minimum requirements in subdivisions 2 to 6, except as provided in this section.~~ At the time that ownership of a funeral establishment changes, the physical location of the establishment changes, or the building housing the funeral establishment or business space of the establishment is remodeled the existing preparation and embalming room must be brought into compliance with the minimum standards in this section and in accordance with subdivision 11.

Sec. 26. Minnesota Statutes 2014, section 149A.97, subdivision 7, is amended to read:

Subd. 7. **Reports to commissioner.** Every funeral provider lawfully doing business in Minnesota that accepts funds under subdivision 2 must make a complete annual report to the commissioner. The reports may be on forms provided by the commissioner or substantially similar forms containing, at least, identification and the state of each trust account, including all transactions involving principal and accrued interest, and must be filed by March 31 of the calendar year following the reporting year along with a filing fee of $25 for each report. Fees shall be paid to the commissioner of management and budget, state of Minnesota, for deposit in the state government special revenue fund in the state treasury. Reports must be signed by an authorized representative of the funeral provider and notarized under oath. All reports to the commissioner shall be reviewed for account inaccuracies or possible violations of this section. If the commissioner has a reasonable belief to suspect that there are account irregularities or possible violations of this section, the commissioner shall report that belief, in a timely manner, to the state auditor or other state agencies as determined by the commissioner. The commissioner may require a funeral provider reporting preneed trust accounts under this section to arrange for and pay an independent third-party auditing firm to complete an audit of the preneed trust accounts every other year. The funeral provider shall report the findings of the audit to the commissioner by March 31 of the calendar year following the reporting year. This report is in addition to the annual report. The commissioner shall also file an annual letter with the state auditor disclosing whether or not any irregularities or possible violations were detected

in review of the annual trust fund reports filed by the funeral providers. This letter shall be filed with the state auditor by May 31 of the calendar year following the reporting year.

Sec. 27. Minnesota Statutes 2014, section 157.16, is amended to read:

157.16 LICENSES REQUIRED; FEES.

Subdivision 1. **License required annually.** A license is required annually for every person, firm, or corporation engaged in the business of conducting a food and beverage service establishment, youth camp, hotel, motel, lodging establishment, public pool, or resort. Any person wishing to operate a place of business licensed in this section shall first make application, pay the required fee specified in this section, and receive approval for operation, including plan review approval. Special event food stands are not required to submit plans. Nonprofit organizations operating a special event food stand with multiple locations at an annual one-day event shall be issued only one license. Application shall be made on forms provided by the commissioner and shall require the applicant to state the full name and address of the owner of the building, structure, or enclosure, the lessee and manager of the food and beverage service establishment, hotel, motel, lodging establishment, public pool, or resort; the name under which the business is to be conducted; and any other information as may be required by the commissioner to complete the application for license.

Subd. 2. **License renewal.** Initial and renewal licenses for all food and beverage service establishments, youth camps, hotels, motels, lodging establishments, public pools, and resorts shall be issued on an annual basis. Any person who operates a place of business after the expiration date of a license or without having submitted an application and paid the fee shall be deemed to have violated the provisions of this chapter and shall be subject to enforcement action, as provided in the Health Enforcement Consolidation Act, sections 144.989 to 144.993. In addition, a penalty of $60 shall be added to the total of the license fee for any food and beverage service establishment operating without a license as a mobile food unit, a seasonal temporary or seasonal permanent food stand, or a special event food stand, and a penalty of $120 shall be added to the total of the license fee for all restaurants, food carts, hotels, motels, lodging establishments, youth camps, public pools, and resorts operating without a license for a period of up to 30 days. A late fee of $360 shall be added to the license fee for establishments operating more than 30 days without a license.

Subd. 2a. **Food manager certification.** An applicant for certification or certification renewal as a food manager must submit to the commissioner a $35 nonrefundable certification fee payable to the Department of Health. The commissioner shall issue a duplicate certificate to replace a lost, destroyed, or mutilated certificate if the applicant

submits a completed application on a form provided by the commissioner for a duplicate certificate and pays $20 to the department for the cost of duplication.

Subd. 3. **Establishment fees; definitions.** (a) The following fees are required for food and beverage service establishments, youth camps, hotels, motels, lodging establishments, public pools, and resorts licensed under this chapter. ~~Food and beverage service establishments must pay the highest applicable fee under paragraph (d), clause (1), (2), (3), or (4), and establishments serving alcohol must pay the highest applicable fee under paragraph (d), clause (6) or (7).~~ The license fee for new operators previously licensed under this chapter for the same calendar year is one-half of the appropriate annual license fee, plus any penalty that may be required. The license fee for operators opening on or after October 1 is one-half of the appropriate annual license fee, plus any penalty that may be required.

(b) Each food and beverage establishment shall pay the applicable fees specified in section 15.445.

~~(b)~~ (c) All ~~food and beverage service establishments, except special event food stands, and all~~ hotels, motels, lodging establishments, public pools, and resorts shall pay an annual base fee of $150, except for establishments that paid for a food and beverage establishment license under paragraph (b).

~~(c) A special event food stand shall pay a flat fee of $50 annually. "Special event food stand" means a fee category where food is prepared or served in conjunction with celebrations, county fairs, or special events from a special event food stand as defined in section 157.15.~~

(d) In addition to the base fee in paragraph ~~(b)~~ (c), ~~each food and beverage service establishment, other than a special event food stand and a school concession stand, and~~ each hotel, motel, lodging establishment, public pool, and resort shall pay an additional annual fee for each applicable fee category~~, additional food service, or required additional inspection~~ specified in this paragraph:

~~(1) Limited food menu selection, $60. "Limited food menu selection" means a fee category that provides one or more of the following:~~

~~(i) prepackaged food that receives heat treatment and is served in the package;~~

~~(ii) frozen pizza that is heated and served;~~

~~(iii) a continental breakfast such as rolls, coffee, juice, milk, and cold cereal;~~

~~(iv) soft drinks, coffee, or nonalcoholic beverages; or~~

~~(v) cleaning for eating, drinking, or cooking utensils, when the only food served is prepared off site.~~

~~(2) Small establishment, including boarding establishments, $120. "Small establishment" means a fee category that has no salad bar and meets one or more of the following:~~

~~(i) possesses food service equipment that consists of no more than a deep fat fryer, a grill, two hot holding containers, and one or more microwave ovens;~~

~~(ii) serves dipped ice cream or soft serve frozen desserts;~~

~~(iii) serves breakfast in an owner-occupied bed and breakfast establishment;~~

~~(iv) is a boarding establishment; or~~

~~(v) meets the equipment criteria in clause (3), item (i) or (ii), and has a maximum patron seating capacity of not more than 50.~~

~~(3) Medium establishment, $310. "Medium establishment" means a fee category that meets one or more of the following:~~

~~(i) possesses food service equipment that includes a range, oven, steam table, salad bar, or salad preparation area;~~

~~(ii) possesses food service equipment that includes more than one deep fat fryer, one grill, or two hot holding containers; or~~

~~(iii) is an establishment where food is prepared at one location and served at one or more separate locations.~~

~~Establishments meeting criteria in clause (2), item (v), are not included in this fee category.~~

~~(4) Large establishment, $540. "Large establishment" means either:~~

~~(i) a fee category that (A) meets the criteria in clause (3), items (i) or (ii), for a medium establishment, (B) seats more than 175 people, and (C) offers the full menu selection an average of five or more days a week during the weeks of operation; or~~

~~(ii) a fee category that (A) meets the criteria in clause (3), item (iii), for a medium establishment, and (B) prepares and serves 500 or more meals per day.~~

~~(5) Other food and beverage service, including food carts, mobile food units, seasonal temporary food stands, and seasonal permanent food stands, $60.~~

~~(6) Beer or wine table service, $60. "Beer or wine table service" means a fee category where the only alcoholic beverage service is beer or wine, served to customers seated at tables.~~

~~(7) Alcoholic beverage service, other than beer or wine table service, $165.~~

~~"Alcohol beverage service, other than beer or wine table service" means a fee category where alcoholic mixed drinks are served or where beer or wine are served from a bar.~~

~~(8)~~ (1) Lodging per sleeping accommodation unit, $10, including hotels, motels, lodging establishments, and resorts, up to a maximum of $1,000. "Lodging per sleeping

accommodation unit" means a fee category including the number of guest rooms, cottages, or other rental units of a hotel, motel, lodging establishment, or resort; or the number of beds in a dormitory.

~~(9)~~ (2) First public pool, $325; each additional public pool, $175. "Public pool" means a fee category that has the meaning given in section 144.1222, subdivision 4.

