ARTICLE 1

CHILDREN AND FAMILIES

Section 1. Minnesota Statutes 2014, section 119B.13, subdivision 1, is amended to read:

Subdivision 1. **Subsidy restrictions.** (a) Beginning ~~February 3, 2014~~ January 2, 2017, the maximum rate paid for child care assistance in any county or county price cluster under the child care fund shall be the ~~greater of the 25th percentile of the 2011 child care provider rate survey or the maximum rate effective November 28, 2011~~ rate for like-care arrangements effective February 3, 2014, increased by seven percent. The commissioner may: (1) assign a county with no reported provider prices to a similar price cluster; and (2) consider county level access when determining final price clusters.

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

(c) The department shall monitor the effect of this paragraph on provider rates. The county shall pay the provider's full charges for every child in care up to the maximum established. The commissioner shall determine the maximum rate for each type of care on an hourly, full-day, and weekly basis, including special needs and disability care. The maximum payment to a provider for one day of care must not exceed the daily rate. The maximum payment to a provider for one week of care must not exceed the weekly rate.

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

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

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

(g) Notwithstanding Minnesota Rules, part 3400.0130, subpart 7, maximum registration fees in effect on January 1, 2013, shall remain in effect.

Sec. 2. Minnesota Statutes 2014, section 145.4716, subdivision 2, is amended to read:

Subd. 2. **Duties of director.** The director of child sex trafficking prevention is responsible for the following:

(1) developing and providing comprehensive training on sexual exploitation of youth for social service professionals, medical professionals, public health workers, and criminal justice professionals;

(2) collecting, organizing, maintaining, and disseminating information on sexual exploitation and services across the state, including maintaining a list of resources on the Department of Health Web site;

(3) monitoring and applying for federal funding for antitrafficking efforts that may benefit victims in the state;

(4) managing grant programs established under sections 145.4716 to 145.4718, and 609.3241, paragraph (c), clause (3);

(5) managing the request for proposals for grants for comprehensive services, including trauma-informed, culturally specific services;

(6) identifying best practices in serving sexually exploited youth, as defined in section 260C.007, subdivision 31;

(7) providing oversight of and technical support to regional navigators pursuant to section 145.4717;

(8) conducting a comprehensive evaluation of the statewide program for safe harbor of sexually exploited youth; and

(9) developing a policy consistent with the requirements of chapter 13 for sharing data related to sexually exploited youth, as defined in section 260C.007, subdivision 31, among regional navigators and community-based advocates.

Sec. 3. Minnesota Statutes 2014, section 145.4716, is amended by adding a subdivision to read:

Subd. 3. **Youth eligible for services.** Youth 24 years of age or younger shall be eligible for all services, support, and programs provided under this section and section 145.4717, and all shelter, housing beds, and services provided by the commissioner of human services to sexually exploited youth and youth at risk of sexual exploitation.

Sec. 4. Minnesota Statutes 2014, section 245A.10, subdivision 2, is amended to read:

Subd. 2. **County fees for background studies and licensing inspections.** (a) Before the implementation of NETStudy 2.0, for purposes of family and group family child care licensing under this chapter, a county agency may charge a fee to an applicant or license holder to recover the actual cost of background studies, but in any case not to exceed $100 annually. A county agency may also charge a license fee to an applicant or license holder not to exceed $50 for a one-year license or $100 for a two-year license.

(b) Before the implementation of NETStudy 2.0, a county agency may charge a fee to a legal nonlicensed child care provider or applicant for authorization to recover the

actual cost of background studies completed under section 119B.125, but in any case not to exceed $100 annually.

(c) Counties may elect to reduce or waive the fees in paragraph (a) or (b):

(1) in cases of financial hardship;

(2) if the county has a shortage of providers in the county's area;

(3) for new providers; or

(4) for providers who have attained at least 16 hours of training before seeking initial licensure.

(d) Counties may allow providers to pay the applicant fees in paragraph (a) or (b) on an installment basis for up to one year. If the provider is receiving child care assistance payments from the state, the provider may have the fees under paragraph (a) or (b) deducted from the child care assistance payments for up to one year and the state shall reimburse the county for the county fees collected in this manner.

(e) For purposes of adult foster care and child foster care licensing, and licensing the physical plant of a community residential setting, under this chapter, a county agency may charge a fee to a corporate applicant or corporate license holder to recover the actual cost of licensing inspections, not to exceed $500 annually.

(f) Counties may elect to reduce or waive the fees in paragraph (e) under the following circumstances:

(1) in cases of financial hardship;

(2) if the county has a shortage of providers in the county's area; or

(3) for new providers.

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

Subd. 6a. **Nonlicensed child care programs.** Beginning October 1, 2017, the commissioner shall conduct background studies on any individual required under section 119B.125 to have a background study completed under this chapter.

Sec. 6. Minnesota Statutes 2014, section 245C.04, subdivision 1, is amended to read:

Subdivision 1. **Licensed programs.** (a) The commissioner shall conduct a background study of an individual required to be studied under section 245C.03, subdivision 1, at least upon application for initial license for all license types.

(b) Effective October 1, 2017, the commissioner shall conduct a background study of an individual ~~required to be studied~~ specified under section 245C.03~~, subdivision 1~~, who is newly affiliated with the license holder. ~~at reapplication for a license for family~~

~~child care.~~ From October 1, 2017, to September 30, 2019, the commissioner shall conduct a background study of individuals required to be studied under section 245C.03, at the time of reapplication for a family child care license.

(1) The individual shall provide information required under section 245C.05, subdivision 1, paragraphs (a), (b), and (d), to the county agency.

(2) The county agency shall provide the commissioner with the information received under clause (1) to complete the background study.

(3) The background study conducted by the commissioner under this paragraph must include a review of the information required under section 245C.08.

(c) The commissioner is not required to conduct a study of an individual at the time of reapplication for a license if the individual's background study was completed by the commissioner of human services and the following conditions are met:

(1) a study of the individual was conducted either at the time of initial licensure or when the individual became affiliated with the license holder;

(2) the individual has been continuously affiliated with the license holder since the last study was conducted; and

(3) the last study of the individual was conducted on or after October 1, 1995.

(d) The commissioner of human services shall conduct a background study of an individual specified under section 245C.03, subdivision 1, paragraph (a), clauses (2) to (6), who is newly affiliated with a child foster care license holder. The county or private agency shall collect and forward to the commissioner the information required under section 245C.05, subdivisions 1 and 5. The background study conducted by the commissioner of human services under this paragraph must include a review of the information required under section 245C.08, subdivisions 1, 3, and 4.

(e) The commissioner shall conduct a background study of an individual specified under section 245C.03, subdivision 1, paragraph (a), clauses (2) to (6), who is newly affiliated with an adult foster care or family adult day services and effective October 1, 2017, with a family child care license holder or a legal nonlicensed child care provider authorized under chapter 119B: (1) the county shall collect and forward to the commissioner the information required under section 245C.05, subdivision 1, paragraphs (a) and (b), and subdivision 5, paragraphs (a) ~~and~~, (b), and (d), for background studies conducted by the commissioner for all family adult day services ~~and~~, for adult foster care when the adult foster care license holder resides in the adult foster care residence, and for family child care and legal nonlicensed child care authorized under chapter 119B; (2) the license holder shall collect and forward to the commissioner the information required under section 245C.05, subdivisions 1, paragraphs (a) and (b); and 5, paragraphs (a) and (b), for background

studies conducted by the commissioner for adult foster care when the license holder does not reside in the adult foster care residence; and (3) the background study conducted by the commissioner under this paragraph must include a review of the information required under section 245C.08, subdivision 1, paragraph (a), and subdivisions 3 and 4.

(f) Applicants for licensure, license holders, and other entities as provided in this chapter must submit completed background study requests to the commissioner using the electronic system known as NETStudy before individuals specified in section 245C.03, subdivision 1, begin positions allowing direct contact in any licensed program.

(g) For an individual who is not on the entity's active roster, the entity must initiate a new background study through NETStudy when:

(1) an individual returns to a position requiring a background study following an absence of 120 or more consecutive days; or

(2) a program that discontinued providing licensed direct contact services for 120 or more consecutive days begins to provide direct contact licensed services again.

The license holder shall maintain a copy of the notification provided to the commissioner under this paragraph in the program's files. If the individual's disqualification was previously set aside for the license holder's program and the new background study results in no new information that indicates the individual may pose a risk of harm to persons receiving services from the license holder, the previous set-aside shall remain in effect.

(h) For purposes of this section, a physician licensed under chapter 147 is considered to be continuously affiliated upon the license holder's receipt from the commissioner of health or human services of the physician's background study results.

(i) For purposes of family child care, a substitute caregiver must receive repeat background studies at the time of each license renewal.

(j) A repeat background study at the time of license renewal is not required if the substitute caregiver's background study was completed by the commissioner on or after October 1, 2017, and the substitute caregiver is on the license holder's active roster in NETStudy 2.0.

Sec. 7. Minnesota Statutes 2014, section 245C.05, subdivision 2b, is amended to read:

Subd. 2b. **County agency to collect and forward information to commissioner.** (a) For background studies related to all family adult day services and to adult foster care when the adult foster care license holder resides in the adult foster care residence, the county agency must collect the information required under subdivision 1 and forward it to the commissioner.

(b) Effective October 1, 2017, for background studies related to family child care and legal nonlicensed child care authorized under chapter 119B, the county agency must collect the information required under subdivision 1 and provide it to the commissioner.

Sec. 8. Minnesota Statutes 2014, section 245C.05, subdivision 4, is amended to read:

Subd. 4. **Electronic transmission.** (a) For background studies conducted by the Department of Human Services, the commissioner shall implement a secure system for the electronic transmission of:

(1) background study information to the commissioner;

(2) background study results to the license holder;

(3) background study results to county and private agencies for background studies conducted by the commissioner for child foster care; and

(4) background study results to county agencies for background studies conducted by the commissioner for adult foster care and family adult day services and, effective October 1, 2017, family child care and legal nonlicensed child care authorized under chapter 119B.

(b) Unless the commissioner has granted a hardship variance under paragraph (c), a license holder or an applicant must use the electronic transmission system known as NETStudy or NETStudy 2.0 to submit all requests for background studies to the commissioner as required by this chapter.

(c) A license holder or applicant whose program is located in an area in which high-speed Internet is inaccessible may request the commissioner to grant a variance to the electronic transmission requirement.

Sec. 9. Minnesota Statutes 2014, section 245C.05, subdivision 7, is amended to read:

Subd. 7. **Probation officer and corrections agent.** (a) A probation officer or corrections agent shall notify the commissioner of an individual's conviction if the individual:

(1) has been affiliated with a program or facility regulated by the Department of Human Services or Department of Health, a facility serving children or youth licensed by the Department of Corrections, or any type of home care agency or provider of personal care assistance services within the preceding year; and

(2) has been convicted of a crime constituting a disqualification under section 245C.14.

(b) For the purpose of this subdivision, "conviction" has the meaning given it in section 609.02, subdivision 5.

(c) The commissioner, in consultation with the commissioner of corrections, shall develop forms and information necessary to implement this subdivision and shall provide the forms and information to the commissioner of corrections for distribution to local probation officers and corrections agents.

(d) The commissioner shall inform individuals subject to a background study that criminal convictions for disqualifying crimes ~~will~~ shall be reported to the commissioner by the corrections system.

(e) A probation officer, corrections agent, or corrections agency is not civilly or criminally liable for disclosing or failing to disclose the information required by this subdivision.

(f) Upon receipt of disqualifying information, the commissioner shall provide the notice required under section 245C.17, as appropriate, to agencies on record as having initiated a background study or making a request for documentation of the background study status of the individual.

(g) This subdivision does not apply to family child care programs for individuals whose background study was completed in NETStudy 2.0.

Sec. 10. Minnesota Statutes 2015 Supplement, 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, including background studies conducted effective October 1, 2017, on legal nonlicensed child care providers authorized under chapter 119B, 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.

(e) The commissioner may inform the entity that initiated a background study under NETStudy 2.0 of the status of processing of the subject's fingerprints.

Sec. 11. Minnesota Statutes 2014, section 245C.08, subdivision 2, is amended to read:

Subd. 2. **Background studies conducted by a county agency for family child care.** (a) Prior to the implementation of NETStudy 2.0, for ~~a~~ background ~~study~~ studies conducted by a county agency for family child care services, including background studies conducted in connection with legal nonlicensed child care authorized under chapter 119B, the commissioner shall review:

(1) information from the county agency's record of substantiated maltreatment of adults and the maltreatment of minors;

(2) information from juvenile courts as required in subdivision 4 for:

(i) individuals listed in section 245C.03, subdivision 1, paragraph (a), who are ages 13 through 23 living in the household where the licensed services will be provided; and

(ii) any other individual listed under section 245C.03, subdivision 1, when there is reasonable cause; and

(3) information from the Bureau of Criminal Apprehension.

(b) If the individual has resided in the county for less than five years, the study shall include the records specified under paragraph (a) for the previous county or counties of residence for the past five years.

(c) Notwithstanding expungement by a court, the county agency may consider information obtained under paragraph (a), clause (3), unless the commissioner received notice of the petition for expungement and the court order for expungement is directed specifically to the commissioner.

Sec. 12. Minnesota Statutes 2014, section 245C.08, subdivision 4, is amended to read:

Subd. 4. **Juvenile court records.** (a) For a background study conducted by the Department of Human Services, the commissioner shall review records from the juvenile courts for an individual studied under section 245C.03, subdivision 1, paragraph (a), when the commissioner has reasonable cause.

(b) For a background study conducted by a county agency <u>for family child care prior to the implementation of NETStudy 2.0</u>, the commissioner shall review records from the juvenile courts for individuals listed in section 245C.03, subdivision 1, who are ages 13 through 23 living in the household where the licensed services will be provided. The commissioner shall also review records from juvenile courts for any other individual listed under section 245C.03, subdivision 1, when the commissioner has reasonable cause.

(c) The juvenile courts shall help with the study by giving the commissioner existing juvenile court records relating to delinquency proceedings held on individuals described in section 245C.03, subdivision 1, paragraph (a), when requested pursuant to this subdivision.

(d) For purposes of this chapter, a finding that a delinquency petition is proven in juvenile court shall be considered a conviction in state district court.