~~(10)~~ (3) First spa, $175; each additional spa, $100. "Spa pool" means a fee category that has the meaning given in Minnesota Rules, part 4717.0250, subpart 9.

~~(11)~~ (4) Private sewer or water, $60. "Individual private water" means a fee category with a water supply other than a community public water supply as ~~defined~~ covered in Minnesota Rules, chapter 4720. "Individual private sewer" means a fee category with an individual sewage treatment system which uses subsurface treatment and disposal.

~~(12) Additional food service, $150. "Additional food service" means a location at a food service establishment, other than the primary food preparation and service area, used to prepare or serve food to the public. Additional food service does not apply to school concession stands.~~

~~(13) Additional inspection fee, $360. "Additional inspection fee" means a fee to conduct the second inspection each year for elementary and secondary education facility school lunch programs when required by the Richard B. Russell National School Lunch Act.~~

(e) Youth camps shall pay an annual single fee for food and lodging as follows:

(1) camps with up to 99 campers, $325;

(2) camps with 100 to 199 campers, $550; and

(3) camps with 200 or more campers, $750.

(f) A youth camp that pays fees under paragraph (b) or (d) is not required to pay fees under paragraph (e).

Subd. 3a. **Construction plan review.** ~~(e)~~ (a) A fee for review of construction plans must accompany the initial license application for restaurants, hotels, motels, lodging establishments, resorts, seasonal food stands, and mobile food units. The fee for this construction plan review is as follows:

Service Area	**Type**	**Fee**
Food	~~limited food menu~~ category 1 establishment	$275
	~~small~~ category 2 establishment	$400
	~~medium~~ category 3 establishment	$450
	~~large food~~ category 4 establishment	$500
	additional food service	$150
~~Transient food service~~ Temporary food establishment	food cart	$250

	seasonal permanent food stand	$250
	seasonal temporary food stand	$250
	mobile food unit	$350
~~Alcohol~~	~~beer or wine table service~~	~~$150~~
	~~alcohol service from bar~~	~~$250~~
Lodging	less than 25 rooms	$375
	25 to less than 100 rooms	$400
	100 rooms or more	$500
	less than five cabins	$350
	five to less than ten cabins	$400
	ten cabins or more	$450

~~(f)~~ (b) When existing food and beverage service establishments, hotels, motels, lodging establishments, resorts, seasonal food stands, and mobile food units are extensively remodeled, a fee must be submitted with the remodeling plans. The fee for this construction plan review is as follows:

Service Area	**Type**	**Fee**
Food	~~limited food menu~~ category 1 establishment	$250
	~~small~~ category 2 establishment	$300
	~~medium~~ category 3 establishment	$350
	~~large~~ category 4 food establishment	$400
	additional food service	$150
~~Transient food service~~ Temporary food establishment	food cart	$250
	seasonal permanent food stand	$250
	seasonal temporary food stand	$250
	mobile food unit	$250
~~Alcohol~~	~~beer or wine table service~~	~~$150~~
	~~alcohol service from bar~~	~~$250~~
Lodging	less than 25 rooms	$250
	25 to less than 100 rooms	$300
	100 rooms or more	$450
	less than five cabins	$250
	five to less than ten cabins	$350
	ten cabins or more	$400

~~(g)~~ (c) Special event food stands are not required to submit construction or remodeling plans for review.

~~(h) Youth camps shall pay an annual single fee for food and lodging as follows:~~

~~(1) camps with up to 99 campers, $325;~~

~~(2) camps with 100 to 199 campers, $550; and~~

~~(3) camps with 200 or more campers, $750.~~

~~(i) A youth camp which pays fees under paragraph (d) is not required to pay fees under paragraph (h).~~

Subd. ~~3a.~~ 3b. **Statewide hospitality fee.** Every person, firm, or corporation that operates a licensed boarding establishment, food and beverage service establishment, seasonal temporary or permanent food stand, special event food stand, mobile food unit, food cart, resort, hotel, motel, or lodging establishment in Minnesota must submit to the commissioner a $35 annual statewide hospitality fee for each licensed activity. The fee for establishments licensed by the Department of Health is required at the same time the licensure fee is due. For establishments licensed by local governments, the fee is due by July 1 of each year.

Subd. 4. **Posting requirements.** Every food and beverage service establishment, for-profit youth camp, hotel, motel, lodging establishment, public pool, or resort must have the original license posted in a conspicuous place at the establishment. ~~Mobile food units, food carts, and seasonal temporary food stands shall be issued decals with the initial license and each calendar year with license renewals. The current license year decal must be placed on the unit or stand in a location determined by the commissioner. Decals are not transferable.~~

Subd. 5. **Special revenue fund.** Fees collected under this section shall be deposited in the state treasury and credited to the state government special revenue fund.

ARTICLE 9

HEALTH LICENSING BOARD FEE MODIFICATIONS

Section 1. Minnesota Statutes 2014, section 148.57, subdivision 1, is amended to read:

Subdivision 1. **Examination.** (a) A person not authorized to practice optometry in the state and desiring to do so shall apply to the state Board of Optometry by filling out and swearing to an application for a license granted by the board and accompanied by a fee ~~in an amount of $87~~ established by the board, not to exceed the amount specified in section 148.59. With the submission of the application form, the candidate shall prove that the candidate:

(1) is of good moral character;

(2) has obtained a clinical doctorate degree from a board-approved school or college of optometry, or is currently enrolled in the final year of study at such an institution; and

(3) has passed all parts of an examination.

(b) The examination shall include both a written portion and a clinical practical portion and shall thoroughly test the fitness of the candidate to practice in this state. In regard to the written and clinical practical examinations, the board may:

(1) prepare, administer, and grade the examination itself;

(2) recognize and approve in whole or in part an examination prepared, administered and graded by a national board of examiners in optometry; or

(3) administer a recognized and approved examination prepared and graded by or under the direction of a national board of examiners in optometry.

(c) The board shall issue a license to each applicant who satisfactorily passes the examinations and fulfills the other requirements stated in this section and section 148.575 for board certification for the use of legend drugs. Applicants for initial licensure do not need to apply for or possess a certificate as referred to in sections 148.571 to 148.574. The fees mentioned in this section are for the use of the board and in no case shall be refunded.

Sec. 2. Minnesota Statutes 2014, section 148.57, subdivision 2, is amended to read:

Subd. 2. **Endorsement.** An optometrist who holds a current license from another state, and who has practiced in that state not less than three years immediately preceding application, may apply for licensure in Minnesota by filling out and swearing to an application for license by endorsement furnished by the board. The completed application with all required documentation shall be filed at the board office along with a fee ~~of $87~~ established by the board, not to exceed the amount specified in section 148.59. The application fee shall be for the use of the board and in no case shall be refunded. To verify that the applicant possesses the knowledge and ability essential to the practice of optometry in this state, the applicant must provide evidence of:

(1) having obtained a clinical doctorate degree from a board-approved school or college of optometry;

(2) successful completion of both written and practical examinations for licensure in the applicant's original state of licensure that thoroughly tested the fitness of the applicant to practice;

(3) successful completion of an examination of Minnesota state optometry laws;

(4) compliance with the requirements for board certification in section 148.575;

(5) compliance with all continuing education required for license renewal in every state in which the applicant currently holds an active license to practice; and

(6) being in good standing with every state board from which a license has been issued.

Documentation from a national certification system or program, approved by the board, which supports any of the listed requirements, may be used as evidence. The applicant may then be issued a license if the requirements for licensure in the other state are deemed by the board to be equivalent to those of sections 148.52 to 148.62.

Sec. 3. Minnesota Statutes 2014, section 148.59, is amended to read:

148.59 LICENSE RENEWAL; ~~FEE~~ LICENSE AND REGISTRATION FEES.

A licensed optometrist shall pay to the state Board of Optometry a fee as set by the board in order to renew a license as provided by board rule. No fees shall be refunded. Fees may not exceed the following amounts but may be adjusted lower by board direction and are for the exclusive use of the board:

(1) optometry licensure application, $160;

(2) optometry annual licensure renewal, $135;

(3) optometry late penalty fee, $75;

(4) annual license renewal card, $10;

(5) continuing education provider application, $45;

(6) emeritus registration, $10;

(7) endorsement/reciprocity application, $160;

(8) replacement of initial license, $12; and

(9) license verification, $50.

Sec. 4. Minnesota Statutes 2014, section 148E.180, subdivision 2, is amended to read:

Subd. 2. **License fees.** License fees are as follows:

(1) for a licensed social worker, $81;

(2) for a licensed graduate social worker, $144;

(3) for a licensed independent social worker, $216;

(4) for a licensed independent clinical social worker, $238.50;

(5) for an emeritus inactive license, $43.20; ~~and~~

(6) for an emeritus active license, one-half of the renewal fee specified in subdivision 3; and

(7) for a temporary leave fee, the same as the renewal fee specified in subdivision 3.

If the licensee's initial license term is less or more than 24 months, the required license fees must be prorated proportionately.

Sec. 5. Minnesota Statutes 2014, section 148E.180, subdivision 5, is amended to read:

Subd. 5. **Late fees.** Late fees are as follows:

(1) renewal late fee, one-fourth of the renewal fee specified in subdivision 3; ~~and~~

(2) supervision plan late fee, $40~~.~~; and

(3) license late fee, $100 plus the prorated share of the license fee specified in subdivision 2 for the number of months during which the individual practiced social work without a license.

Sec. 6. Minnesota Statutes 2014, section 150A.091, subdivision 4, is amended to read:

Subd. 4. **Annual license fees.** Each limited faculty or resident dentist shall submit with an annual license renewal application a fee established by the board not to exceed the following amounts:

(1) limited faculty dentist, $168; and

(2) resident dentist or dental provider, ~~$59~~ $85.

Sec. 7. Minnesota Statutes 2014, section 150A.091, subdivision 5, is amended to read:

Subd. 5. **Biennial license or permit fees.** Each of the following applicants shall submit with a biennial license or permit renewal application a fee as established by the board, not to exceed the following amounts:

(1) dentist or full faculty dentist, ~~$336~~ $475;

(2) dental therapist, ~~$180~~ $300;

(3) dental hygienist, ~~$118~~ $200;

(4) licensed dental assistant, ~~$80~~ $150; and

(5) dental assistant with a permit as described in Minnesota Rules, part 3100.8500, subpart 3, $24.

Sec. 8. Minnesota Statutes 2014, section 150A.091, subdivision 11, is amended to read:

Subd. 11. **Certificate application fee for anesthesia/sedation.** Each dentist shall submit with a general anesthesia or moderate sedation application ~~or~~, a contracted sedation provider application, or biennial renewal, a fee as established by the board not to exceed the following amounts:

(1) for both a general anesthesia and moderate sedation application, ~~$250~~ $400;

(2) for a general anesthesia application only, ~~$250~~ $400;

(3) for a moderate sedation application only, ~~$250~~ $400; and

(4) for a contracted sedation provider application, ~~$250~~ $400.

Sec. 9. Minnesota Statutes 2014, section 150A.091, is amended by adding a subdivision to read:

Subd. 17. **Advanced dental therapy examination fee.** Any dental therapist eligible to sit for the advanced dental therapy certification examination must submit with the application a fee as established by the board, not to exceed $250.

Sec. 10. Minnesota Statutes 2014, section 150A.091, is amended by adding a subdivision to read:

Subd. 18. **Corporation or professional firm late fee.** Any corporation or professional firm whose annual fee is not postmarked or otherwise received by the board by the due date of December 31 shall, in addition to the fee, submit a late fee as established by the board, not to exceed $15.

Sec. 11. Minnesota Statutes 2014, section 150A.31, is amended to read:

150A.31 FEES.

(a) The initial biennial registration fee is $50.

(b) The biennial renewal registration fee is ~~$25~~ not to exceed $80.

(c) The fees specified in this section are nonrefundable and shall be deposited in the state government special revenue fund.

Sec. 12. Minnesota Statutes 2014, section 151.065, subdivision 1, is amended to read:

Subdivision 1. **Application fees.** Application fees for licensure and registration are as follows:

(1) pharmacist licensed by examination, ~~$130~~ $145;

(2) pharmacist licensed by reciprocity, ~~$225~~ $240;

(3) pharmacy intern, ~~$30~~ $37.50;

(4) pharmacy technician, ~~$30~~ $37.50;

(5) pharmacy, ~~$190~~ $225;

(6) drug wholesaler, legend drugs only, ~~$200~~ $235;

(7) drug wholesaler, legend and nonlegend drugs, ~~$200~~ $235;

(8) drug wholesaler, nonlegend drugs, veterinary legend drugs, or both, ~~$175~~ $210;

(9) drug wholesaler, medical gases, ~~$150~~ $175;

(10) drug wholesaler, also licensed as a pharmacy in Minnesota, ~~$125~~ $150;

(11) drug manufacturer, legend drugs only, ~~$200~~ $235;

(12) drug manufacturer, legend and nonlegend drugs, ~~$200~~ $235;

(13) drug manufacturer, nonlegend or veterinary legend drugs, ~~$175~~ $210;

(14) drug manufacturer, medical gases, ~~$150~~ $185;

(15) drug manufacturer, also licensed as a pharmacy in Minnesota, ~~$125~~ $150;

(16) medical gas distributor, ~~$75~~ $110;

(17) controlled substance researcher, ~~$50~~ $75; and

(18) pharmacy professional corporation, ~~$100~~ $125.

Sec. 13. Minnesota Statutes 2014, section 151.065, subdivision 2, is amended to read:

Subd. 2. **Original license fee.** The pharmacist original licensure fee, ~~$130~~ $145.

Sec. 14. Minnesota Statutes 2014, section 151.065, subdivision 3, is amended to read:

Subd. 3. **Annual renewal fees.** Annual licensure and registration renewal fees are as follows:

(1) pharmacist, ~~$130~~ $145;

(2) pharmacy technician, ~~$30~~ $37.50;

(3) pharmacy, ~~$190~~ $225;

(4) drug wholesaler, legend drugs only, ~~$200~~ $235;

(5) drug wholesaler, legend and nonlegend drugs, ~~$200~~ $235;

(6) drug wholesaler, nonlegend drugs, veterinary legend drugs, or both, ~~$175~~ $210;

(7) drug wholesaler, medical gases, ~~$150~~ $185;

(8) drug wholesaler, also licensed as a pharmacy in Minnesota, ~~$125~~ $150;

(9) drug manufacturer, legend drugs only, ~~$200~~ $235;

(10) drug manufacturer, legend and nonlegend drugs, ~~$200~~ $235;

(11) drug manufacturer, nonlegend, veterinary legend drugs, or both, ~~$175~~ $210;

(12) drug manufacturer, medical gases, ~~$150~~ $185;

(13) drug manufacturer, also licensed as a pharmacy in Minnesota, ~~$125~~ $150;

(14) medical gas distributor, ~~$75~~ $110;

(15) controlled substance researcher, ~~$50~~ $75; and

(16) pharmacy professional corporation, ~~$45~~ $75.

Sec. 15. Minnesota Statutes 2014, section 151.065, subdivision 4, is amended to read:

Subd. 4. **Miscellaneous fees.** Fees for issuance of affidavits and duplicate licenses and certificates are as follows:

(1) intern affidavit, ~~$15~~ $20;

(2) duplicate small license, ~~$15~~ $20; and

(3) duplicate large certificate, ~~$25~~ $30.

ARTICLE 10

HEALTH AND HUMAN SERVICES APPROPRIATIONS

Section 1. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are appropriated to the agencies and for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2016" and "2017" used in this article mean that the appropriations listed under them are available for the fiscal year ending June 30, 2016, or

June 30, 2017, respectively. "The first year" is fiscal year 2016. "The second year" is fiscal year 2017. "The biennium" is fiscal years 2016 and 2017.

	APPROPRIATIONS Available for the Year Ending June 30	
	2016	**2017**

Sec. 2. **COMMISSIONER OF HUMAN SERVICES**

Subdivision 1. **Total Appropriation** **$ 7,206,221,000 $ 7,544,129,000**

Appropriations by Fund

	2016	2017
General	6,287,850,000	6,543,610,000
State Government Special Revenue	4,514,000	4,274,000
Health Care Access	645,221,000	730,343,000
Federal TANF	266,743,000	264,006,000
Lottery Prize	1,893,000	1,896,000

Receipts for Systems Projects. Appropriations and federal receipts for information systems projects for MAXIS, PRISM, MMIS, ISDS, and SSIS must be deposited in the state systems account authorized in Minnesota Statutes, section 256.014. Money appropriated for computer projects approved by the commissioner of the Office of MN.IT Services, funded by the legislature, and approved by the commissioner of management and budget may be transferred from one project to another and from development to operations as the commissioner of human services considers necessary. Any unexpended balance in the appropriation for these projects does not cancel but is available for ongoing development and operations.

Nonfederal Share Transfers. The nonfederal share of activities for which

federal administrative reimbursement is appropriated to the commissioner may be transferred to the special revenue fund.