(e) Juvenile courts shall provide orders of involuntary and voluntary termination of parental rights under section 260C.301 to the commissioner upon request for purposes of conducting a background study under this chapter.

Sec. 13. Minnesota Statutes 2014, section 245C.11, subdivision 3, is amended to read:

Subd. 3. **Criminal history data.** County agencies shall have access to the criminal history data in the same manner as county licensing agencies under this chapter for

purposes of background studies completed prior to the implementation of NETStudy 2.0 by county agencies on legal nonlicensed child care providers to determine eligibility for child care funds under chapter 119B.

Sec. 14. Minnesota Statutes 2014, section 245C.17, subdivision 6, is amended to read:

Subd. 6. **Notice to county agency.** For studies on individuals related to a license to provide adult foster care and family adult day services and, effective October 1, 2017, family child care and legal nonlicensed child care authorized under chapter 119B, the commissioner shall also provide a notice of the background study results to the county agency that initiated the background study.

Sec. 15. Minnesota Statutes 2014, section 245C.23, subdivision 2, is amended to read:

Subd. 2. **Commissioner's notice of disqualification that is not set aside.** (a) The commissioner shall notify the license holder of the disqualification and order the license holder to immediately remove the individual from any position allowing direct contact with persons receiving services from the license holder if:

(1) the individual studied does not submit a timely request for reconsideration under section 245C.21;

(2) the individual submits a timely request for reconsideration, but the commissioner does not set aside the disqualification for that license holder under section 245C.22, unless the individual has a right to request a hearing under section 245C.27, 245C.28, or 256.045;

(3) an individual who has a right to request a hearing under sections 245C.27 and 256.045, or 245C.28 and chapter 14 for a disqualification that has not been set aside, does not request a hearing within the specified time; or

(4) an individual submitted a timely request for a hearing under sections 245C.27 and 256.045, or 245C.28 and chapter 14, but the commissioner does not set aside the disqualification under section 245A.08, subdivision 5, or 256.045.

(b) If the commissioner does not set aside the disqualification under section 245C.22, and the license holder was previously ordered under section 245C.17 to immediately remove the disqualified individual from direct contact with persons receiving services or to ensure that the individual is under continuous, direct supervision when providing direct contact services, the order remains in effect pending the outcome of a hearing under sections 245C.27 and 256.045, or 245C.28 and chapter 14.

(c) If the commissioner does not set aside the disqualification under section 245C.22, and the license holder was not previously ordered under section 245C.17 to immediately remove the disqualified individual from direct contact with persons receiving services or

to ensure that the individual is under continuous direct supervision when providing direct contact services, the commissioner shall order the individual to remain under continuous direct supervision pending the outcome of a hearing under sections 245C.27 and 256.045, or 245C.28 and chapter 14.

(d) For background studies related to child foster care, the commissioner shall also notify the county or private agency that initiated the study of the results of the reconsideration.

(e) For background studies related to family child care, adult foster care, and family adult day services, the commissioner shall also notify the county that initiated the study of the results of the reconsideration.

Sec. 16. Minnesota Statutes 2015 Supplement, section 256M.41, subdivision 3, is amended to read:

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

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

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

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

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

least 90 percent of the total number of such visits that would occur if every child were visited once per month. The commissioner shall make such determinations in ~~January~~ February of each year and payments to counties meeting the performance outcome threshold shall occur in ~~February~~ March of each year. Any withheld funds from this appropriation for counties that do not meet this requirement shall be reallocated by the commissioner to those counties meeting the requirement. ~~For 2015, the commissioner shall only apply the standard for monthly foster care visits.~~

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

EFFECTIVE DATE. This section is effective July 1, 2016, for allocations made in state fiscal year 2017 using calendar year 2016 data.

Sec. 17. Minnesota Statutes 2014, section 256N.26, subdivision 3, is amended to read:

Subd. 3. **Basic monthly rate.** From ~~January 1, 2015~~ July 1, 2016, to June 30, ~~2016~~ 2017, the basic monthly rate must be according to the following schedule:

Ages 0-5	~~$565~~ $650 per month
Ages 6-12	~~$670~~ $770 per month
Ages 13 and older	~~$790~~ $910 per month

Sec. 18. Minnesota Statutes 2015 Supplement, section 256P.06, subdivision 3, is amended to read:

Subd. 3. **Income inclusions.** The following must be included in determining the income of an assistance unit:

(1) earned income; and

(2) unearned income, which includes:

(i) interest and dividends from investments and savings;

(ii) capital gains as defined by the Internal Revenue Service from any sale of real property;

(iii) proceeds from rent and contract for deed payments in excess of the principal and interest portion owed on property;

(iv) income from trusts, excluding special needs and supplemental needs trusts;

(v) interest income from loans made by the participant or household;

(vi) cash prizes and winnings;

(vii) unemployment insurance income;

(viii) retirement, survivors, and disability insurance payments;

(ix) nonrecurring income over $60 per quarter unless earmarked and used for the purpose for which it is intended. Income and use of this income is subject to verification requirements under section 256P.04;

(x) retirement benefits;

(xi) cash assistance benefits, as defined by each program in chapters 119B, 256D, 256I, and 256J;

(xii) tribal per capita payments unless excluded by federal and state law;

(xiii) income and payments from service and rehabilitation programs that meet or exceed the state's minimum wage rate;

(xiv) income from members of the United States armed forces unless excluded from income taxes according to federal or state law;

(xv) all child support payments for programs under chapters 119B, 256D, and 256I;

(xvi) the amount of ~~current~~ child support received that exceeds $100 for assistance units with one child and $200 for assistance units with two or more children for programs under chapter 256J; and

(xvii) spousal support.

Sec. 19. **[260C.125] CASE TRANSFER PROCESS.**

Subdivision 1. **Purpose.** This section pertains to the transfer of responsibility for the placement and care of an Indian child in out-of-home placement from the responsible social services agency to a tribal title IV-E agency or an Indian tribe in and outside of Minnesota with a title IV-E agreement.

Subd. 2. **Establishment of transfer procedures.** The responsible social services agency shall establish and maintain procedures, in consultation with Indian tribes, for the transfer of responsibility for placement and care of a child to a tribal agency. Transfer of a child's case under this section shall not affect the child's title IV-E and Medicaid eligibility.

Subd. 3. **Title IV-E eligibility.** If a child's title IV-E eligibility has not been determined by the responsible social services agency by the time of transfer, it shall be established at the time of the transfer by the responsible social services agency.

Subd. 4. **Documentation and information.** Essential documents and information shall be transferred to a tribal agency, including but not limited to:

(1) district court judicial determinations to the effect that continuation in the home from which the child was removed would be contrary to the welfare of the child and that reasonable efforts were made to ensure placement prevention and family reunification pursuant to section 260.012;

(2) documentation related to the child's permanency proceeding under sections 260C.503 to 260C.521;

(3) documentation from the responsible social services agency related to the child's title IV-E eligibility;

(4) documentation regarding the child's eligibility or potential eligibility for other federal benefits;

(5) the child's case plan, developed pursuant to sections 475(1) and 475A of the Social Security Act, including health and education records of the child pursuant to section 475(1)(c) of the Social Security Act; and section 260C.212, subdivision 1, and information; and

(6) documentation of the child's placement setting, including a copy of the most recent provider's license.

Sec. 20. Minnesota Statutes 2015 Supplement, 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 14 or older~~,~~:

(1) in addition to any administrative review conducted by the responsible social services 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 (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~~.~~; and

~~(e) At the court review required under paragraph (d) for a child age 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. 21. Minnesota Statutes 2015 Supplement, 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. The child may select one member of the case planning team to be designated as the child's adviser and to advocate with respect to the application of the reasonable and prudent parenting standards. The responsible social services agency may reject an individual selected by the child if the agency has good cause to believe that the individual would not act in the best interest of the child. 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. For a child 18 years of age or older, the responsible social services agency shall involve the child and the child's parents as appropriate. 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 26b or 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 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);

(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;

(8) efforts to ensure the child's educational stability while in foster care~~, including~~ for a child who attained the minimum age for compulsory school attendance under state law and is enrolled full time in elementary or secondary school, or instructed in elementary or secondary education at home, or instructed in an independent study elementary or secondary program, or incapable of attending school on a full-time basis due to a medical condition that is documented and supported by regularly updated information in the child's case plan. Educational stability efforts include:

(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 and attendance; 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;

(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;

(10) the efforts by the ~~local~~ responsible social services 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~~ shall be monitored and treated while the child is in foster care;

(iii) how the child's medical information ~~will~~ shall 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~~ shall 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;

(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;

(12) an independent living plan for a child ~~age~~ 14 years of age or older, developed in consultation with the child. The child may select one member of the case planning team to be designated as the child's adviser and to advocate with respect to the application of the reasonable and prudent parenting standards in subdivision 14. 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 responsible social services agency to ensure that the ~~youth~~ child annually receives, at no cost to the ~~youth~~ child, 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;

(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~~

(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~~.~~; and

(14) for a child 14 years of age or older, a signed acknowledgment that describes the child's rights regarding education, health care, visitation, safety and protection from exploitation, and court participation; receipt of the documents identified in section 260C.45; and receipt of an annual credit report. The acknowledgment shall state that the rights were explained in an age-appropriate manner to the child.

(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. 22. Minnesota Statutes 2015 Supplement, section 260C.212, subdivision 14, is amended to read:

Subd. 14. **Support age-appropriate and developmentally appropriate activities for foster children.** (a) Responsible social services agencies and licensed 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. "Developmentally appropriate" means based on a child's cognitive, emotional, physical, and behavioral capacities that are typical for an age or age group. 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.

(b) "Reasonable and prudent parenting" means the standards ~~are~~ characterized by careful and sensible parenting decisions that maintain the child's health and safety, cultural, religious, and ~~are made in the child's~~ tribal values, and best ~~interest~~ interests while encouraging the child's emotional and developmental growth.

(c) The commissioner shall provide guidance about the childhood activities and factors a foster parent and authorized residential facility staff must consider when applying the reasonable and prudent parenting standards. The factors must include the:

(1) child's age, maturity, and developmental level;

(2) risk of activity;

(3) best interests of the child;

(4) importance of the experience in the child's emotional and developmental growth;

(5) importance of a family-like experience;

(6) behavioral history of the child; and

(7) wishes of the child's parent or legal guardian, as appropriate.

(d) A residential facility licensed under chapter 2960 must have at least one onsite staff person who is trained on the standards according to section 260C.515, subdivision 4, and authorized to apply the reasonable and prudent parenting standards to decisions involving the approval of a foster child's participation in age and developmentally appropriate extracurricular, social, or cultural activities. The onsite staff person referenced in this paragraph is not required to be available 24 hours per day.

(e) The foster parent or designated staff at residential facilities demonstrating compliance with the reasonable and prudent parenting standards shall not incur civil liability if a foster child is harmed or injured because of participating in approved extracurricular, enrichment, cultural, and social activities.

Sec. 23. Minnesota Statutes 2015 Supplement, section 260C.215, subdivision 4, is amended to read:

Subd. 4. **Duties of commissioner.** The commissioner of human services shall:

(1) provide practice guidance to responsible social services agencies and licensed child-placing agencies that reflect federal and state laws and policy direction on placement of children;

(2) develop criteria for determining whether a prospective adoptive or foster family has the ability to understand and validate the child's cultural background;

(3) provide a standardized training curriculum for adoption and foster care workers and administrators who work with children. Training must address the following objectives:

(i) developing and maintaining sensitivity to all cultures;

(ii) assessing values and their cultural implications;

(iii) making individualized placement decisions that advance the best interests of a particular child under section 260C.212, subdivision 2; and

(iv) issues related to cross-cultural placement;

(4) provide a training curriculum for all prospective adoptive and foster families that prepares them to care for the needs of adoptive and foster children taking into consideration the needs of children outlined in section 260C.212, subdivision 2, paragraph (b), and, as necessary, preparation is continued after placement of the child and includes the knowledge and skills related to reasonable and prudent parenting standards for the participation of the child in age or developmentally appropriate activities, according to section 260C.212, subdivision 14;

(5) develop and provide to responsible social services agencies and licensed child-placing agencies a home study format to assess the capacities and needs of prospective adoptive and foster families. The format must address problem-solving skills; parenting skills; evaluate the degree to which the prospective family has the ability to understand and validate the child's cultural background, and other issues needed to provide sufficient information for agencies to make an individualized placement decision consistent with section 260C.212, subdivision 2. For a study of a prospective foster parent, the format must also address the capacity of the prospective foster parent to provide a safe, healthy, smoke-free home environment. If a prospective adoptive parent has also been a foster parent, any update necessary to a home study for the purpose of adoption may be completed by the licensing authority responsible for the foster parent's license. If a prospective adoptive parent with an approved adoptive home study also applies for a foster care license, the license application may be made with the same agency which provided the adoptive home study; and

(6) consult with representatives reflecting diverse populations from the councils established under sections 3.922 and 15.0145, and other state, local, and community organizations.

Sec. 24. Minnesota Statutes 2015 Supplement, section 260C.451, subdivision 6, is amended to read:

Subd. 6. **Reentering foster care and accessing services after ~~age~~ 18 years of age and up to 21 years of age.** (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 (c), clause (12), and to assist the individual to meet one or more of the eligibility criteria in subdivision 4 if the individual wants to reenter foster care. The responsible social services agency shall provide foster care as required to implement the plan. The responsible social services agency shall enter into a voluntary placement agreement under section 260C.229 with the individual if the plan includes foster care.

(b) Individuals who had not been under the guardianship of the commissioner of human services prior to 18 years of age ~~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 responsible social services agency shall enter into a voluntary placement agreement with the individual if the plan includes foster care.

(d) ~~Youth~~ A child who left foster care while under guardianship of the commissioner of human services ~~retain~~ retains eligibility for foster care for placement at any time ~~between the ages of 18 and~~ prior to 21 years of age.

Sec. 25. Minnesota Statutes 2014, section 260C.451, is amended by adding a subdivision to read:

Subd. 9. **Administrative or court review of placements.** (a) The court shall conduct reviews at least annually to ensure the responsible social services agency is making reasonable efforts to finalize the permanency plan for the child.