TANF Maintenance of Effort. (a) In order to meet the basic maintenance of effort (MOE) requirements of the TANF block grant specified under Code of Federal Regulations, title 45, section 263.1, the commissioner may only report nonfederal money expended for allowable activities listed in the following clauses as TANF/MOE expenditures:

(1) MFIP cash, diversionary work program, and food assistance benefits under Minnesota Statutes, chapter 256J;

(2) the child care assistance programs under Minnesota Statutes, sections 119B.03 and 119B.05, and county child care administrative costs under Minnesota Statutes, section 119B.15;

(3) state and county MFIP administrative costs under Minnesota Statutes, chapters 256J and 256K;

(4) state, county, and tribal MFIP employment services under Minnesota Statutes, chapters 256J and 256K;

(5) expenditures made on behalf of legal noncitizen MFIP recipients who qualify for the MinnesotaCare program under Minnesota Statutes, chapter 256L;

(6) qualifying working family credit expenditures under Minnesota Statutes, section 290.0671; and

(7) qualifying Minnesota education credit expenditures under Minnesota Statutes, section 290.0674.

(b) The commissioner shall ensure that sufficient qualified nonfederal expenditures are made each year to meet the state's TANF/MOE requirements. For the activities listed in paragraph (a), clauses (2) to (7), the commissioner may only report expenditures that are excluded from the definition of assistance under Code of Federal Regulations, title 45, section 260.31.

(c) For fiscal years beginning with state fiscal year 2003, the commissioner shall ensure that the maintenance of effort used by the commissioner of management and budget for the February and November forecasts required under Minnesota Statutes, section 16A.103, contains expenditures under paragraph (a), clause (1), equal to at least 16 percent of the total required under Code of Federal Regulations, title 45, section 263.1.

(d) The requirement in Minnesota Statutes, section 256.011, subdivision 3, that federal grants or aids secured or obtained under that subdivision be used to reduce any direct appropriations provided by law, does not apply if the grants or aids are federal TANF funds.

(e) For the federal fiscal years beginning on or after October 1, 2007, the commissioner may not claim an amount of TANF/MOE in excess of the 75 percent standard in Code of Federal Regulations, title 45, section 263.1(a)(2), except:

(1) to the extent necessary to meet the 80 percent standard under Code of Federal Regulations, title 45, section 263.1(a)(1), if it is determined by the commissioner that the state will not meet the TANF work participation target rate for the current year;

(2) to provide any additional amounts under Code of Federal Regulations, title 45, section 264.5, that relate to replacement of TANF funds due to the operation of TANF penalties; and

(3) to provide any additional amounts that may contribute to avoiding or reducing TANF work participation penalties through the operation of the excess MOE provisions of Code of Federal Regulations, title 45, section 261.43(a)(2).

For the purposes of clauses (1) to (3), the commissioner may supplement the MOE claim with working family credit expenditures or other qualified expenditures to the extent such expenditures are otherwise available after considering the expenditures allowed in this subdivision, subdivision 2, and subdivision 3.

(f) Notwithstanding any contrary provision in this article, paragraphs (a) to (e) expire June 30, 2019.

Working Family Credit Expenditure as TANF/MOE. The commissioner may claim as TANF maintenance of effort up to $6,707,000 per year of working family credit expenditures in each fiscal year.

Subd. 2. **Working Family Credit to be Claimed for TANF/MOE**

The commissioner may count the following additional amounts of working family credit expenditures as TANF maintenance of effort:

(1) fiscal year 2016, $0;

(2) fiscal year 2017, $1,283,000;

(3) fiscal year 2018, $0; and

(4) fiscal year 2019, $0.

Notwithstanding any contrary provision in this article, this subdivision expires June 30, 2019.

Subd. 3. **TANF Transfer To Federal Child Care and Development Fund**

(a) The following TANF fund amounts are appropriated to the commissioner for purposes of MFIP/transition year child care assistance under Minnesota Statutes, section 119B.05:

(1) fiscal year 2016, $49,135,000;

(2) fiscal year 2017, $49,658,000;

(3) fiscal year 2018, $49,658,000; and

(4) fiscal year 2019, $49,658,000.

(b) The commissioner shall authorize the transfer of sufficient TANF funds to the federal child care and development fund to meet this appropriation and shall ensure that all transferred funds are expended according to federal child care and development fund regulations.

Subd. 4. **Central Office**

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) **Operations**

	Appropriations by Fund	
General	113,514,000	111,463,000
State Government Special Revenue	4,389,000	4,149,000
Health Care Access	14,646,000	13,751,000
Federal TANF	100,000	100,000

Base Level Adjustment. The general fund base is increased by $561,000 in fiscal years 2018 and 2019. The health care access fund base is decreased by $455,000 in fiscal years 2018 and 2019.

Administrative Recovery; Set-Aside. The commissioner may invoice local entities through the SWIFT accounting system as an alternative means to recover the actual cost of administering the following provisions:

(1) Minnesota Statutes, section 125A.744, subdivision 3;

(2) Minnesota Statutes, section 245.495, paragraph (b);

(3) Minnesota Statutes, section 256B.0625, subdivision 20, paragraph (k);

(4) Minnesota Statutes, section 256B.0924, subdivision 6, paragraph (g);

(5) Minnesota Statutes, section 256B.0945, subdivision 4, paragraph (d); and

(6) Minnesota Statutes, section 256F.10, subdivision 6, paragraph (b).

IT Appropriations Generally. This appropriation includes funds for information technology projects, services, and support. Notwithstanding Minnesota Statutes, section 16E.0466, funding for information technology project costs shall be incorporated into the service level agreement and paid

to the Office of MN.IT Services by the Department of Human Services under the rates and mechanism specified in that agreement.

Continued Development of MNsure IT System. The following amounts are appropriated for transfer to the state systems account under Minnesota Statutes, section 256.014:

(1) $5,180,000 in fiscal year 2016 and $2,590,000 in fiscal year 2017 are from the general fund for the state share of Medicaid-allocated costs for the acceleration of the MNsure IT system development project. The general fund base is $3,045,000 each year in fiscal years 2018 and 2019; and

(2) $1,820,000 in fiscal year 2016 and $910,000 in fiscal year 2017 are from the health care access fund for the state share of MinnesotaCare-allocated costs for the acceleration of the MNsure IT system development project. The health care access fund base is $455,000 each year in fiscal years 2018 and 2019.

(b) **Children and Families**

	Appropriations by Fund	
General	11,609,000	11,993,000
Federal TANF	2,582,000	2,582,000

Base Level Adjustment. The general fund base is increased by $31,000 in fiscal years 2018 and 2019.

Financial Institution Data Match and Payment of Fees. The commissioner is authorized to allocate up to $310,000 each year in fiscal year 2016 and fiscal year

2017 from the PRISM special revenue account to make payments to financial institutions in exchange for performing data matches between account information held by financial institutions and the public authority's database of child support obligors as authorized by Minnesota Statutes, section 13B.06, subdivision 7.

(c) **Health Care**

	Appropriations by Fund	
General	15,534,000	16,119,000
Health Care Access	30,174,000	30,216,000

Base Level Adjustment. The general fund base is decreased by $16,000 in fiscal year 2018 and is decreased by $114,000 in fiscal year 2019. The health care access fund base is increased by $1,740,000 in fiscal year 2018 only.

(d) **Continuing Care**

	Appropriations by Fund	
General	31,367,000	29,235,000
State Government Special Revenue	125,000	125,000

Base Level Adjustment. The general fund base is increased by $111,000 in fiscal years 2018 and 2019.

(e) **Chemical and Mental Health**

	Appropriations by Fund	
General	6,855,000	7,270,000
Lottery Prize	160,000	163,000

Base Level Adjustment. The general fund base is decreased by $213,000 in fiscal year 2018 and is decreased by $265,000 in fiscal year 2019.

Subd. 5. **Forecasted Programs**

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) **MFIP/DWP**

	Appropriations by Fund	
General	91,040,000	93,952,000
Federal TANF	86,139,000	82,546,000

(b) **MFIP Child Care Assistance** 99,736,000 107,296,000

(c) **General Assistance** 55,884,000 58,600,000

General Assistance Standard. The commissioner shall set the monthly standard of assistance for general assistance units consisting of an adult recipient who is childless and unmarried or living apart from parents or a legal guardian at $203. The commissioner may reduce this amount according to Laws 1997, chapter 85, article 3, section 54.