(b) The court shall find that the responsible social services agency is making reasonable efforts to finalize the permanency plan for the child when the responsible social services agency:

(1) provides appropriate support to the child and foster care provider to ensure continuing stability and success in placement;

(2) works with the child to plan for transition to adulthood and assists the child in demonstrating progress in achieving related goals;

(3) works with the child to plan for independent living skills and assists the child in demonstrating progress in achieving independent living goals; and

(4) prepares the child for independence according to sections 260C.203, paragraph (d), and 260C.452, subdivision 4.

(c) The responsible social services agency must ensure that an administrative review that meets the requirements of this section and section 260C.203 is completed at least six months after each of the court's annual reviews.

Sec. 26. **[260C.452] SUCCESSFUL TRANSITION TO ADULTHOOD.**

Subdivision 1. **Scope.** This section pertains to a child who is under the guardianship of the commissioner of human services, or who has a permanency disposition of permanent custody to the agency, or who will leave foster care at 18 to 21 years of age.

Subd. 2. **Independent living plan.** When the child is 14 years of age or older, the responsible social services agency, in consultation with the child, shall complete the independent living plan according to section 260C.212, subdivision 1, paragraph (c), clause (12).

Subd. 3. **Notification.** Six months before the child is expected to be discharged from foster care, the responsible social services agency shall provide written notice regarding the right to continued access to services for certain children in foster care past 18 years of age and of the right to appeal a denial of social services under section 256.045.

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

(b) The responsible social services agency shall file a copy of the notification required in subdivision 3 with the court. If the responsible social services agency does not file the notice by the time the child is 17-1/2 years of age, the court shall require the responsible social services agency to file the notice.

(c) The court shall ensure that the responsible social services agency assists the child in obtaining the following documents before the child leaves foster care: a Social Security

card; an official or certified copy of the child's birth certificate; a state identification card or driver's license, tribal enrollment identification card, green card, or school visa; health insurance information; 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.

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

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

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

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

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

(5) workforce supports and employment services;

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

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

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

Subd. 5. **Notice of termination of foster care.** (a) When a child leaves foster care at 18 years of age or older, the responsible social services agency shall give the child written notice that foster care shall terminate 30 days from the date the notice is sent.

(b) The child or the child's guardian ad litem may file a motion asking the court to review the responsible social services agency's determination within 15 days of receiving the notice. The child shall not be discharged from foster care until the motion is heard. The responsible social services agency shall work with the child to transition out of foster care.

(c) The written notice of termination of benefits shall be on a form prescribed by the commissioner and shall give notice of the right to have the responsible social services agency's determination reviewed by the court under this section or sections 260C.203, 260C.317, and 260C.515, subdivision 5 or 6. A copy of the termination notice shall

be sent to the child and the child's attorney, if any, the foster care provider, the child's guardian ad litem, and the court. The responsible social services agency is not responsible for paying foster care benefits for any period of time after the child leaves foster care.

Sec. 27. Minnesota Statutes 2015 Supplement, 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 responsible social services agency made intensive, ongoing, and, as of the date of the hearing, unsuccessful effort to return the child home or secure a placement for the child with a fit and willing relative, custodian, or adoptive parent, and an 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 responsible social services agency is assisting the child to build connections to the child's family and community; ~~and~~

(3) that the responsible social services 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~~ adulthood that may occur if the child continues in foster care without another permanency disposition order~~.~~;

(4) the child's foster family home or child care institution is following the reasonable and prudent parenting standards; and

(5) the child has regular, ongoing opportunities to engage in age or developmentally appropriate activities by consulting with the child in an age-appropriate manner about the opportunities.

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

(1) ensure that permanent custody to the responsible social services 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;~~ by reviewing the compelling reasons it continues not to be in the best interest of the child to:

(i) return home;

(ii) be placed for adoption; or

(iii) be placed with a fit and willing relative through an order for permanent legal and physical custody under section 260C.515, subdivision 4;

(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 responsible social services agency has made reasonable efforts to finalize the permanent plan for the child when:

(1) the responsible social services 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;

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

(3) the responsible social services agency's engagement of the child in planning for ~~independent living~~ a successful transition to adulthood is reasonable and appropriate.

Sec. 28. **[260D.14] SUCCESSFUL TRANSITION TO ADULTHOOD FOR CHILDREN IN VOLUNTARY PLACEMENT.**

Subdivision 1. **Case planning.** When the child is 14 years of age or older, the responsible social services agency shall ensure a child in foster care under this chapter is provided with the case plan requirements in section 260C.212, subdivisions 1 and 14.

Subd. 2. **Notification.** The responsible social services agency shall provide written notice of the right to continued access to services for certain children in foster care past 18 years of age under section 260C.452, subdivision 3, and of the right to appeal a denial of social services under section 256.045. The notice must be provided to the child six months before the child's 18th birthday.

Subd. 3. **Administrative or court reviews.** When the child is 17 years of age or older, the administrative review or court hearing must include a review of the responsible

social services agency's support for the child's successful transition to adulthood as required in section 260C.452, subdivision 4.

Sec. 29. Minnesota Statutes 2014, section 518.175, subdivision 5, is amended to read:

Subd. 5. **Modification of parenting plan or order for parenting time.** (a) If a parenting plan or an order granting parenting time cannot be used to determine the number of overnights or overnight equivalents the child has with each parent, the court shall modify the parenting plan or order granting parenting time so that the number of overnights or overnight equivalents the child has with each parent can be determined. For purposes of this section, "overnight equivalents" has the meaning given in section 518A.36, subdivision 1.

(b) If modification would serve the best interests of the child, the court shall modify the decision-making provisions of a parenting plan or an order granting or denying parenting time, if the modification would not change the child's primary residence. Consideration of a child's best interest includes a child's changing developmental needs.

~~(b)~~ (c) Except as provided in section 631.52, the court may not restrict parenting time unless it finds that:

(1) parenting time is likely to endanger the child's physical or emotional health or impair the child's emotional development; or

(2) the parent has chronically and unreasonably failed to comply with court-ordered parenting time.

A modification of parenting time which increases a parent's percentage of parenting time to an amount that is between 45.1 to 54.9 percent parenting time is not a restriction of the other parent's parenting time.

~~(c)~~ (d) If a parent makes specific allegations that parenting time by the other parent places the parent or child in danger of harm, the court shall hold a hearing at the earliest possible time to determine the need to modify the order granting parenting time. Consistent with subdivision 1a, the court may require a third party, including the local social services agency, to supervise the parenting time or may restrict a parent's parenting time if necessary to protect the other parent or child from harm. If there is an existing order for protection governing the parties, the court shall consider the use of an independent, neutral exchange location for parenting time.

EFFECTIVE DATE. This section is effective August 1, 2018.

Sec. 30. Minnesota Statutes 2015 Supplement, section 518A.26, subdivision 14, is amended to read:

Subd. 14. **Obligor.** "Obligor" means a person obligated to pay maintenance or support. For purposes of ordering medical support under section 518A.41, a parent who has primary physical custody of a child may be an obligor subject to a payment agreement under section 518A.69. If a parent has more than 55 percent court-ordered parenting time, there is a rebuttable presumption that the parent has a zero dollar basic support obligation. A party seeking to overcome this presumption must show, and the court must consider, the following:

(1) a significant income disparity, which may include potential income determined under section 518A.32;

(2) the benefit and detriment to the child and the ability of each parent to meet the needs of the child; and

(3) whether the application of the presumption would have an unjust or inappropriate result.

The presumption of a zero dollar basic support obligation does not eliminate a parent's obligation to pay child support arrears under section 518A.60. The presumption of a zero dollar basic support obligation does not apply to an action under section 256.87, subdivision 1 or 1a.

EFFECTIVE DATE. This section is effective August 1, 2018.

Sec. 31. Minnesota Statutes 2014, section 518A.34, is amended to read:

518A.34 COMPUTATION OF CHILD SUPPORT OBLIGATIONS.

(a) To determine the presumptive child support obligation of a parent, the court shall follow the procedure set forth in this section.

(b) To determine the obligor's basic support obligation, the court shall:

(1) determine the gross income of each parent under section 518A.29;

(2) calculate the parental income for determining child support (PICS) of each parent, by subtracting from the gross income the credit, if any, for each parent's nonjoint children under section 518A.33;

(3) determine the percentage contribution of each parent to the combined PICS by dividing the combined PICS into each parent's PICS;

(4) determine the combined basic support obligation by application of the guidelines in section 518A.35;

(5) determine ~~the obligor's~~ each parent's share of the combined basic support obligation by multiplying the percentage figure from clause (3) by the combined basic support obligation in clause (4); and

(6) ~~determine the parenting expense adjustment, if any, as~~ apply the parenting expense adjustment formula provided in section 518A.36~~, and adjust the obligor's basic support obligation accordingly~~ to determine the obligor's basic support obligation. ~~If the parenting time of the parties is presumed equal, section 518A.36, subdivision 3, applies to the calculation of the basic support obligation and a determination of which parent is the obligor.~~

(c) If the parents have split custody of joint children, child support must be calculated for each joint child as follows:

(1) the court shall determine each parent's basic support obligation under paragraph (b) and include the amount of each parent's obligation in the court order. If the basic support calculation results in each parent owing support to the other, the court shall offset the higher basic support obligation with the lower basic support obligation to determine the amount to be paid by the parent with the higher obligation to the parent with the lower obligation. For the purpose of the cost-of-living adjustment required under section 518A.75, the adjustment must be based on each parent's basic support obligation prior to offset. For the purposes of this paragraph, "split custody" means that there are two or more joint children and each parent has at least one joint child more than 50 percent of the time;

(2) if each parent pays all child care expenses for at least one joint child, the court shall calculate child care support for each joint child as provided in section 518A.40. The court shall determine each parent's child care support obligation and include the amount of each parent's obligation in the court order. If the child care support calculation results in each parent owing support to the other, the court shall offset the higher child care support obligation with the lower child care support obligation to determine the amount to be paid by the parent with the higher obligation to the parent with the lower obligation; and

(3) if each parent pays all medical or dental insurance expenses for at least one joint child, medical support shall be calculated for each joint child as provided in section 518A.41. The court shall determine each parent's medical support obligation and include the amount of each parent's obligation in the court order. If the medical support calculation results in each parent owing support to the other, the court shall offset the higher medical support obligation with the lower medical support obligation to determine the amount to be paid by the parent with the higher obligation to the parent with the lower obligation. Unreimbursed and uninsured medical expenses are not included in the presumptive amount of support owed by a parent and are calculated and collected as provided in section 518A.41.

(d) The court shall determine the child care support obligation for the obligor as provided in section 518A.40.

~~(d)~~ (e) The court shall determine the medical support obligation for each parent as provided in section 518A.41. Unreimbursed and uninsured medical expenses are not included in the presumptive amount of support owed by a parent and are calculated and collected as described in section 518A.41.

~~(e)~~ (f) The court shall determine each parent's total child support obligation by adding together each parent's basic support, child care support, and health care coverage obligations as provided in this section.

~~(f)~~ (g) If Social Security benefits or veterans' benefits are received by one parent as a representative payee for a joint child based on the other parent's eligibility, the court shall subtract the amount of benefits from the other parent's net child support obligation, if any.

~~(g)~~ (h) The final child support order shall separately designate the amount owed for basic support, child care support, and medical support. If applicable, the court shall use the self-support adjustment and minimum support adjustment under section 518A.42 to determine the obligor's child support obligation.

EFFECTIVE DATE. This section is effective August 1, 2018.

Sec. 32. Minnesota Statutes 2014, section 518A.35, subdivision 1, is amended to read:

Subdivision 1. **Determination of support obligation.** (a) The guideline in this section is a rebuttable presumption and shall be used in any judicial or administrative proceeding to establish or modify a support obligation under this chapter.

(b) The basic child support obligation shall be determined by referencing the guideline for the appropriate number of joint children and the combined parental income for determining child support of the parents.

(c) If a child is not in the custody of either parent and a support order is sought against one or both parents, the basic child support obligation shall be determined by referencing the guideline for the appropriate number of joint children, and the parent's individual parental income for determining child support, not the combined parental incomes for determining child support of the parents. Unless a parent has court-ordered parenting time, the parenting expense adjustment formula under section 518A.34 must not be applied.

(d) If a child is in custody of either parent and a support order is sought by the public authority under section 256.87, unless the parent against whom the support order is sought has court-ordered parenting time, the support obligation must be determined by referencing the guideline for the appropriate number of joint children and the parent's individual income without application of the parenting expense adjustment formula under section 518A.34.

(e) For combined parental incomes for determining child support exceeding $15,000 per month, the presumed basic child support obligations shall be as for parents with

combined parental income for determining child support of $15,000 per month. A basic child support obligation in excess of this level may be demonstrated for those reasons set forth in section 518A.43.

EFFECTIVE DATE. This section is effective August 1, 2018.

Sec. 33. Minnesota Statutes 2014, section 518A.36, is amended to read:

518A.36 PARENTING EXPENSE ADJUSTMENT.

Subdivision 1. **General.** (a) The parenting expense adjustment under this section reflects the presumption that while exercising parenting time, a parent is responsible for and incurs costs of caring for the child, including, but not limited to, food, clothing, transportation, recreation, and household expenses. Every child support order shall specify the percentage of parenting time granted to or presumed for each parent. For purposes of this section, the percentage of parenting time means the percentage of time a child is scheduled to spend with the parent during a calendar year according to a court order averaged over a two-year period. Parenting time includes time with the child whether it is designated as visitation, physical custody, or parenting time. The percentage of parenting time may be determined by calculating the number of overnights or overnight equivalents that a ~~child~~ parent spends with a ~~parent, or~~ child pursuant to a court order. For purposes of this section, overnight equivalents are calculated by using a method other than overnights if the parent has significant time periods on separate days where the child is in the parent's physical custody and under the direct care of the parent but does not stay overnight. The court may consider the age of the child in determining whether a child is with a parent for a significant period of time.

(b) If there is not a court order awarding parenting time, the court shall determine the child support award without consideration of the parenting expense adjustment. If a parenting time order is subsequently issued or is issued in the same proceeding, then the child support order shall include application of the parenting expense adjustment.

Subd. 2. **Calculation of parenting expense adjustment.** (a) For the purposes of this section, the following terms have the meanings given:

(1) "parent A" means the parent with whom the child or children will spend the least number of overnights under the court order; and

(2) "parent B" means the parent with whom the child or children will spend the greatest number of overnights under the court order.

~~The obligor is entitled to a parenting expense adjustment calculated as provided in this subdivision.~~ (b) The court shall apply the following formula to determine which parent is the obligor and calculate the basic support obligation:

~~(1) find the adjustment percentage corresponding to the percentage of parenting time allowed to the obligor below:~~

	~~Percentage Range of Parenting Time~~	~~Adjustment Percentage~~
~~(i)~~	~~less than 10 percent~~	~~no adjustment~~
~~(ii)~~	~~10 percent to 45 percent~~	~~12 percent~~
~~(iii)~~	~~45.1 percent to 50 percent~~	~~presume parenting time is equal~~

~~(2) multiply the adjustment percentage by the obligor's basic child support obligation to arrive at the parenting expense adjustment; and~~

~~(3) subtract the parenting expense adjustment from the obligor's basic child support obligation. The result is the obligor's basic support obligation after parenting expense adjustment.~~

(1) raise to the power of three the approximate number of annual overnights the child or children will likely spend with parent A;

(2) raise to the power of three the approximate number of annual overnights the child or children will likely spend with parent B;

(3) multiply the result of clause (1) times parent B's share of the combined basic support obligation as determined in section 518A.34, paragraph (b), clause (5);

(4) multiply the result of clause (2) times parent A's share of the combined basic support obligation as determined in section 518A.34, paragraph (b), clause (5);

(5) subtract the result of clause (4) from the result of clause (3); and

(6) divide the result of clause (5) by the sum of clauses (1) and (2).

(c) If the result is a negative number, parent A is the obligor, the negative number becomes its positive equivalent, and the result is the basic support obligation. If the result is a positive number, parent B is the obligor and the result is the basic support obligation.

Subd. 3. **Calculation of basic support when parenting time ~~presumed~~ is equal.** ~~(a)~~ If the parenting time is equal and the parental incomes for determining child support of the parents also are equal, no basic support shall be paid unless the court determines that the expenses for the child are not equally shared.

~~(b) If the parenting time is equal but the parents' parental incomes for determining child support are not equal, the parent having the greater parental income for determining child support shall be obligated for basic child support, calculated as follows:~~

~~(1) multiply the combined basic support calculated under section 518A.34 by 0.75;~~

~~(2) prorate the amount under clause (1) between the parents based on each parent's proportionate share of the combined PICS; and~~

~~(3) subtract the lower amount from the higher amount.~~

~~The resulting figure is the obligation after parenting expense adjustment for the parent with the greater parental income for determining child support.~~

EFFECTIVE DATE. This section is effective August 1, 2018.

Sec. 34. Minnesota Statutes 2015 Supplement, section 518A.39, subdivision 2, is amended to read:

Subd. 2. **Modification.** (a) The terms of an order respecting maintenance or support may be modified upon a showing of one or more of the following, any of which makes the terms unreasonable and unfair: (1) substantially increased or decreased gross income of an obligor or obligee; (2) substantially increased or decreased need of an obligor or obligee or the child or children that are the subject of these proceedings; (3) receipt of assistance under the AFDC program formerly codified under sections 256.72 to 256.87 or 256B.01 to 256B.40, or chapter 256J or 256K; (4) a change in the cost of living for either party as measured by the Federal Bureau of Labor Statistics; (5) extraordinary medical expenses of the child not provided for under section 518A.41; (6) a change in the availability of appropriate health care coverage or a substantial increase or decrease in health care coverage costs; (7) the addition of work-related or education-related child care expenses of the obligee or a substantial increase or decrease in existing work-related or education-related child care expenses; or (8) upon the emancipation of the child, as provided in subdivision 5.

(b) It is presumed that there has been a substantial change in circumstances under paragraph (a) and the terms of a current support order shall be rebuttably presumed to be unreasonable and unfair if:

(1) the application of the child support guidelines in section 518A.35, to the current circumstances of the parties results in a calculated court order that is at least 20 percent and at least $75 per month higher or lower than the current support order or, if the current support order is less than $75, it results in a calculated court order that is at least 20 percent per month higher or lower;

(2) the medical support provisions of the order established under section 518A.41 are not enforceable by the public authority or the obligee;

(3) health coverage ordered under section 518A.41 is not available to the child for whom the order is established by the parent ordered to provide;

(4) the existing support obligation is in the form of a statement of percentage and not a specific dollar amount;

(5) the gross income of an obligor or obligee has decreased by at least 20 percent through no fault or choice of the party; or

(6) a deviation was granted based on the factor in section 518A.43, subdivision 1, clause (4), and the child no longer resides in a foreign country or the factor is otherwise no longer applicable.

(c) A child support order is not presumptively modifiable solely because an obligor or obligee becomes responsible for the support of an additional nonjoint child, which is born after an existing order. Section 518A.33 shall be considered if other grounds are alleged which allow a modification of support.

(d) If child support was established by applying a parenting expense adjustment or presumed equal parenting time calculation under previously existing child support guidelines and there is no parenting plan or order from which overnights or overnight equivalents can be determined, there is a rebuttable presumption that the established adjustment or calculation will continue after modification so long as the modification is not based on a change in parenting time. In determining an obligation under previously existing child support guidelines, it is presumed that the court shall:

(1) if a 12 percent parenting expense adjustment was applied, multiply the obligor's share of the combined basic support obligation calculated under section 518A.34, paragraph (b), clause (5), by .88; or

(2) if the parenting time was presumed equal but the parents' parental incomes for determining child support were not equal:

(i) multiply the combined basic support obligation under section 518A.34, paragraph (b), clause (5), by .075;

(ii) prorate the amount under item (i) between the parents based on each parent's proportionate share of the combined PICS; and

(iii) subtract the lower amount from the higher amount.

(e) On a motion for modification of maintenance, including a motion for the extension of the duration of a maintenance award, the court shall apply, in addition to all other relevant factors, the factors for an award of maintenance under section 518.552 that exist at the time of the motion. On a motion for modification of support, the court:

(1) shall apply section 518A.35, and shall not consider the financial circumstances of each party's spouse, if any; and

(2) shall not consider compensation received by a party for employment in excess of a 40-hour work week, provided that the party demonstrates, and the court finds, that:

(i) the excess employment began after entry of the existing support order;

(ii) the excess employment is voluntary and not a condition of employment;

(iii) the excess employment is in the nature of additional, part-time employment, or overtime employment compensable by the hour or fractions of an hour;

(iv) the party's compensation structure has not been changed for the purpose of affecting a support or maintenance obligation;

(v) in the case of an obligor, current child support payments are at least equal to the guidelines amount based on income not excluded under this clause; and

(vi) in the case of an obligor who is in arrears in child support payments to the obligee, any net income from excess employment must be used to pay the arrearages until the arrearages are paid in full.

~~(e)~~ (f) A modification of support or maintenance, including interest that accrued pursuant to section 548.091, 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, unless the court adopts an alternative effective date under paragraph (l). The court's adoption of an alternative effective date under paragraph (l) shall not be considered a retroactive modification of maintenance or support.

~~(f)~~ (g) Except for an award of the right of occupancy of the homestead, provided in section 518.63, all divisions of real and personal property provided by section 518.58 shall be final, and may be revoked or modified only where the court finds the existence of conditions that justify reopening a judgment under the laws of this state, including motions under section 518.145, subdivision 2. The court may impose a lien or charge on the divided property at any time while the property, or subsequently acquired property, is owned by the parties or either of them, for the payment of maintenance or support money, or may sequester the property as is provided by section 518A.71.

~~(g)~~ (h) The court need not hold an evidentiary hearing on a motion for modification of maintenance or support.

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

~~(i)~~ (j) Except as expressly provided, an enactment, amendment, or repeal of law does not constitute a substantial change in the circumstances for purposes of modifying a child support order.

~~(j) MS 2006 [Expired]~~

(k) On the first modification ~~under the income shares method of calculation~~ following implementation of amended child support guidelines, the modification of basic support may be limited if the amount of the full variance would create hardship for either the obligor or the obligee. Hardship includes, but is not limited to, eligibility for assistance under chapter 256J.

(l) The court may select an alternative effective date for a maintenance or support order if the parties enter into a binding agreement for an alternative effective date.

EFFECTIVE DATE. This section is effective August 1, 2018.

Sec. 35. Minnesota Statutes 2014, section 609.3241, is amended to read:

609.3241 PENALTY ASSESSMENT AUTHORIZED.

(a) When a court sentences an adult convicted of violating section 609.322 or 609.324, while acting other than as a prostitute, the court shall impose an assessment of not less than $500 and not more than $750 for a violation of section 609.324, subdivision 2, or a misdemeanor violation of section 609.324, subdivision 3; otherwise the court shall impose an assessment of not less than $750 and not more than $1,000. The assessment shall be distributed as provided in paragraph (c) and is in addition to the surcharge required by section 357.021, subdivision 6.

(b) The court may not waive payment of the minimum assessment required by this section. If the defendant qualifies for the services of a public defender or the court finds on the record that the convicted person is indigent or that immediate payment of the assessment would create undue hardship for the convicted person or that person's immediate family, the court may reduce the amount of the minimum assessment to not less than $100. The court also may authorize payment of the assessment in installments.

(c) The assessment collected under paragraph (a) must be distributed as follows:

(1) 40 percent of the assessment shall be forwarded to the political subdivision that employs the arresting officer for use in enforcement, training, and education activities related to combating sexual exploitation of youth, or if the arresting officer is an employee of the state, this portion shall be forwarded to the commissioner of public safety for those purposes identified in clause (3);

(2) 20 percent of the assessment shall be forwarded to the prosecuting agency that handled the case for use in training and education activities relating to combating sexual exploitation activities of youth; and

(3) 40 percent of the assessment must be forwarded to the commissioner of ~~public safety~~ health to be deposited in the safe harbor for youth account in the special revenue

fund and are appropriated to the commissioner for distribution to crime victims services organizations that provide services to sexually exploited youth, as defined in section 260C.007, subdivision 31.

(d) A safe harbor for youth account is established as a special account in the state treasury.

Sec. 36. Minnesota Statutes 2015 Supplement, section 626.556, subdivision 2, is amended to read:

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

(a) "Accidental" means a sudden, not reasonably foreseeable, and unexpected occurrence or event which:

(1) is not likely to occur and could not have been prevented by exercise of due care; and

(2) if occurring while a child is receiving services from a facility, happens when the facility and the employee or person providing services in the facility are in compliance with the laws and rules relevant to the occurrence or event.

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

(c) "Facility" means:

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

(2) a school as defined in section 120A.05, subdivisions 9, 11, and 13; and chapter 124E; or

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

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

(e) "Investigation" means fact gathering related to the current safety of a child and the risk of subsequent maltreatment that determines whether child maltreatment occurred and whether child protective services are needed. An investigation must be used when reports involve sexual abuse or substantial child endangerment, and for reports of

maltreatment in facilities required to be licensed under chapter 245A or 245D; under sections 144.50 to 144.58 and 241.021; in a school as defined in section 120A.05, subdivisions 9, 11, and 13, and chapter 124E; or in a nonlicensed personal care provider association as defined in section 256B.0625, subdivision 19a.

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

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

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

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

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

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

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

(6) prenatal exposure to a controlled substance, as defined in section 253B.02, subdivision 2, used by the mother for a nonmedical purpose, as evidenced by withdrawal symptoms in the child at birth, results of a toxicology test performed on the mother at delivery or the child at birth, medical effects or developmental delays during the child's

first year of life that medically indicate prenatal exposure to a controlled substance, or the presence of a fetal alcohol spectrum disorder;

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

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

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

(h) "Nonmaltreatment mistake" means:

(1) at the time of the incident, the individual was performing duties identified in the center's child care program plan required under Minnesota Rules, part 9503.0045;

(2) the individual has not been determined responsible for a similar incident that resulted in a finding of maltreatment for at least seven years;

(3) the individual has not been determined to have committed a similar nonmaltreatment mistake under this paragraph for at least four years;

(4) any injury to a child resulting from the incident, if treated, is treated only with remedies that are available over the counter, whether ordered by a medical professional or not; and

(5) except for the period when the incident occurred, the facility and the individual providing services were both in compliance with all licensing requirements relevant to the incident.

This definition only applies to child care centers licensed under Minnesota Rules, chapter 9503. If clauses (1) to (5) apply, rather than making a determination of substantiated maltreatment by the individual, the commissioner of human services shall determine that a nonmaltreatment mistake was made by the individual.

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

(j) "Person responsible for the child's care" means (1) an individual functioning within the family unit and having responsibilities for the care of the child such as a parent, guardian, or other person having similar care responsibilities, or (2) an individual functioning outside the family unit and having responsibilities for the care of the child such as a teacher, school administrator, other school employees or agents, or other lawful custodian of a child having either full-time or short-term care responsibilities including,

but not limited to, day care, babysitting whether paid or unpaid, counseling, teaching, and coaching.

(k) "Physical abuse" means any physical injury, mental injury, or threatened injury, inflicted by a person responsible for the child's care on a child other than by accidental means, or any physical or mental injury that cannot reasonably be explained by the child's history of injuries, or any aversive or deprivation procedures, or regulated interventions, that have not been authorized under section 125A.0942 or 245.825.

Abuse does not include reasonable and moderate physical discipline of a child administered by a parent or legal guardian which does not result in an injury. Abuse does not include the use of reasonable force by a teacher, principal, or school employee as allowed by section 121A.582. Actions which are not reasonable and moderate include, but are not limited to, any of the following:

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

(2) striking a child with a closed fist;

(3) shaking a child under age three;

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

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

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

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

(8) striking a child who is at least age one but under age four on the face or head, which results in an injury;

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

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

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

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

(m) "Report" means any communication received by the local welfare agency, police department, county sheriff, or agency responsible for child protection pursuant to this section that describes neglect or physical or sexual abuse of a child and contains sufficient content to identify the child and any person believed to be responsible for the neglect or abuse, if known.