Emergency General Assistance. The amount appropriated for emergency general assistance is limited to no more than $6,729,812 in fiscal year 2016 and $6,729,812 in fiscal year 2017. Funds to counties shall be allocated by the commissioner using the allocation method under Minnesota Statutes, section 256D.06.

(d) **Minnesota Supplemental Aid** 39,668,000 40,207,000

(e) **Group Residential Housing** 156,612,000 170,619,000

(f) **Northstar Care for Children** 45,206,000 49,599,000

(g) **MinnesotaCare** 398,264,000 472,748,000

This appropriation is from the health care access fund.

(h) **Medical Assistance**

	Appropriations by Fund		
General	4,887,942,000	5,109,885,000	
Health Care Access	196,186,000	206,650,000	

Critical Access Nursing Facilities. $1,500,000 each fiscal year is for critical access nursing facilities under Minnesota Statutes, section 256B.441, subdivision 63.

(i) **Alternative Care** 43,996,000 43,220,000

Alternative Care Transfer. Any money allocated to the alternative care program that is not spent for the purposes indicated does not cancel but must be transferred to the medical assistance account.

(j) **Chemical Dependency Treatment Fund** 82,454,000 88,983,000

Subd. 6. **Grant Programs**

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) **Support Services Grants**

Appropriations by Fund		
General	13,258,000	8,840,000
Federal TANF	96,311,000	96,311,000

Base Level Adjustment. The general fund base is increased by $227,000 in fiscal years 2018 and 2019.

(b) **Basic Sliding Fee Child Care Assistance Grants** 52,269,000 53,145,000

Basic Sliding Fee Waiting List Allocation. Notwithstanding Minnesota Statutes, section 119B.03, funds appropriated to reduce the basic sliding fee program waiting list in state fiscal year 2016 are allocated as follows:

(1) The calendar year 2016 allocation shall be increased to serve families on the waiting

list. To receive funds appropriated for this purpose, a county must have:

(i) a waiting list in the most recent published waiting list month;

(ii) an average of at least ten families on the most recent six months of published waiting list; and

(iii) total expenditures in calendar year 2014 that met or exceeded 80 percent of the county's available final allocation.

(2) Funds shall be distributed proportionately based on the average of the most recent six months of published waiting lists to counties that meet the criteria in clause (1).

(3) Allocations in calendar years 2017 and beyond shall be calculated using the allocation formula in Minnesota Statutes, section 119B.03.

(4) The guaranteed floor for calendar year 2017 shall be based on the revised calendar year 2016 allocation.

Base Level Adjustment. The general fund base is increased by $3,545,000 in fiscal years 2018 and 2019.

(c) **Child Care Development Grants**	2,600,000	3,347,000
(d) **Child Support Enforcement Grants**	50,000	50,000

(e) **Children's Services Grants**

Appropriations by Fund		
General	14,600,000	14,600,000
Federal TANF	140,000	140,000

Base Level Adjustment. The general fund base is increased by $865,000 in fiscal years 2018 and 2019.

Title IV-E Adoption Assistance. Additional federal reimbursement to the state as a result of the Fostering Connections to Success and Increasing Adoptions Act's expanded eligibility for title IV-E adoption assistance is appropriated to the commissioner for postadoption services, including a parent-to-parent support network.

Adoption Assistance Incentive Grants. Federal funds available during fiscal years 2016 and 2017 for adoption incentive grants are appropriated to the commissioner for these purposes.

(f) **Children and Community Service Grants**	57,701,000	57,701,000

White Earth Band of Ojibwe Human Services. $1,400,000 in fiscal year 2016 and $1,400,000 in fiscal year 2017 are appropriated for a grant to the White Earth Band of Ojibwe for the direct implementation and administrative costs of the White Earth transfer authorized under Laws 2011, First Special Session chapter 9, article 9, section 18. This appropriation is added to the base.

(g) **Children and Economic Support Grants**	23,610,000	23,793,000

Minnesota Food Assistance Program. Unexpended funds for the Minnesota food assistance program for fiscal year 2016 do not cancel but are available for this purpose in fiscal year 2017.

Base Level Adjustment. The general fund base is increased by $209,000 in fiscal year 2018 and is increased by $447,000 in fiscal year 2019.

(h) **Health Care Grants**

	Appropriations by Fund	
General	90,000	640,000
Health Care Access	3,341,000	3,465,000

Base Level Adjustment. The general fund base is increased by $600,000 in fiscal year 2018 only.

(i) **Aging and Adult Services Grants**	27,713,000	27,412,000
(j) **Deaf and Hard-of-Hearing Grants**	1,875,000	1,875,000
(k) **Disabilities Grants**	21,798,000	21,983,000

Transition Populations. $1,551,000 in fiscal year 2016 and $1,725,000 in fiscal year 2017 are appropriated for home and community-based services transition grants to assist in providing home and community-based services and treatment for transition populations under Minnesota Statutes, section 256.478.

(l) **Adult Mental Health Grants**

	Appropriations by Fund	
General	67,392,000	68,244,000
Health Care Access	2,610,000	3,513,000
Lottery Prize	1,733,000	1,733,000

Base Level Adjustment. The general fund base is increased by $3,076,000 in fiscal year 2018 and is increased by $3,376,000 in fiscal year 2019. The health care access fund base is decreased by $2,763,000 in fiscal years 2018 and 2019.

Funding Usage. Up to 75 percent of a fiscal year's appropriation for adult mental health grants may be used to fund allocations in that portion of the fiscal year ending December 31.

Problem Gambling. $225,000 in fiscal year 2016 and $225,000 in fiscal year 2017 are appropriated from the lottery prize fund for a grant to the state affiliate recognized by the National Council on Problem Gambling. The affiliate must provide services to increase public awareness of problem gambling, education, and training for individuals and organizations providing effective treatment services to problem gamblers and their families, and research related to problem gambling.

Assertive Community Treatment. Of the general fund amount, $250,000 for fiscal year 2016 and $500,000 for fiscal year 2017 are for the development of new assertive community treatment services, including a forensic assertive community treatment team, and to enhance the quality of current assertive community treatment services.

Housing with Supports. Of the general fund amount, $825,000 in fiscal year 2016 and $1,723,000 in fiscal year 2017 are for housing with supports for adults with serious mental illness and increasing existing amounts allocated to housing with supports grant funds.

Housing with Supports. Of the health care access fund appropriation, $675,000 in fiscal year 2016 and $1,277,000 in fiscal year 2017 are for housing with supports for adults with serious mental illness and increasing existing amounts allocated to housing with supports grant funds.

Mental Health Crisis Services. Of the health care access fund appropriation, $1,035,000 in fiscal year 2016 and $1,040,000 in fiscal year 2017 are for increasing existing amounts allocated to adult mental health crisis grants.

Sustainability Grants. $2,125,000 in fiscal year 2016 and $2,125,000 in fiscal year 2017 are for sustainability grants under Minnesota Statutes, section 256B.0622, subdivision 11.

(m) **Child Mental Health Grants** 21,921,000 23,188,000

Early Childhood Mental Health Grants. $922,000 in fiscal year 2017 is for increasing existing amounts allocated to early childhood intervention grant funding to provide mental health consultation.

Mental Health Crisis Services. $1,035,000 in fiscal year 2016 and $1,040,000 in fiscal year 2017 are for increasing existing amounts allocated to children's mental health crisis grants.

Respite Care. $250,000 in fiscal year 2016 and $500,000 in fiscal year 2017 are for increasing existing amounts allocated to children's mental health respite care grants.

Services and Supports for First Episode Psychosis. $90,000 for fiscal year 2017 is for grants to mental health providers to pilot evidence-based interventions for youth at risk of developing or experiencing a first episode of psychosis and for a public awareness campaign on the signs and symptoms of psychosis.

Base Level Adjustment. The general fund base is increased by $1,324,000 in fiscal year

2018 and is increased by $1,689,000 in fiscal year 2019.

Funding Usage. Up to 75 percent of a fiscal year's appropriation for child mental health grants may be used to fund allocations in that portion of the fiscal year ending December 31.

(n) **Chemical Dependency Treatment Support Grants** 1,161,000 1,161,000

Subd. 7. **DCT State-Operated Services**

Transfer Authority for State-Operated Services. Money appropriated for state-operated services may be transferred between fiscal years of the biennium with the approval of the commissioner of management and budget.

The amounts that may be spent from the appropriation for each purpose are as follows:

(a) **DCT State-Operated Services Mental Health** 126,244,000 125,065,000

Base Level Adjustment. The general fund base is increased by $5,351,000 in fiscal year 2018 and is increased by $10,701,000 in fiscal year 2019.