(n) "Sexual abuse" means the subjection of a child by a person responsible for the child's care, by a person who has a significant relationship to the child, as defined in section 609.341, or by a person in a position of authority, as defined in section 609.341, subdivision 10, to any act which constitutes a violation of section 609.342 (criminal sexual conduct in the first degree), 609.343 (criminal sexual conduct in the second degree), 609.344 (criminal sexual conduct in the third degree), 609.345 (criminal sexual conduct in the fourth degree), or 609.3451 (criminal sexual conduct in the fifth degree). Sexual abuse also includes any act which involves a minor which constitutes a violation of prostitution offenses under sections 609.321 to 609.324 or 617.246. Effective May 29, 2017, sexual abuse includes all reports of known or suspected child sex trafficking involving a child who is identified as a victim of sex trafficking. Sexual abuse includes child sex trafficking as defined in section 609.321, subdivisions 7a and 7b. Sexual abuse includes threatened sexual abuse which includes the status of a parent or household member who has committed a violation which requires registration as an offender under section 243.166, subdivision 1b, paragraph (a) or (b), or required registration under section 243.166, subdivision 1b, paragraph (a) or (b).

(o) "Substantial child endangerment" means a person responsible for a child's care, by act or omission, commits or attempts to commit an act against a child under their care that constitutes any of the following:

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

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

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

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

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

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

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

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

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

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

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

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

(p) "Threatened injury" means a statement, overt act, condition, or status that represents a substantial risk of physical or sexual abuse or mental injury. Threatened injury includes, but is not limited to, exposing a child to a person responsible for the child's care, as defined in paragraph (j), clause (1), who has:

(1) subjected a child to, or failed to protect a child from, an overt act or condition that constitutes egregious harm, as defined in section 260C.007, subdivision 14, or a similar law of another jurisdiction;

(2) been found to be palpably unfit under section 260C.301, subdivision 1, paragraph (b), clause (4), or a similar law of another jurisdiction;

(3) committed an act that has resulted in an involuntary termination of parental rights under section 260C.301, or a similar law of another jurisdiction; or

(4) committed an act that has resulted in the involuntary transfer of permanent legal and physical custody of a child to a relative under Minnesota Statutes 2010, section 260C.201, subdivision 11, paragraph (d), clause (1), section 260C.515, subdivision 4, or a similar law of another jurisdiction.

A child is the subject of a report of threatened injury when the responsible social services agency receives birth match data under paragraph (q) from the Department of Human Services.

(q) Upon receiving data under section 144.225, subdivision 2b, contained in a birth record or recognition of parentage identifying a child who is subject to threatened injury under paragraph (p), the Department of Human Services shall send the data to the responsible social services agency. The data is known as "birth match" data. Unless the responsible social services agency has already begun an investigation or assessment of the report due to the birth of the child or execution of the recognition of parentage and the parent's previous history with child protection, the agency shall accept the birth match data as a report under this section. The agency may use either a family assessment or investigation to determine whether the child is safe. All of the provisions of this section apply. If the child is determined to be safe, the agency shall consult with the county attorney to determine the appropriateness of filing a petition alleging the child is in need of protection or services under section 260C.007, subdivision 6, clause (16), in order to

deliver needed services. If the child is determined not to be safe, the agency and the county attorney shall take appropriate action as required under section 260C.503, subdivision 2.

(r) Persons who conduct assessments or investigations under this section shall take into account accepted child-rearing practices of the culture in which a child participates and accepted teacher discipline practices, which are not injurious to the child's health, welfare, and safety.

Sec. 37. Minnesota Statutes 2015 Supplement, section 626.556, subdivision 3c, is amended to read:

Subd. 3c. **Local welfare agency, Department of Human Services or Department of Health responsible for assessing or investigating reports of maltreatment or death.** (a) Except as provided in paragraph (b), the county local welfare agency is the agency responsible for assessing or investigating allegations of maltreatment in child foster care that do not involve the death of a foster child, family child care, legally unlicensed child care, juvenile correctional facilities licensed under section 241.021 located in the local welfare agency's county, and reports involving children served by an unlicensed personal care provider organization under section 256B.0659. Copies of findings related to personal care provider organizations under section 256B.0659 must be forwarded to the Department of Human Services provider enrollment.

(b) The Department of Human Services is the agency responsible for assessing or investigating allegations of maltreatment in:

(1) facilities licensed under chapters 245A and 245D, except ~~for~~ in child foster care and family child care homes that are monitored by county agencies according to section 245A.16, subdivision 1;

(2) child foster care homes that are monitored by private agencies that have been licensed by the commissioner to perform licensing functions and activities according to section 245A.16, subdivision 1; and

(3) child foster care and family child care homes that are monitored by county agencies according to section 245A.16, subdivision 1, upon agreement by the county and Department of Human Services for a specific case.

(c) The Department of Human Services is responsible for investigating the death of a child placed in a foster care program.

(d) The Department of Health is the agency responsible for assessing or investigating allegations of child maltreatment in facilities licensed under sections 144.50 to 144.58 ~~and 144A.46~~.

Sec. 38. Minnesota Statutes 2014, section 626.556, subdivision 3e, is amended to read:

Subd. 3e. **Agency responsible for assessing or investigating reports of sexual abuse.** The local welfare agency is the agency responsible for investigating allegations of sexual abuse if the alleged offender is the parent, guardian, sibling, or an individual functioning within the family unit as a person responsible for the child's care, or a person with a significant relationship to the child if that person resides in the child's household. Effective May 29, 2017, the local welfare agency is also responsible for investigating when a child is identified as a victim of sex trafficking.

Sec. 39. Minnesota Statutes 2015 Supplement, section 626.556, subdivision 10b, is amended to read:

Subd. 10b. **Duties of commissioner; neglect ~~or~~, abuse, or death in a facility.** (a) This section applies to the commissioners of human services, health, and education. The commissioner of the agency responsible for assessing or investigating the report shall immediately assess or investigate if the report alleges that:

(1) a child who is in the care of a facility as defined in subdivision 2 is neglected, physically abused, sexually abused, or is the victim of maltreatment in a facility by an individual in that facility, or has been so neglected or abused, or been the victim of maltreatment in a facility by an individual in that facility within the three years preceding the report; or

(2) a child was neglected, physically abused, sexually abused, or is the victim of maltreatment in a facility by an individual in a facility defined in subdivision 2, while in the care of that facility within the three years preceding the report.

The commissioner of the agency responsible for assessing or investigating the report shall arrange for the transmittal to the commissioner of reports received by local agencies and may delegate to a local welfare agency the duty to investigate reports. In conducting an investigation under this section, the commissioner has the powers and duties specified for local welfare agencies under this section. The commissioner of the agency responsible for assessing or investigating the report or local welfare agency may interview any children who are or have been in the care of a facility under investigation and their parents, guardians, or legal custodians.

(b) Prior to any interview, the commissioner of the agency responsible for assessing or investigating the report or local welfare agency shall notify the parent, guardian, or legal custodian of a child who will be interviewed in the manner provided for in subdivision 10d, paragraph (a). If reasonable efforts to reach the parent, guardian, or legal custodian of a child in an out-of-home placement have failed, the child may be interviewed if there

is reason to believe the interview is necessary to protect the child or other children in the facility. The commissioner of the agency responsible for assessing or investigating the report or local agency must provide the information required in this subdivision to the parent, guardian, or legal custodian of a child interviewed without parental notification as soon as possible after the interview. When the investigation is completed, any parent, guardian, or legal custodian notified under this subdivision shall receive the written memorandum provided for in subdivision 10d, paragraph (c).

(c) In conducting investigations under this subdivision the commissioner or local welfare agency shall obtain access to information consistent with subdivision 10, paragraphs (h), (i), and (j). In conducting assessments or investigations under this subdivision, the commissioner of education shall obtain access to reports and investigative data that are relevant to a report of maltreatment and are in the possession of a school facility as defined in subdivision 2, paragraph (c), notwithstanding the classification of the data as educational or personnel data under chapter 13. This includes, but is not limited to, school investigative reports, information concerning the conduct of school personnel alleged to have committed maltreatment of students, information about witnesses, and any protective or corrective action taken by the school facility regarding the school personnel alleged to have committed maltreatment.

(d) The commissioner may request assistance from the local social services agency.

(e) The commissioner of human services shall investigate every incident involving the death of a child during placement in a child foster care home licensed under chapter 245A and Minnesota Rules, chapter 2960. The investigation, notifications, and data classifications are governed by this section, even if abuse or neglect is not alleged or determined in the report.

Sec. 40. Minnesota Statutes 2014, section 626.556, subdivision 10f, is amended to read:

Subd. 10f. **Notice of determinations.** Within ten working days of the conclusion of a family assessment, the local welfare agency shall notify the parent or guardian of the child of the need for services to address child safety concerns or significant risk of subsequent child maltreatment. The local welfare agency and the family may also jointly agree that family support and family preservation services are needed. Within ten working days of the conclusion of an investigation, the local welfare agency or agency responsible for investigating the report shall notify the parent or guardian of the child, the person determined to be maltreating the child, and, if applicable, the director of the facility, of the determination and a summary of the specific reasons for the determination. When the investigation involves a child foster care setting that is monitored by a private licensing

agency under section 245A.16, the ~~local welfare agency responsible for investigating the report~~ Department of Human Services shall notify the private licensing agency of the determination and shall provide a summary of the specific reasons for the determination. The notice to the private licensing agency must include identifying private data, but not the identity of the reporter of maltreatment. The notice must also include a certification that the information collection procedures under subdivision 10, paragraphs (h), (i), and (j), were followed and a notice of the right of a data subject to obtain access to other private data on the subject collected, created, or maintained under this section. In addition, the notice shall include the length of time that the records will be kept under subdivision 11c. The investigating agency shall notify the parent or guardian of the child who is the subject of the report, and any person or facility determined to have maltreated a child, of their appeal or review rights under this section. The notice must also state that a finding of maltreatment may result in denial of a license application or background study disqualification under chapter 245C related to employment or services that are licensed by the Department of Human Services under chapter 245A, the Department of Health under chapter 144 or 144A, the Department of Corrections under section 241.021, and from providing services related to an unlicensed personal care provider organization under chapter 256B.

Sec. 41. **CHILD CARE IS AN ALLOWABLE SERVICE FOR PURPOSES OF CHILD PROTECTION.**

The commissioner shall change the brass code related to allowable child protection services to include child care.

Sec. 42. **DIRECTION TO COMMISSIONERS; INCOME AND ASSET EXCLUSION.**

(a) The commissioner of human services shall not count payments made to families by the income and child development in the first three years of life demonstration project as income or assets for purposes of determining or redetermining eligibility for child care assistance programs under Minnesota Statutes, chapter 119B; the Minnesota family investment program, work benefit program, or diversionary work program under Minnesota Statutes, chapter 256J, during the duration of the demonstration.

(b) The commissioner of human services shall not count payments made to families by the income and child development in the first three years of life demonstration project as income for purposes of determining or redetermining eligibility for medical assistance under Minnesota Statutes, chapter 256B, and MinnesotaCare under Minnesota Statutes, chapter 256L.

(c) For the purposes of this section, "income and child development in the first three years of life demonstration project" means a demonstration project funded by the United States Department of Health and Human Services National Institutes of Health to evaluate whether the unconditional cash payments have a causal effect on the cognitive, socioemotional, and brain development of infants and toddlers.

(d) This section shall only be implemented if Minnesota is chosen as a site for the child development in the first three years of life demonstration site, and expires January 1, 2022.

(e) The commissioner of human services shall provide a report to the legislative committees having jurisdiction over human services issues by January 1, 2023, informing the legislature on the progress and outcomes of the demonstration under this section.

EFFECTIVE DATE. Paragraph (b) is effective August 16, 2016, or upon federal approval, whichever is later.

Sec. 43. **REVIEW OF RULE 4 CHILD FOSTER CARE PRIVATE AGENCIES.**

The commissioner of human services shall convene a working group to review the impact of removing the licensing responsibilities from private agencies, and replacing those duties with responsibilities to provide technical assistance for prospective foster care providers, care coordination for children in foster care, and training support for foster parents. The commissioner shall submit a report to the 2017 legislative committees with jurisdiction over foster care issues by January 15, 2017, with language and an analysis of costs associated with these changes.

ARTICLE 2

MENTAL HEALTH

Section 1. Minnesota Statutes 2015 Supplement, section 245.735, subdivision 3, is amended to read:

Subd. 3. **~~Reform projects~~ Certified community behavioral health clinics.** (a) The commissioner shall establish ~~standards for~~ a state certification ~~of clinics as~~ process for certified community behavioral health clinics~~, in accordance~~ (CCBHCs) to be eligible for the prospective payment system in paragraph (f). Entities that choose to be CCBHCs must:

(1) comply with the CCBHC 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)~~ (2) employ or contract for clinic staff who have backgrounds in diverse disciplines, ~~include~~ including licensed mental health professionals, and staff who are culturally and linguistically trained to serve the needs of the clinic's patient population;

~~(2)~~ (3) ensure that clinic services are available and accessible to patients of all ages and genders and that crisis management services are available 24 hours per day;

~~(3)~~ (4) establish fees for clinic services ~~are established~~ for non-medical assistance patients using a sliding fee scale ~~and~~ that ensures that 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) comply with quality assurance reporting requirements and other reporting requirements, including any required reporting of encounter data, clinical outcomes data, and quality data;

~~(5) services provided by clinics include~~ (6) provide crisis mental health services, withdrawal management 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.~~ (7) 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:

(i) counties, health plans, pharmacists, pharmacies, rural health clinics, federally qualified health centers, inpatient psychiatric facilities, substance use and detoxification facilities, community-based mental health providers; and

(ii) 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;

(8) be certified as mental health clinics under section 245.69, subdivision 2;

(9) comply with standards relating to integrated treatment for co-occurring mental illness and substance use disorders in adults or children under Minnesota Rules, chapter 9533;

(10) comply with standards relating to mental health services in Minnesota Rules, parts 9505.0370 to 9505.0372;

(11) be licensed to provide chemical dependency treatment under Minnesota Rules, parts 9530.6405 to 9530.6505;

(12) be certified to provide children's therapeutic services and supports under section 256B.0943;

(13) be certified to provide adult rehabilitative mental health services under section 256B.0623;

(14) be enrolled to provide mental health crisis response services under section 256B.0624;

(15) be enrolled to provide mental health targeted case management under section 256B.0625, subdivision 20;

(16) comply with standards relating to mental health case management in Minnesota Rules, parts 9520.0900 to 9520.0926; and

(17) provide services that comply with the evidence-based practices described in paragraph (e).