Dedicated Receipts Available. Of the revenue received under Minnesota Statutes, section 246.18, subdivision 8, paragraph (a), up to $1,000,000 each year is available for the purposes of Minnesota Statutes, section 246.18, subdivision 8, paragraph (b), clause (1); up to $1,000,000 each year is available to transfer to the adult mental health grants budget activity for the purposes of Minnesota Statutes, section 246.18, subdivision 8, paragraph (b), clause (2); and

up to $2,713,000 each year is available for the purposes of Minnesota Statutes, section 246.18, subdivision 8, paragraph (b), clause (3).

Public Psychiatric Residency Collaboration. $118,000 in fiscal year 2016 and $236,000 in fiscal year 2017 are for paying psychiatric resident stipends for residents enrolled in the University of Minnesota psychiatry residency program. This appropriation is added to the base.

(b) **DCT State-Operated Services Enterprise Services**	6,031,000	1,799,000

Base Level Adjustment. The general fund base is decreased by $1,023,000 in fiscal years 2018 and 2019.

Community Addiction Recovery Enterprise (C.A.R.E.). $6,031,000 in fiscal year 2016 and $1,799,000 in fiscal year 2017 are for the Community Addiction Recovery Enterprise (C.A.R.E.) program. The commissioner must transfer $6,031,000 in fiscal year 2016 and $1,799,000 in fiscal year 2017 to the enterprise fund for the Community Addiction Recovery Enterprise.

(c) **DCT State-Operated Services Minnesota Security Hospital**	81,647,000	82,862,000
Subd. 8. **DCT Minnesota Sex Offender Program**	86,473,000	89,464,000

Individual Evaluations of MSOP Client. $1,487,000 in fiscal year 2016 and $1,487,000 in fiscal year 2017 are to conduct biennial individual evaluations of MSOP clients on statutory criteria for reduction in custody. This appropriation is added to the base.

Transfer Authority for Minnesota Sex Offender Program. Money appropriated for the Minnesota sex offender program may be transferred between fiscal years of the biennium with the approval of the commissioner of management and budget.

Limited Carryforward Allowed. Notwithstanding any contrary provision in this article, of this appropriation, up to $875,000 in fiscal year 2016 and $2,625,000 in fiscal year 2017 are available until June 30, 2019.

Base Level Adjustment. The general fund base is decreased by $2,625,000 in fiscal years 2018 and 2019.

Subd. 9. **Technical Activities** 81,471,000 82,327,000

This appropriation is from the federal TANF fund.

Base Level Adjustment. The federal TANF fund base is increased by $204,000 in fiscal year 2018 and is increased by $192,000 in fiscal year 2019.

Sec. 3. **COMMISSIONER OF HEALTH**

Subdivision 1. **Total Appropriation** **$ 175,960,000 $ 177,528,000**

Appropriations by Fund

	2016	2017
General	80,318,000	81,921,000
State Government Special Revenue	55,092,000	55,562,000
Health Care Access	28,837,000	28,332,000
Federal TANF	11,713,000	11,713,000

The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **Health Improvement**

	Appropriations by Fund	
General	59,602,000	61,062,000
State Government Special Revenue	6,261,000	6,179,000
Health Care Access	28,837,000	28,332,000
Federal TANF	11,713,000	11,713,000

Local and Tribal Public Health Grants. (a) $894,000 in fiscal year 2016 and $894,000 in fiscal year 2017 are for an increase in local public health grants for community health boards under Minnesota Statutes, section 145A.131, subdivision 1, paragraph (e).

(b) $106,000 in fiscal year 2016 and $106,000 in fiscal year 2017 are for an increase in special grants to tribal governments under Minnesota Statutes, section 145A.14, subdivision 2a.

Evidence-Based Home Visiting. $650,000 in fiscal year 2016 and $2,000,000 in fiscal year 2017 from the general fund are for competitive evidence-based home visiting grants to community health boards and tribal governments under Minnesota Statutes, section 145A.17.

Family Planning Special Projects. $1,000,000 in fiscal year 2016 and $1,000,000 in fiscal year 2017 from the general fund are for family planning special project grants under Minnesota Statutes, section 145.925.

TANF Appropriations. (a) $1,156,000 of the TANF funds is appropriated each year of the biennium to the commissioner for family

planning grants under Minnesota Statutes, section 145.925.

(b) $3,579,000 of the TANF funds is appropriated each year of the biennium to the commissioner for home visiting and nutritional services listed under Minnesota Statutes, section 145.882, subdivision 7, clauses (6) and (7). Funds must be distributed to community health boards according to Minnesota Statutes, section 145A.131, subdivision 1, paragraph (a).

(c) $2,000,000 of the TANF funds is appropriated each year of the biennium to the commissioner for decreasing racial and ethnic disparities in infant mortality rates under Minnesota Statutes, section 145.928, subdivision 7.

(d) $4,978,000 of the TANF funds is appropriated each year of the biennium to the commissioner for the family home visiting grant program according to Minnesota Statutes, section 145A.17. $4,000,000 of the funding must be distributed to community health boards according to Minnesota Statutes, section 145A.131, subdivision 1, paragraph (a). $978,000 of the funding must be distributed to tribal governments based on Minnesota Statutes, section 145A.14, subdivision 2a.

(e) The commissioner may use up to 6.23 percent of the funds appropriated each fiscal year to conduct the ongoing evaluations required under Minnesota Statutes, section 145A.17, subdivision 7, and training and technical assistance as required under

Minnesota Statutes, section 145A.17, subdivisions 4 and 5.

TANF Carryforward. Any unexpended balance of the TANF appropriation in the first year of the biennium does not cancel but is available for the second year.

Base Level Adjustments. The general fund base is reduced by $50,000 in fiscal year 2018. The state government special revenue fund base is increased by $33,000 in fiscal year 2018. The health care access fund base is increased by $600,000 in fiscal year 2018.

Subd. 3. **Health Protection**

	Appropriations by Fund	
General	12,506,000	12,635,000
State Government Special Revenue	48,831,000	49,383,000

Base Level Adjustments. The state government special revenue fund base is increased by $70,000 in fiscal year 2018 and is increased by $43,000 in fiscal year 2019.

Subd. 4. **Administrative Support Services** 8,210,000 8,224,000

Sec. 4. **HEALTH-RELATED BOARDS**

Subdivision 1. **Total Appropriation** **$ 19,707,000 $ 19,597,000**

This appropriation is from the state government special revenue fund. The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **Board of Chiropractic Examiners** 507,000 513,000

Subd. 3. **Board of Dentistry** 2,192,000 2,206,000

This appropriation includes $864,000 in fiscal year 2016 and $878,000 in fiscal year 2017 for the health professional services program.

Subd. 4. **Board of Dietetics and Nutrition Practice**	113,000	115,000
Subd. 5. **Board of Marriage and Family Therapy**	234,000	237,000
Subd. 6. **Board of Medical Practice**	3,933,000	3,962,000
Subd. 7. **Board of Nursing**	4,189,000	4,243,000
Subd. 8. **Board of Nursing Home Administrators**	2,365,000	2,062,000

Administrative Services Unit - Operating Costs. Of this appropriation, $1,482,000 in fiscal year 2016 and $1,497,000 in fiscal year 2017 are for operating costs of the administrative services unit. The administrative services unit may receive and expend reimbursements for services performed by other agencies.

Administrative Services Unit - Volunteer Health Care Provider Program. Of this appropriation, $150,000 in fiscal year 2016 and $150,000 in fiscal year 2017 are to pay for medical professional liability coverage required under Minnesota Statutes, section 214.40.

Administrative Services Unit - Retirement Costs. Of this appropriation, $320,000 in fiscal year 2016 is a onetime appropriation to the administrative services unit to pay for the retirement costs of health-related board employees. This funding may be transferred to the health board incurring the retirement costs. These funds are available either year of the biennium.

Administrative Services Unit - Contested Cases and Other Legal Proceedings. Of this appropriation, $200,000 in fiscal year

2016 and $200,000 in fiscal year 2017 are for costs of contested case hearings and other unanticipated costs of legal proceedings involving health-related boards funded under this section. Upon certification by a health-related board to the administrative services unit that the costs will be incurred and that there is insufficient money available to pay for the costs out of money currently available to that board, the administrative services unit is authorized to transfer money from this appropriation to the board for payment of those costs with the approval of the commissioner of management and budget.