(b) If an entity is unable to provide one or more of the services listed in paragraph (a), clauses (6) to (17), the commissioner may certify the entity as a CCBHC if it has a current contract with another entity that has the required authority to provide that service and that meets federal CCBHC criteria as a designated collaborating organization; or, to the extent allowed by the federal CCBHC criteria, the commissioner may approve a referral arrangement. The CCBHC must meet federal requirements regarding the type and scope of services to be provided directly by the CCBHC.

(c) Notwithstanding other law that requires a county contract or other form of county approval for certain services listed in paragraph (a), clause (6), a clinic that otherwise meets CCBHC requirements may receive the prospective payment under paragraph (f) for those services without a county contract or county approval. There is no county share when medical assistance pays the CCBHC prospective payment. As part of the certification process in paragraph (a), the commissioner shall require a letter of support from the CCBHC's host county confirming that the CCBHC and the county or counties it serves have an ongoing relationship to facilitate access and continuity of care, especially for individuals who are uninsured or who may go on and off medical assistance.

(d) When the standards listed in paragraph (a) or other applicable standards conflict or address similar issues in duplicative or incompatible ways, the commissioner may grant variances to state requirements if the variances do not conflict with federal requirements. If standards overlap, the commissioner may substitute all or a part of a licensure or certification that is substantially the same as another licensure or certification. The commissioner shall consult with stakeholders, as described in subdivision 4, before granting variances under this provision.

(e) The commissioner shall issue a list of required evidence-based practices to be delivered by certified community behavioral health clinics, and may also provide a list of recommended evidence-based practices. The commissioner may update the list to reflect advances in outcomes research and medical services for persons living with mental illnesses or substance use disorders. The commissioner shall take into consideration the adequacy of evidence to support the efficacy of the practice, the quality of workforce available, and the current availability of the practice in the state. At least 30 days before issuing the initial list and any revisions, the commissioner shall provide stakeholders with an opportunity to comment.

~~(b)~~ (f) 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~~ an enhanced federal medical assistance percentage. The commissioner may include quality bonus payments in the prospective payment system based on federal criteria and on a clinic's provision of the evidence-based practices in paragraph (e). The prospective payments system does not apply to MinnesotaCare. Implementation of the prospective payment system is effective July 1, 2017, or upon federal approval, whichever is later.

(g) The commissioner shall seek federal approval to continue federal financial participation in payment for CCBHC services after the federal demonstration period ends for clinics that were certified as CCBHCs during the demonstration period and that continue to meet the CCBHC certification standards in paragraph (a). Payment for CCBHC services shall cease effective July 1, 2019, if continued federal financial participation for the payment of CCBHC services cannot be obtained.

(h) To the extent allowed by federal law, the commissioner may limit the number of certified clinics so that the projected claims for certified clinics will not exceed the funds budgeted for this purpose. The commissioner shall give preference to clinics that:

(1) are located in both rural and urban areas, with at least one in each, as defined by federal criteria;

(2) provide a comprehensive range of services and evidence-based practices for all age groups, with services being fully coordinated and integrated; and

(3) enhance the state's ability to meet the federal priorities to be selected as a CCBHC demonstration state.

(i) The commissioner shall recertify CCBHCs at least every three years. The commissioner shall establish a process for decertification and shall require corrective action, medical assistance repayment, or decertification of a CCBHC that no longer meets the requirements in this section or that fails to meet the standards provided by the commissioner in the application and certification process.

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

Sec. 2. Minnesota Statutes 2015 Supplement, section 245.735, subdivision 4, is amended to read:

Subd. 4. **Public participation.** In developing ~~the projects~~ and implementing certified community behavioral health clinics under subdivision 3, the commissioner shall consult, collaborate, and partner with stakeholders, including but not limited to mental health providers, substance use disorder treatment providers, advocacy organizations, licensed mental health professionals, counties, tribes, hospitals, other health care providers, and Minnesota public health care program enrollees who receive mental health services and their families.

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

Sec. 3. Minnesota Statutes 2014, section 245.99, subdivision 2, is amended to read:

Subd. 2. **Rental assistance.** The program shall pay up to 90 days of housing assistance for persons with a serious ~~and persistent~~ mental illness who require inpatient or residential care for stabilization. The commissioner of human services may extend the length of assistance on a case-by-case basis.

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

Sec. 4. Minnesota Statutes 2014, section 254B.01, subdivision 4a, is amended to read:

Subd. 4a. **Culturally specific program.** (a) "Culturally specific program" means a substance use disorder treatment service program or subprogram that is recovery-focused and culturally specific when the program:

(1) improves service quality to and outcomes of a specific population by advancing health equity to help eliminate health disparities; and

(2) ensures effective, equitable, comprehensive, and respectful quality care services that are responsive to an individual within a specific population's values, beliefs and practices, health literacy, preferred language, and other communication needs.

(b) A tribally licensed substance use disorder program that is designated as serving a culturally specific population by the applicable tribal government is deemed to satisfy this subdivision.

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

Sec. 5. Minnesota Statutes 2014, section 254B.03, subdivision 4, is amended to read:

Subd. 4. **Division of costs.** (a) Except for services provided by a county under section 254B.09, subdivision 1, or services provided under section 256B.69 ~~or 256D.03, subdivision 4, paragraph (b)~~, the county shall, out of local money, pay the state for 22.95 percent of the cost of chemical dependency services, including those services provided to persons eligible for medical assistance under chapter 256B and general assistance medical care under chapter 256D. Counties may use the indigent hospitalization levy for treatment and hospital payments made under this section.

(b) 22.95 percent of any state collections from private or third-party pay, less 15 percent for the cost of payment and collections, must be distributed to the county that paid for a portion of the treatment under this section.

(c) For fiscal year 2017 only, the 22.95 percentages under paragraphs (a) and (b) are equal to 15 percent.

Sec. 6. Minnesota Statutes 2014, section 254B.04, subdivision 2a, is amended to read:

Subd. 2a. **Eligibility for treatment in residential settings.** Notwithstanding provisions of Minnesota Rules, part 9530.6622, subparts 5 and 6, related to an assessor's discretion in making placements to residential treatment settings, a person eligible for services under this section must score at level 4 on assessment dimensions related to relapse, continued use, or recovery environment in order to be assigned to services with a room and board component reimbursed under this section. Whether a treatment facility has been designated an institution for mental diseases under United States Code, title 42, section 1396d, shall not be a factor in making placements.

Sec. 7. Minnesota Statutes 2015 Supplement, 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;

(7) high-intensity residential treatment services that are licensed according to Minnesota Rules, parts 9530.6405 to 9530.6480 and 9530.6505, or applicable tribal license, which provide 30 hours of clinical services each week provided by a state-operated vendor or to clients who have been civilly committed to the commissioner, present the most complex and difficult care needs, and are a potential threat to the community; and

(8) room and board facilities that meet the requirements of subdivision 1a.

(c) The commissioner shall establish higher rates for programs that meet the requirements of paragraph (b) and one of the following additional requirements:

(1) programs that serve parents with their children if the program:

(i) provides on-site child care during the hours of treatment activity that:

(A) is licensed under chapter 245A as a child care center under Minnesota Rules, chapter 9503; or

(B) meets the licensure exclusion criteria of section 245A.03, subdivision 2, paragraph (a), clause (6), and meets the requirements under Minnesota Rules, part 9530.6490, subpart 4; or

(ii) arranges for off-site child care during hours of treatment activity at a facility that is licensed under chapter 245A as:

(A) a child care center under Minnesota Rules, chapter 9503; or

(B) a family child care home under Minnesota Rules, chapter 9502;

(2) culturally specific programs as defined in section 254B.01, subdivision 4a, or programs or subprograms serving special populations, if the program or subprogram meets the following requirements ~~in Minnesota Rules, part 9530.6605, subpart 13;~~:

(i) is designed to address the unique needs of individuals who share a common language, racial, ethnic, or social background;

(ii) is governed with significant input from individuals of that specific background; and

(iii) employs individuals to provide individual or group therapy, at least 50 percent of whom are of that specific background, except when the common social background of the individuals served is a traumatic brain injury or cognitive disability and the program employs treatment staff who have the necessary professional training, as approved by the commissioner, to serve clients with the specific disabilities that the program is designed to serve.

(3) programs that offer medical services delivered by appropriately credentialed health care staff in an amount equal to two hours per client per week if the medical needs of the client and the nature and provision of any medical services provided are documented in the client file; and

(4) programs that offer services to individuals with co-occurring mental health and chemical dependency problems if:

(i) the program meets the co-occurring requirements in Minnesota Rules, part 9530.6495;

(ii) 25 percent of the counseling staff are licensed mental health professionals, as defined in section 245.462, subdivision 18, clauses (1) to (6), or are students or licensing candidates under the supervision of a licensed alcohol and drug counselor supervisor and licensed mental health professional, except that no more than 50 percent of the mental health staff may be students or licensing candidates with time documented to be directly related to provisions of co-occurring services;

(iii) clients scoring positive on a standardized mental health screen receive a mental health diagnostic assessment within ten days of admission;

(iv) the program has standards for multidisciplinary case review that include a monthly review for each client that, at a minimum, includes a licensed mental health professional and licensed alcohol and drug counselor, and their involvement in the review is documented;

(v) family education is offered that addresses mental health and substance abuse disorders and the interaction between the two; and

(vi) co-occurring counseling staff ~~will~~ shall receive eight hours of co-occurring disorder training annually.

(d) In order to be eligible for a higher rate under paragraph (c), clause (1), a program that provides arrangements for off-site child care must maintain current documentation at the chemical dependency facility of the child care provider's current licensure to provide child care services. Programs that provide child care according to paragraph (c), clause (1), must be deemed in compliance with the licensing requirements in Minnesota Rules, part 9530.6490.

(e) Adolescent residential programs that meet the requirements of Minnesota Rules, parts 2960.0430 to 2960.0490 and 2960.0580 to 2960.0690, are exempt from the requirements in paragraph (c), clause (4), items (i) to (iv).

(f) Subject to federal approval, chemical dependency services that are otherwise covered as direct face-to-face services may be provided via two-way interactive video. The use of two-way interactive video must be medically appropriate to the condition and needs of the person being served. Reimbursement shall be at the same rates and under the same conditions that would otherwise apply to direct face-to-face services. The interactive video equipment and connection must comply with Medicare standards in effect at the time the service is provided.

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

Sec. 8. Minnesota Statutes 2014, section 254B.06, subdivision 2, is amended to read:

Subd. 2. **Allocation of collections.** (a) The commissioner shall allocate all federal financial participation collections to a special revenue account. The commissioner shall allocate 77.05 percent of patient payments and third-party payments to the special revenue account and 22.95 percent to the county financially responsible for the patient.

(b) For fiscal year 2017 only, the percentage under paragraph (a) that the commissioner shall pay is 85 percent, and the percentage the county shall pay is 15 percent.

Sec. 9. Minnesota Statutes 2014, section 254B.06, is amended by adding a subdivision to read:

Subd. 4. **Reimbursement for institutions for mental diseases.** The commissioner shall not deny reimbursement to a program designated as an institution for mental diseases under United States Code, title 42, section 1396d, due to a reduction in federal financial participation and the addition of new residential beds.

Sec. 10. Minnesota Statutes 2014, section 256B.0621, subdivision 10, is amended to read:

Subd. 10. **Payment rates.** The commissioner shall set payment rates for targeted case management under this subdivision. Case managers may bill according to the following criteria:

(1) for relocation targeted case management, case managers may bill for direct case management activities, including face-to-face ~~and~~, telephone contacts, and interactive video contact in accordance with section 256B.0924, subdivision 4a, in the lesser of:

(i) 180 days preceding an eligible recipient's discharge from an institution; or

(ii) the limits and conditions which apply to federal Medicaid funding for this service;

(2) for home care targeted case management, case managers may bill for direct case management activities, including face-to-face and telephone contacts; and

(3) billings for targeted case management services under this subdivision shall not duplicate payments made under other program authorities for the same purpose.

Sec. 11. Minnesota Statutes 2014, section 256B.0622, is amended by adding a subdivision to read:

Subd. 12. **Start-up grants.** The commissioner may, within available appropriations, disburse grant funding to counties, Indian tribes, or mental health service providers to establish additional assertive community treatment teams, intensive residential treatment services, or crisis residential services.

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

Sec. 12. Minnesota Statutes 2015 Supplement, section 256B.0625, subdivision 20, is amended to read:

Subd. 20. **Mental health case management.** (a) To the extent authorized by rule of the state agency, medical assistance covers case management services to persons with serious and persistent mental illness and children with severe emotional disturbance. Services provided under this section must meet the relevant standards in sections 245.461 to 245.4887, the Comprehensive Adult and Children's Mental Health Acts, Minnesota Rules, parts 9520.0900 to 9520.0926, and 9505.0322, excluding subpart 10.

(b) Entities meeting program standards set out in rules governing family community support services as defined in section 245.4871, subdivision 17, are eligible for medical assistance reimbursement for case management services for children with severe emotional disturbance when these services meet the program standards in Minnesota Rules, parts 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10.

(c) Medical assistance and MinnesotaCare payment for mental health case management shall be made on a monthly basis. In order to receive payment for an eligible child, the provider must document at least a face-to-face contact with the child, the child's parents, or the child's legal representative. To receive payment for an eligible adult, the provider must document:

(1) at least a face-to-face contact with the adult or the adult's legal representative or a contact by interactive video that meets the requirements of subdivision 20b; or

(2) at least a telephone contact with the adult or the adult's legal representative and document a face-to-face contact or a contact by interactive video that meets the requirements of subdivision 20b with the adult or the adult's legal representative within the preceding two months.

(d) Payment for mental health case management provided by county or state staff shall be based on the monthly rate methodology under section 256B.094, subdivision 6, paragraph (b), with separate rates calculated for child welfare and mental health, and within mental health, separate rates for children and adults.

(e) Payment for mental health case management provided by Indian health services or by agencies operated by Indian tribes may be made according to this section or other relevant federally approved rate setting methodology.

(f) Payment for mental health case management provided by vendors who contract with a county or Indian tribe shall be based on a monthly rate negotiated by the host county or tribe. The negotiated rate must not exceed the rate charged by the vendor for the same service to other payers. If the service is provided by a team of contracted vendors, the county or tribe may negotiate a team rate with a vendor who is a member of the team. The

team shall determine how to distribute the rate among its members. No reimbursement received by contracted vendors shall be returned to the county or tribe, except to reimburse the county or tribe for advance funding provided by the county or tribe to the vendor.