Subd. 9. **Board of Optometry**	138,000	143,000
Subd. 10. **Board of Pharmacy**	2,847,000	2,888,000
Subd. 11. **Board of Physical Therapy**	354,000	359,000
Subd. 12. **Board of Podiatry**	78,000	79,000
Subd. 13. **Board of Psychology**	874,000	884,000
Subd. 14. **Board of Social Work**	1,141,000	1,155,000
Subd. 15. **Board of Veterinary Medicine**	262,000	265,000
Subd. 16. **Board of Behavioral Health and Therapy**	480,000	486,000

Sec. 5. **EMERGENCY MEDICAL SERVICES REGULATORY BOARD** **$** **2,872,000** **$** **3,006,000**

Regional Grants. $585,000 in fiscal year 2016 and $585,000 in fiscal year 2017 are for regional emergency medical services programs, to be distributed equally to the eight emergency medical service regions.

Cooper/Sams Volunteer Ambulance Program. $700,000 in fiscal year 2016 and

$700,000 in fiscal year 2017 are for the Cooper/Sams volunteer ambulance program under Minnesota Statutes, section 144E.40.

(a) Of this amount, $611,000 in fiscal year 2016 and $611,000 in fiscal year 2017 are for the ambulance service personnel longevity award and incentive program under Minnesota Statutes, section 144E.40.

(b) Of this amount, $89,000 in fiscal year 2016 and $89,000 in fiscal year 2017 are for the operations of the ambulance service personnel longevity award and incentive program under Minnesota Statutes, section 144E.40.

Ambulance Training Grant. $361,000 in fiscal year 2016 and $361,000 in fiscal year 2017 are for training grants.

EMSRB Board Operations. $1,226,000 in fiscal year 2016 and $1,360,000 in fiscal year 2017 are for board operations.

Sec. 6. **COUNCIL ON DISABILITY** **$ 622,000 $ 629,000**

Sec. 7. **OMBUDSMAN FOR MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES** **$ 2,097,000 $ 2,217,000**

Sec. 8. **OMBUDSPERSONS FOR FAMILIES** **$ 392,000 $ 453,000**

Sec. 9. Minnesota Statutes 2014, section 256.01, is amended by adding a subdivision to read:

Subd. 40. **Nonfederal share transfers.** The nonfederal share of activities for which federal administrative reimbursement is appropriated to the commissioner may be transferred to the special revenue fund.

Sec. 10. **TRANSFERS.**

Subdivision 1. **Grants.** The commissioner of human services, with the approval of the commissioner of management and budget, may transfer unencumbered appropriation balances for the biennium ending June 30, 2017, within fiscal years among the MFIP, general assistance, general assistance medical care under Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 3, medical assistance, MinnesotaCare, MFIP child care assistance under Minnesota Statutes, section 119B.05, Minnesota supplemental aid, and group residential housing programs, the entitlement portion of Northstar Care for Children under Minnesota Statutes, chapter 256N, and the entitlement portion of the chemical dependency consolidated treatment fund, and between fiscal years of the biennium. The commissioner shall inform the chairs and ranking minority members of the senate Health and Human Services Finance Division and the house of representatives Health and Human Services Finance Committee quarterly about transfers made under this subdivision.

Subd. 2. **Administration.** Positions, salary money, and nonsalary administrative money may be transferred within the Departments of Health and Human Services as the commissioners consider necessary, with the advance approval of the commissioner of management and budget. The commissioner shall inform the chairs and ranking minority members of the senate Health and Human Services Finance Division and the house of representatives Health and Human Services Finance Committee quarterly about transfers made under this subdivision.

Sec. 11. **INDIRECT COSTS NOT TO FUND PROGRAMS.**

The commissioners of health and human services shall not use indirect cost allocations to pay for the operational costs of any program for which they are responsible.

Sec. 12. **EXPIRATION OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires on June 30, 2017, unless a different expiration date is explicit.

Sec. 13. **EFFECTIVE DATE.**

This article is effective July 1, 2015, unless a different effective date is specified.

APPENDIX
Article locations in S0825-1

124D.142 QUALITY RATING AND IMPROVEMENT SYSTEM.

(a) There is established a quality rating and improvement system (QRIS) framework to ensure that Minnesota's children have access to high-quality early learning and care programs in a range of settings so that they are fully ready for kindergarten by 2020. Creation of a standards-based voluntary quality rating and improvement system includes:

(1) quality opportunities in order to improve the educational outcomes of children so that they are ready for school. The framework shall be based on the Minnesota quality rating system rating tool and a common set of child outcome and program standards and informed by evaluation results;

(2) a tool to increase the number of publicly funded and regulated early learning and care services in both public and private market programs that are high quality. If a program or provider chooses to participate, the program or provider will be rated and may receive public funding associated with the rating. The state shall develop a plan to link future early learning and care state funding to the framework in a manner that complies with federal requirements; and

(3) tracking progress toward statewide access to high-quality early learning and care programs, progress toward the number of low-income children whose parents can access quality programs, and progress toward increasing the number of children who are fully prepared to enter kindergarten.

(b) In planning a statewide quality rating and improvement system framework in paragraph (a), the state shall use evaluation results of the Minnesota quality rating system rating tool in use in fiscal year 2008 to recommend:

(1) a framework of a common set of child outcome and program standards for a voluntary statewide quality rating and improvement system;

(2) a plan to link future funding to the framework described in paragraph (a), clause (2); and

(3) a plan for how the state will realign existing state and federal administrative resources to implement the voluntary quality rating and improvement system framework. The state shall provide the recommendation in this paragraph to the early childhood education finance committees of the legislature by March 15, 2011.

(c) Prior to the creation of a statewide quality rating and improvement system in paragraph (a), the state shall employ the Minnesota quality rating system rating tool in use in fiscal year 2008 in the original Minnesota Early Learning Foundation pilot areas and additional pilot areas supported by private or public funds with its modification as a result of the evaluation results of the pilot project.

256.969 PAYMENT RATES.

Subd. 30. **Payment rates for births.** (a) For admissions occurring on or after November 1, 2014, the total operating and property payment rate, excluding disproportionate population adjustment, for the following diagnosis-related groups, as they fall within the APR-DRG categories: (1) 5601, 5602, 5603, 5604 vaginal delivery; and (2) 5401, 5402, 5403, 5404 cesarean section, shall be no greater than $3,528.

(b) The rates described in this subdivision do not include newborn care.

(c) Payments to managed care and county-based purchasing plans under section 256B.69, 256B.692, or 256L.12 shall be reduced for services provided on or after October 1, 2009, to reflect the adjustments in paragraph (a).

(d) Prior authorization shall not be required before reimbursement is paid for a cesarean section delivery.

256B.69 PREPAID HEALTH PLANS.

Subd. 32. **Initiatives to reduce incidence of low birth weight.** The commissioner shall require managed care and county-based purchasing plans, as a condition of contract, to implement strategies to reduce the incidence of low birth weight in geographic areas identified by the commissioner as having a higher than average incidence of low birth weight. The strategies must coordinate health care with social services and the local public health system. Each plan shall develop and report to the commissioner outcome measures related to reducing the incidence of

low birth weight. The commissioner shall consider the outcomes reported when considering plan participation in the competitive bidding program established under subdivision 33.

256L.02 PROGRAM ADMINISTRATION.

Subd. 3. **Financial management.** (a) The commissioner shall manage spending for the MinnesotaCare program in a manner that maintains a minimum reserve. As part of each state revenue and expenditure forecast, the commissioner must make an assessment of the expected expenditures for the covered services for the remainder of the current biennium and for the following biennium. The estimated expenditure, including the reserve, shall be compared to an estimate of the revenues that will be available in the health care access fund. Based on this comparison, and after consulting with the chairs of the house of representatives Ways and Means Committee and the senate Finance Committee, the commissioner shall, as necessary, make the adjustments specified in paragraph (b) to ensure that expenditures remain within the limits of available revenues for the remainder of the current biennium and for the following biennium. The commissioner shall not hire additional staff using appropriations from the health care access fund until the commissioner of management and budget makes a determination that the adjustments implemented under paragraph (b) are sufficient to allow MinnesotaCare expenditures to remain within the limits of available revenues for the remainder of the current biennium and for the following biennium.

(b) The adjustments the commissioner shall use must be implemented in this order: first, stop enrollment of single adults and households without children; second, upon 45 days' notice, stop coverage of single adults and households without children already enrolled in the MinnesotaCare program; third, upon 90 days' notice, decrease the premium subsidy amounts by ten percent for families with gross annual income above 200 percent of the federal poverty guidelines; fourth, upon 90 days' notice, decrease the premium subsidy amounts by ten percent for families with gross annual income at or below 200 percent; and fifth, require applicants to be uninsured for at least six months prior to eligibility in the MinnesotaCare program. If these measures are insufficient to limit the expenditures to the estimated amount of revenue, the commissioner shall further limit enrollment or decrease premium subsidies.

256L.05 APPLICATION PROCEDURES.

Subd. 1b. **MinnesotaCare enrollment by county agencies.** Beginning September 1, 2006, county agencies shall enroll single adults and households with no children formerly enrolled in general assistance medical care in MinnesotaCare according to Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 3. County agencies shall perform all duties necessary to administer the MinnesotaCare program ongoing for these enrollees, including the redetermination of MinnesotaCare eligibility at renewal.

Subd. 1c. **Open enrollment and streamlined application and enrollment process.**

Subd. 3c. **Retroactive coverage.** Notwithstanding subdivision 3, the effective date of coverage shall be the first day of the month following termination from medical assistance for families and individuals who are eligible for MinnesotaCare and who submitted a written request for retroactive MinnesotaCare coverage with a completed application within 30 days of the mailing of notification of termination from medical assistance. The applicant must provide all required verifications within 30 days of the written request for verification. For retroactive coverage, premiums must be paid in full for any retroactive month, current month, and next month within 30 days of the premium billing. This subdivision does not apply, and shall not be implemented by the commissioner, once eligibility determination for MinnesotaCare is conducted by the MNsure eligibility determination system.

Subd. 5. **Availability of private insurance.** The commissioner, in consultation with the commissioners of health and commerce, shall provide information regarding the availability of private health insurance coverage and the possibility of disenrollment under section 256L.07, subdivision 1, to all: (1) families enrolled in the MinnesotaCare program whose gross family income is equal to or more than 225 percent of the federal poverty guidelines; and (2) single adults and households without children enrolled in the MinnesotaCare program whose gross family income is equal to or more than 165 percent of the federal poverty guidelines. This information must be provided upon initial enrollment and annually thereafter. The commissioner shall also include information regarding the availability of private health insurance coverage in the notice of ineligibility provided to persons subject to disenrollment under section 256L.07, subdivision 1.

8840.5900 DRIVER QUALIFICATIONS.

Subp. 12. **Criminal record.** A driver must not have a criminal record for which the person was convicted of or pled guilty to, either crimes against persons or crimes reasonably related to providing special transportation services.

A. For purposes of this subpart, "criminal record" means the conviction records of the Minnesota Bureau of Criminal Apprehension or other states' criminal history repository in which the last date of discharge from the criminal justice system is less than 15 years.

B. Conviction has the meaning given it in Minnesota Statutes, section 171.01, subdivision 29.

C. Criminal record and driving record includes a conviction, suspension, cancellation, or revocation for a crime in another jurisdiction that would be a violation under this part.

D. The following offenses are considered crimes against persons or reasonably related to providing special transportation services, or both:

(1) Minnesota Statutes, section 609.17, attempts;

(2) Minnesota Statutes, section 609.175, conspiracy;

(3) Minnesota Statutes, section 609.185, murder in the first degree;

(4) Minnesota Statutes, section 609.19, murder in the second degree;

(5) Minnesota Statutes, section 609.195, murder in the third degree;

(6) Minnesota Statutes, section 609.20, manslaughter in the first degree;

(7) Minnesota Statutes, section 609.205, manslaughter in the second degree;

(8) Minnesota Statutes, section 609.2112, 609.2113, or 609.2114, or Minnesota Statutes 2012, section 609.21, criminal vehicular homicide and injury;

(9) Minnesota Statutes, section 609.215, suicide;

(10) Minnesota Statutes, section 609.221, assault in the first degree;

(11) Minnesota Statutes, section 609.222, assault in the second degree;

(12) Minnesota Statutes, section 609.223, assault in the third degree;

(13) Minnesota Statutes, section 609.2231, assault in the fourth degree;

(14) Minnesota Statutes, section 609.224, assault in the fifth degree;

(15) Minnesota Statutes, section 609.228, great bodily harm caused by distribution of drugs;

(16) Minnesota Statutes, section 609.23, mistreatment of persons confined;

(17) Minnesota Statutes, section 609.231, mistreatment of residents or patients;

(18) Minnesota Statutes, section 609.235, use of drugs to injure or facilitate crime;

(19) Minnesota Statutes, section 609.24, simple robbery;

(20) Minnesota Statutes, section 609.245, aggravated robbery;

(21) Minnesota Statutes, section 609.25, kidnapping;

(22) Minnesota Statutes, section 609.255, false imprisonment;

(23) Minnesota Statutes, section 609.265, abduction;

(24) Minnesota Statutes, section 609.2661, murder of an unborn child in the first degree;

(25) Minnesota Statutes, section 609.2662, murder of an unborn child in the second degree;

(26) Minnesota Statutes, section 609.2663, murder of an unborn child in the third degree;

(27) Minnesota Statutes, section 609.2664, manslaughter of an unborn child in the first degree;

(28) Minnesota Statutes, section 609.2665, manslaughter of an unborn child in the second degree;

(29) Minnesota Statutes, section 609.267, assault of an unborn child in the first degree;

(30) Minnesota Statutes, section 609.2671, assault of an unborn child in the second degree;

(31) Minnesota Statutes, section 609.2672, assault of an unborn child in the third degree;

(32) Minnesota Statutes, section 609.268, injury or death of an unborn child in the commission of a crime;

(33) Minnesota Statutes, section 609.322, solicitation, inducement, and promotion of prostitution;

(34) Minnesota Statutes, section 609.323, receiving profit from prostitution;

(35) Minnesota Statutes, section 609.324, subdivisions 1 and 1a, other prohibited acts;

(36) Minnesota Statutes, section 609.33, disorderly house;

(37) Minnesota Statutes, section 609.342, criminal sexual conduct in the first degree;

(38) Minnesota Statutes, section 609.343, criminal sexual conduct in the second degree;

(39) Minnesota Statutes, section 609.344, criminal sexual conduct in the third degree;

(40) Minnesota Statutes, section 609.345, criminal sexual conduct in the fourth degree;

(41) Minnesota Statutes, section 609.3451, criminal sexual conduct in the fifth degree;

(42) Minnesota Statutes, section 609.352, solicitation of children to engage in sexual conduct;

(43) Minnesota Statutes, section 609.365, incest;

(44) Minnesota Statutes, section 609.377, malicious punishment of a child;

(45) Minnesota Statutes, section 609.378, neglect or endangerment of a child;

(46) Minnesota Statutes, section 609.498, tampering with a witness;

(47) Minnesota Statutes, section 609.52, felony theft;

(48) Minnesota Statutes, section 609.561, arson in the first degree;

(49) Minnesota Statutes, section 609.582, subdivisions 1 and 2, burglary;

(50) Minnesota Statutes, section 609.713, terroristic threats;

(51) Minnesota Statutes, section 609.749, nonfelony, harassment and stalking;

(52) Minnesota Statutes, section 617.23, indecent exposure;

(53) Minnesota Statutes, section 617.241, obscene materials and performances;

(54) Minnesota Statutes, section 617.243, indecent literature, distribution;

(55) Minnesota Statutes, section 617.246, use of minors in sexual performance;

(56) Minnesota Statutes, section 617.247, possession of pictorial representations of minors;

(57) Minnesota Statutes, section 617.293, harmful materials; dissemination and display to minors; and

(58) felony convictions under Minnesota Statutes, chapter 152, prohibited drugs.

8840.5900 DRIVER QUALIFICATIONS.

Subp. 14. **Provider responsibility; driver's traffic and criminal record.** Before using or hiring a driver to provide special transportation service, a provider must obtain and review the driving and criminal records of a driver. In addition, a provider shall annually review the driving and criminal record of a driver it uses or employs.

A. The driving and criminal record review must include an examination of the records of the Department of Public Safety, Division of Driver and Vehicle Services, to determine if the driver meets the standards of subparts 9, 10, and 11. The review must also include an examination of the conviction records of the Minnesota Bureau of Criminal Apprehension to determine if the driver has a criminal record of convictions for crimes listed in subpart 12.

B. A provider satisfies the requirements of this subpart by obtaining a background check from the Minnesota Bureau of Criminal Apprehension. A private business or local law enforcement agency may be used for conducting the criminal background check if the review consists of an examination of the records of the Minnesota Bureau of Criminal Apprehension.

C. If a person has resided in Minnesota for less than ten years, the provider shall also conduct a search of the criminal history repository records in each state where the person has resided for the preceding ten years.

D. If a person has held a driver's license in a state other than Minnesota for the preceding three years, the provider shall review the driving record in each state where the person has held a driver's license for the preceding three-year period.