(g) If the service is provided by a team which includes contracted vendors, tribal staff, and county or state staff, the costs for county or state staff participation in the team shall be included in the rate for county-provided services. In this case, the contracted vendor, the tribal agency, and the county may each receive separate payment for services provided by each entity in the same month. In order to prevent duplication of services, each entity must document, in the recipient's file, the need for team case management and a description of the roles of the team members.

(h) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for mental health case management shall be provided by the recipient's county of responsibility, as defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds used to match other federal funds. If the service is provided by a tribal agency, the nonfederal share, if any, shall be provided by the recipient's tribe. When this service is paid by the state without a federal share through fee-for-service, 50 percent of the cost shall be provided by the recipient's county of responsibility.

(i) Notwithstanding any administrative rule to the contrary, prepaid medical assistance, general assistance medical care, and MinnesotaCare include mental health case management. When the service is provided through prepaid capitation, the nonfederal share is paid by the state and the county pays no share.

(j) The commissioner may suspend, reduce, or terminate the reimbursement to a provider that does not meet the reporting or other requirements of this section. The county of responsibility, as defined in sections 256G.01 to 256G.12, or, if applicable, the tribal agency, is responsible for any federal disallowances. The county or tribe may share this responsibility with its contracted vendors.

(k) The commissioner shall set aside a portion of the federal funds earned for county expenditures under this section to repay the special revenue maximization account under section 256.01, subdivision 2, paragraph (o). The repayment is limited to:

(1) the costs of developing and implementing this section; and

(2) programming the information systems.

(l) Payments to counties and tribal agencies for case management expenditures under this section shall only be made from federal earnings from services provided under this section. When this service is paid by the state without a federal share through fee-for-service, 50 percent of the cost shall be provided by the state. Payments to

county-contracted vendors shall include the federal earnings, the state share, and the county share.

(m) Case management services under this subdivision do not include therapy, treatment, legal, or outreach services.

(n) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital, and the recipient's institutional care is paid by medical assistance, payment for case management services under this subdivision is limited to the lesser of:

(1) the last 180 days of the recipient's residency in that facility and may not exceed more than six months in a calendar year; or

(2) the limits and conditions which apply to federal Medicaid funding for this service.

(o) Payment for case management services under this subdivision shall not duplicate payments made under other program authorities for the same purpose.

(p) If the recipient is receiving care in a hospital, nursing facility, or a residential setting licensed under chapter 245A or 245D that is staffed 24 hours per day, seven days per week, mental health targeted case management services are expected to actively support identification of community alternatives for the recipient and discharge planning.

Sec. 13. Minnesota Statutes 2014, section 256B.0625, is amended by adding a subdivision to read:

Subd. 20b. **Mental health targeted case management through interactive video.** (a) Subject to federal approval, contact made for targeted case management by interactive video shall be eligible for payment if:

(1) the person receiving targeted case management services is residing in:

(i) a hospital;

(ii) a nursing facility; or

(iii) a residential setting licensed under chapter 245A or 245D, or a boarding and lodging establishment or lodging establishment that provides supportive services or health supervision services according to section 157.17, which is staffed 24 hours per day, seven days per week;

(2) interactive video is in the best interests of the person and is deemed appropriate by the person receiving targeted case management or their legal guardian, the case management provider, and the provider operating the setting where the person is residing;

(3) the use of interactive video is approved as part of the person's written personal service or case plan taking into consideration the person's vulnerability and active personal relationships; and

(4) interactive video is used for up to, but not more than, 50 percent of the minimum required face-to-face contacts.

(b) The person receiving targeted case management or their legal guardian have the right to choose and consent to the use of interactive video under this subdivision, and has the right to refuse the use of interactive video at any time.

(c) The commissioner shall establish criteria that a targeted case management provider must attest to in order to demonstrate the safety or efficacy of delivering the service via interactive video. The attestation may include that the case management provider:

(1) has written policies and procedures specific to interactive video services that are regularly reviewed and updated;

(2) has polices and procedures that adequately address client safety before, during, and after the interactive video service is rendered;

(3) has established protocols addressing how and when to discontinue interactive video services; and

(4) has an established quality assurance process related to interactive video services.

(d) As a condition of payment, the targeted case management provider must document each occurrence of targeted case management provided by interactive video and must document:

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

(2) the basis for determining that interactive video is an appropriate and effective means for delivering the service to the enrollees;

(3) the mode of transmission of the interactive video service and records evidencing that a particular mode of transmission was utilized;

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

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

Sec. 14. Minnesota Statutes 2014, section 256B.0924, is amended by adding a subdivision to read:

Subd. 4a. **Targeted case management through interactive video.** (a) Subject to federal approval, contact made for targeted case management by interactive video shall be eligible for payment if:

(1) the person receiving targeted case management services is residing in:

(i) a hospital;

(ii) a nursing facility; or

(iii) a residential setting licensed under chapter 245A or 245D, or a boarding and lodging establishment or lodging establishment that provides supportive services or health supervision services according to section 157.17, and that is staffed 24 hours per day, seven days a week;

(2) interactive video is in the best interests of the person and is deemed appropriate by the person receiving targeted case management or their legal guardian, the case management provider, and the provider operating the setting where the person is residing;

(3) the use of interactive video is approved as part of the person's written personal service or case plan; and

(4) interactive video is used for up to, but not more than, 50 percent of the minimum required face-to-face contacts.

(b) The person receiving targeted case management or their legal guardian have the right to choose and consent to the use of interactive video under this subdivision, and has the right to refuse the use of interactive video at any time.

(c) The commissioner shall establish criteria that a targeted case management provider must attest to in order to demonstrate the safety or efficacy of delivering the service via interactive video. The attestation may include that the case management provider:

(1) has written policies and procedures specific to interactive video services that are regularly reviewed and updated;

(2) has polices and procedures that adequately address client safety before, during, and after the interactive video service is rendered;

(3) has established protocols addressing how and when to discontinue interactive video services; and

(4) has an established quality assurance process related to interactive video services.

(d) As a condition of payment, the targeted case management provider must document each occurrence of targeted case management provided by interactive video and must document:

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

(2) the basis for determining that interactive video is an appropriate and effective means for delivering the service to the enrollees;

(3) the mode of transmission of the interactive video service and records evidencing that a particular mode of transmission was utilized;

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

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

Sec. 15. **CHILDREN'S MENTAL HEALTH COLLABORATIVE; YOUTH AND YOUNG ADULT MENTAL HEALTH DEMONSTRATION PROJECT.**

(a) The commissioner of human services shall grant funds to a children's mental health collaborative for a rural demonstration project to assist transition-aged youth and young adults with emotional behavioral disturbance (EBD) or mental illnesses in making a successful transition into adulthood.

(b) The demonstration project must:

(1) build on and streamline transition services by identifying rural youth ages 15 to 25 currently in the mental health system or with emerging mental health conditions;

(2) support youth to achieve, within their potential, their personal goals in employment, education, housing, and community life functioning;

(3) provide individualized motivational coaching;

(4) build on needed social supports;

(5) demonstrate how services can be enhanced for youth to successfully navigate the complexities associated with their unique needs;

(6) utilize all available funding streams;

(7) demonstrate collaboration with the local children's mental health collaborative in designing and implementing the demonstration project;

(8) evaluate the effectiveness of the project by specifying and measuring outcomes showing the level of progress for involved youth; and

(9) compare differences in outcomes and costs to youth without previous access to this project.

(c) The commissioner shall report to the committee members of the senate and house of representatives committees with jurisdiction over mental health issues on the status and outcomes of the demonstration project by January 15, 2019. The children's mental health collaborative administering the demonstration project shall collect and report outcome data, as outlined by the commissioner, to support the development of this report.

Sec. 16. **COMMISSIONER DUTY TO SEEK FEDERAL APPROVAL FOR INTERACTIVE VIDEO CONTACT.**

The commissioner of human services shall seek federal approval that is necessary to implement the sections of this article related to reimbursement for interactive video contact.

ARTICLE 3

DIRECT CARE AND TREATMENT

Section 1. Minnesota Statutes 2015 Supplement, section 245.4889, subdivision 1, is amended to read:

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

(1) counties;

(2) Indian tribes;

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

(4) mental health service providers.

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

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

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

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

(4) children's mental health crisis services;

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

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

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

(8) school-linked mental health services;

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

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

(11) mental health first aid training;

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

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

(14) early childhood mental health consultation;

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

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

(17) sustaining extended-stay inpatient psychiatric hospital services for children and adolescents.

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

Sec. 2. Minnesota Statutes 2014, section 246.50, subdivision 7, is amended to read:

Subd. 7. **Client's county.** "Client's county" means the county of ~~the client's legal settlement for poor relief purposes at the time of commitment or voluntary admission to a state facility, or if the client has no such legal settlement in this state, it means the county of commitment~~ financial responsibility under chapter 256G, except that where a client with no ~~such legal settlement~~ residence in this state is committed while serving a sentence at a penal institution, it means the county from which the client was sentenced.

Sec. 3. Minnesota Statutes 2014, section 246.54, as amended by Laws 2015, chapter 71, article 4, section 2, is amended to read:

246.54 LIABILITY OF COUNTY; REIMBURSEMENT.

Subdivision 1. ~~**County portion for cost of care**~~ **Generally.** ~~(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:~~.

Subd. 1a. **Anoka Metro Regional Treatment Center.** (a) A county's payment of the cost of care provided at Anoka Metro Regional Treatment Center shall be according to the following schedule:

(1) zero percent for the first 30 days;

(2) 20 percent for days 31 and over if the stay is determined to be clinically appropriate for the client; and

(3) 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) 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 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.

Subd. 1b. **Community behavioral health hospitals.** A county's payment of the cost of care provided at state-operated community-based behavioral health hospitals shall be according to the following schedule:

(1) 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; and

(2) 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.

Subd. 1c. **State-operated forensic services.** A county's payment of the cost of care provided at state-operated forensic services shall be according to the following schedule:

(1) Minnesota Security Hospital: ten percent for each day, or portion thereof, that the client spends in a Minnesota Security Hospital program. If payments received by the state under sections 246.50 to 246.53 for services provided at the Minnesota Security Hospital exceed 90 percent of the cost of care, 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 the client's relatives except as provided in section 246.53;

(2) forensic nursing home: ten percent for each day, or portion thereof, that the client spends in a forensic nursing home program. If payments received by the state under sections 246.50 to 246.53 for services provided at the forensic nursing home exceed 90 percent of the cost of care, 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 the client's relatives except as provided in section 246.53;

(3) forensic transition services: 50 percent for each day, or portion thereof, that the client spends in the forensic transition services program. If payments received by the state under sections 246.50 to 246.53 for services provided in the forensic transition services exceed 50 percent of the cost of care, 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 the client's relatives except as provided in section 246.53; and

(4) residential competency restoration program:

(i) 20 percent for each day, or portion thereof, that the client spends in a residential competency restoration program while the client is in need of restoration services;

(ii) 50 percent for each day, or portion thereof, that the client spends in a residential competency restoration program once the examiner opines that the client no longer needs restoration services; and

(iii) 100 percent for each day, or portion thereof, once charges against a client have been resolved or dropped.

Subd. 2. **Exceptions.** ~~(a) Subdivision 1 does not apply to services provided at the Minnesota Security Hospital. For services at the Minnesota Security Hospital, a county's payment shall be made from the county's own sources of revenue and payments. Excluding the state-operated forensic transition service, payments to the state from the county shall equal ten percent of the cost of care, as determined by the commissioner, for each day, or the portion thereof, that the client spends at the facility. For the state-operated forensic transition service, payments to the state from the county shall equal 50 percent of the cost of care, as determined by the commissioner, for each day, or the portion thereof, that the client spends in the program. If payments received by the state under sections 246.50 to 246.53 for services provided at the Minnesota Security Hospital, excluding the state-operated forensic transition service, exceed 90 percent of the cost of care, the county shall be responsible for paying the state only the remaining amount. If payments received by the state under sections 246.50 to 246.53 for the state-operated forensic transition service exceed 50 percent of the cost of care, 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~~.

~~(b)~~ Regardless of the facility to which the client is committed, ~~subdivision 1 does~~ subdivisions 1, 1a, 1b, and 1c, do not apply to the following individuals:

(1) clients who are committed as sexual psychopathic personalities under section 253D.02, subdivision 15; and

(2) clients who are committed as sexually dangerous persons under section 253D.02, subdivision 16.

Sec. 4. Minnesota Statutes 2014, section 246B.01, subdivision 1b, is amended to read:

Subd. 1b. **Civilly committed sex offender's county.** "Civilly committed sex offender's county" means the county of ~~the civilly committed sex offender's legal settlement for poor relief purposes at the time of commitment. If the civilly committed sex offender has no legal settlement for poor relief in this state, it means the county of commitment~~ financial responsibility under chapter 256G, except that when a civilly

committed sex offender with no ~~legal settlement for poor relief~~ residence in this state is committed while serving a sentence at a penal institution, it means the county from which the civilly committed sex offender was sentenced.

Sec. 5. 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 or on provisional discharge from 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. 6. Minnesota Statutes 2014, section 246B.035, is amended to read:

246B.035 ANNUAL PERFORMANCE REPORT REQUIRED.

The executive director of the Minnesota sex offender program shall submit electronically a performance report to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over funding for the program by ~~January~~ February 15 of each year beginning in ~~2010~~ 2017. The report must include the following:

(1) a description of the program, including the strategic mission, goals, objectives, and outcomes;

(2) the programwide per diem reported in a standard calculated method as outlined in the program policies and procedures;

(3) program annual statistics as outlined in the departmental policies and procedures; and

(4) the sex offender program evaluation report required under section 246B.03. The executive director shall submit a printed copy upon request.

Sec. 7. Minnesota Statutes 2014, section 246B.10, is amended to read:

246B.10 LIABILITY OF COUNTY; REIMBURSEMENT.

(a) The civilly committed sex offender's county shall pay to the state a portion of the cost of care provided ~~in~~ by 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 Department of Human Services operated facility or while on provisional discharge.

(b) If payments received by the state under this chapter exceed 75 percent of the cost of care, the county is responsible for paying the state the remaining amount.

(c) 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. This section is effective the day following final enactment.

Sec. 8. **REPORT ON ANOKA-METRO REGIONAL TREATMENT CENTER (AMRTC), MINNESOTA SECURITY HOSPITAL (MSH), AND COMMUNITY BEHAVIORAL HEALTH HOSPITALS (CBHH).**

The commissioner of human services shall issue a public quarterly report to the chairs and minority leaders on the senate and house of representatives committees having jurisdiction over health and human services issues on the AMRTC, MSH, and the CBHH. The report shall contain information on the number of licensed beds, budgeted capacity, occupancy rate, number of clinical positions funded, and percentage of those positions that are filled.

ARTICLE 4

CONTINUING CARE

Section 1. Minnesota Statutes 2014, section 245A.10, subdivision 4, is amended to read:

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

Licensed Capacity	Child Care Center License Fee
1 to 24 persons	$200
25 to 49 persons	$300
50 to 74 persons	$400
75 to 99 persons	$500
100 to 124 persons	$600
125 to 149 persons	$700
150 to 174 persons	$800
175 to 199 persons	$900
200 to 224 persons	$1,000
225 or more persons	$1,100

(b)(1) A program licensed to provide one or more of the home and community-based services and supports identified under chapter 245D to persons with disabilities or age 65 and older, shall pay an annual nonrefundable license fee ~~based on~~ of 0.27 percent of revenues derived from the provision of services that would require licensure under this chapter ~~245D~~ and that are specified under section 245D.03, subdivision 1, during the calendar year immediately preceding the year in which the license fee is paid~~, according to the following schedule:~~. If the calculated fee is less than $450, the fee shall be $450.

~~License Holder Annual Revenue~~	~~License Fee~~
~~less than or equal to $10,000~~	~~$200~~
~~greater than $10,000 but less than or equal to $25,000~~	~~$300~~
~~greater than $25,000 but less than or equal to $50,000~~	~~$400~~
~~greater than $50,000 but less than or equal to $100,000~~	~~$500~~
~~greater than $100,000 but less than or equal to $150,000~~	~~$600~~
~~greater than $150,000 but less than or equal to $200,000~~	~~$800~~
~~greater than $200,000 but less than or equal to $250,000~~	~~$1,000~~
~~greater than $250,000 but less than or equal to $300,000~~	~~$1,200~~
~~greater than $300,000 but less than or equal to $350,000~~	~~$1,400~~
~~greater than $350,000 but less than or equal to $400,000~~	~~$1,600~~
~~greater than $400,000 but less than or equal to $450,000~~	~~$1,800~~
~~greater than $450,000 but less than or equal to $500,000~~	~~$2,000~~
~~greater than $500,000 but less than or equal to $600,000~~	~~$2,250~~
~~greater than $600,000 but less than or equal to $700,000~~	~~$2,500~~
~~greater than $700,000 but less than or equal to $800,000~~	~~$2,750~~
~~greater than $800,000 but less than or equal to $900,000~~	~~$3,000~~
~~greater than $900,000 but less than or equal to $1,000,000~~	~~$3,250~~
~~greater than $1,000,000 but less than or equal to $1,250,000~~	~~$3,500~~
~~greater than $1,250,000 but less than or equal to $1,500,000~~	~~$3,750~~
~~greater than $1,500,000 but less than or equal to $1,750,000~~	~~$4,000~~

~~greater than $1,750,000 but less than or equal to $2,000,000~~	~~$4,250~~
~~greater than $2,000,000 but less than or equal to $2,500,000~~	~~$4,500~~
~~greater than $2,500,000 but less than or equal to $3,000,000~~	~~$4,750~~
~~greater than $3,000,000 but less than or equal to $3,500,000~~	~~$5,000~~
~~greater than $3,500,000 but less than or equal to $4,000,000~~	~~$5,500~~
~~greater than $4,000,000 but less than or equal to $4,500,000~~	~~$6,000~~
~~greater than $4,500,000 but less than or equal to $5,000,000~~	~~$6,500~~
~~greater than $5,000,000 but less than or equal to $7,500,000~~	~~$7,000~~
~~greater than $7,500,000 but less than or equal to $10,000,000~~	~~$8,500~~
~~greater than $10,000,000 but less than or equal to $12,500,000~~	~~$10,000~~
~~greater than $12,500,000 but less than or equal to $15,000,000~~	~~$14,000~~
~~greater than $15,000,000~~	~~$18,000~~

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

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

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

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

(2) The commissioner shall calculate the licensing fee for providers of home and community-based services and supports under this paragraph and invoice the license holder annually. Upon challenge of the invoiced fee amount by the license holder, the commissioner shall provide the license holder with a report identifying the medical

assistance claims paid by the commissioner to the license holder that formed the basis for the licensing fee calculation.

(c) A chemical dependency treatment program licensed under Minnesota Rules, parts 9530.6405 to 9530.6505, to provide chemical dependency treatment shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$600
25 to 49 persons	$800
50 to 74 persons	$1,000
75 to 99 persons	$1,200
100 or more persons	$1,400

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

Licensed Capacity	License Fee
1 to 24 persons	$760
25 to 49 persons	$960
50 or more persons	$1,160

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

Licensed Capacity	License Fee
1 to 24 persons	$1,000
25 to 49 persons	$1,100
50 to 74 persons	$1,200
75 to 99 persons	$1,300
100 or more persons	$1,400

(f) A residential facility licensed under Minnesota Rules, parts 9520.0500 to 9520.0670, to serve persons with mental illness shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$2,525
25 or more persons	$2,725

(g) A residential facility licensed under Minnesota Rules, parts 9570.2000 to 9570.3400, to serve persons with physical disabilities shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$450
25 to 49 persons	$650
50 to 74 persons	$850
75 to 99 persons	$1,050
100 or more persons	$1,250

(h) A program licensed to provide independent living assistance for youth under section 245A.22 shall pay an annual nonrefundable license fee of $1,500.

(i) A private agency licensed to provide foster care and adoption services under Minnesota Rules, parts 9545.0755 to 9545.0845, shall pay an annual nonrefundable license fee of $875.

(j) A program licensed as an adult day care center licensed under Minnesota Rules, parts 9555.9600 to 9555.9730, shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$500
25 to 49 persons	$700
50 to 74 persons	$900
75 to 99 persons	$1,100
100 or more persons	$1,300

(k) A program licensed to provide treatment services to persons with sexual psychopathic personalities or sexually dangerous persons under Minnesota Rules, parts 9515.3000 to 9515.3110, shall pay an annual nonrefundable license fee of $20,000.

(l) A mental health center or mental health clinic requesting certification for purposes of insurance and subscriber contract reimbursement under Minnesota Rules, parts 9520.0750 to 9520.0870, shall pay a certification fee of $1,550 per year. If the mental health center or mental health clinic provides services at a primary location with satellite facilities, the satellite facilities shall be certified with the primary location without an additional charge.

Sec. 2. Minnesota Statutes 2014, section 245A.10, subdivision 8, is amended to read:

Subd. 8. **Deposit of license fees.** A human services licensing account is created in the ~~state government~~ special revenue fund. Fees collected under subdivisions 3 and 4 must be deposited in the human services licensing account and are ~~annually~~ appropriated to the commissioner for licensing activities authorized under this chapter.

Sec. 3. Minnesota Statutes 2015 Supplement, section 245D.03, subdivision 1, is amended to read:

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

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

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

(2) adult companion services as defined under the brain injury, community access for disability inclusion, and elderly waiver plans, excluding adult companion services provided under the Corporation for National and Community ~~Services~~ Service, Senior Companion Program ~~established~~ under ~~the Domestic Volunteer Service Act of 1973, Public Law 98-288~~ Code of Federal Regulations, title 45, subpart B, chapter 25, part 2551 et seq.;

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

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

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

(6) homemaker services as defined under the community access for disability inclusion, brain injury, community alternative care, developmental disability, and elderly waiver plans, excluding providers licensed by the Department of Health under chapter 144A and those providers providing cleaning services only~~.~~; and

(7) individual community living support under section 256B.0915, subdivision 3j.

(c) Intensive support services provide assistance, supervision, and care that is necessary to ensure the health and welfare of the person and services specifically directed

toward the training, habilitation, or rehabilitation of the person. Intensive support services include:

(1) intervention services, including:

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

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

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

(2) in-home support services, including:

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

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

(iii) semi-independent living services;

(3) residential supports and services, including:

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

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

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

(4) day services, including:

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

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

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

(5) supported employment as defined under the brain injury, developmental disability, and community access for disability inclusion waiver plans.

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

Sec. 4. Minnesota Statutes 2014, section 256B.0949, is amended to read:

256B.0949 ~~AUTISM~~ EARLY INTENSIVE DEVELOPMENTAL AND BEHAVIORAL INTERVENTION BENEFIT.

Subdivision 1. **Purpose.** This section creates ~~a new~~ the early intensive developmental and behavioral intervention (EIDBI) benefit to provide early intensive intervention to a child with an autism spectrum disorder diagnosis or related condition. This benefit must provide coverage for ~~diagnosis~~ a comprehensive, multidisciplinary assessment, ongoing progress evaluation, and medically necessary early intensive treatment of autism spectrum disorder or related conditions.

Subd. 2. **Definitions.** (a) For the purposes of this section, the terms defined in this subdivision have the meanings given.

(b) "Agency" means the legal entity that is enrolled with Minnesota health care programs as a medical assistance provider according to Minnesota Rules, part 9505.0195, to provide EIDBI and that has the legal responsibility to ensure that its employees or contractors carry out the responsibilities defined in this section. The definition of "agency" includes licensed individual professionals who practice independently and act as an agency.

~~(b)~~ (c) "Autism spectrum disorder ~~diagnosis~~" ~~is defined by diagnostic code 299~~ or "ASD" has the meaning given in ~~the current version of~~ the Diagnostic and Statistical Manual of Mental Disorders (DSM).

(d) "ASD and related conditions" means a condition that is found to be closely related to autism spectrum disorder and may include but is not limited to autism, Asperger's syndrome, pervasive developmental disorder-not otherwise specified, fetal alcohol spectrum disorder, Rhett's syndrome, and autism-related diagnosis as identified under the current version of the DSM and meets all of the following criteria:

(1) is severe and chronic;

(2) results in impairment of adaptive behavior and function similar to that of persons with ASD;

(3) requires treatment or services similar to those required for persons with ASD; and

(4) results in substantial functional limitations in three core developmental deficits of ASD: social interaction; nonverbal or social communication; and restrictive, repetitive behaviors or hyperreactivity or hyporeactivity to sensory input; and may include deficits in one or more of the following related developmental domains:

(i) self-regulation;

(ii) self-care;

(iii) behavioral challenges;

(iv) expressive communication;

(v) receptive communication;

(vi) cognitive functioning;

(vii) safety; and

(viii) level of support needed.

~~(e)~~ (e) "Child" means a person under the age of ~~18~~ 22.

(f) "Clinical supervision" means the overall responsibility for the control and direction of EIDBI service delivery, including individual treatment planning, staff supervision, progress monitoring, and treatment review for each client. Clinical supervision is provided by a QSP who takes full professional responsibility for the services provided by each of the supervisees. All EIDBI services must be billed by and either provided by or under the clinical supervision of a QSP.

~~(d)~~ (g) "Commissioner" means the commissioner of human services, unless otherwise specified.

(h) "Comprehensive multidisciplinary evaluation" or "CMDE" means a comprehensive evaluation of a child's developmental status to determine medical necessity for EIDBI based on the requirements in section 256B.0949, subdivision 5.

~~(e)~~ (i) "Early intensive developmental and behavioral intervention benefit" or "EIDBI" means ~~autism treatment options~~ intensive treatment interventions based in behavioral and developmental science~~, which may include modalities such as applied behavior analysis, developmental treatment approaches, and naturalistic and parent training models~~ that include the services covered under subdivision 13.

~~(f)~~ (j) "Generalizable goals" means results or gains that are observed during a variety of activities over time with different people, such as providers, family members, other adults, and children, and in different environments including, but not limited to, clinics, homes, schools, and the community.

(k) "Individual treatment plan" or "ITP" means the person-centered, individualized written plan of care that integrates and coordinates child and family information from the comprehensive multidisciplinary evaluation for a child who meets medical necessity for the early intensive developmental and behavioral intervention benefit. An individual treatment plan must meet the standards in subdivision 6.

(l) "Legal representative" means the parent of a person who is under 18 years of age, a court-appointed guardian, or other representative with legal authority to make decisions about services for a person. Other representatives with legal authority to make decisions include but are not limited to a health care agent or an attorney-in-fact authorized through a health care directive or power of attorney.

(m) "Level I treatment provider" means a person who meets the EIDBI provider qualifications under subdivision 15, paragraph (a).

(n) "Level II treatment provider" means a person who meets the EIDBI provider qualifications under subdivision 15, paragraph (b).

(o) "Level III treatment provider" means a person who meets the EIDBI provider qualifications under subdivision 15, paragraph (c).

~~(g)~~ (p) "Mental health professional" has the meaning given in section 245.4871, subdivision 27, clauses (1) to (6).

(q) "Person-centered" means services that respond to the identified needs, interests, values, preferences, and desired outcomes of the child and the child's legal representative. Person-centered planning identifies what is important to the child and the child's legal representative, respects each child's history, dignity, and cultural background, and allows inclusion and participation in the child's community.

(r) "Qualified CMDE provider" means a person meeting the CMDE provider qualification requirements under subdivision 5a.

(s) "Qualified EIDBI professional" means a person who is a QSP or a level I, level II, or level III treatment provider.

(t) "Qualified supervising professional" or "QSP" means a person who meets the EIDBI provider qualifications under subdivision 15, paragraph (d).

Subd. 3. **~~Initial~~ EIDBI eligibility.** This benefit is available to a child enrolled in medical assistance who:

(1) has ~~an autism spectrum disorder~~ a diagnosis of ASD or a related condition that meets the criteria of subdivision 4; and

(2) ~~has had a diagnostic assessment described in subdivision 5, which recommends early intensive intervention services; and~~

~~(3)~~ meets the criteria for medically necessary autism early intensive intervention services.

Subd. 3a. **Culturally and linguistically appropriate requirement.** The child's and family's primary spoken language, culture, preferences, goals, and values must be reflected throughout the process of diagnosis, CMDE, ITP development, ITP progress evaluation monitoring, family or caregiver training and counseling services, and coordination of care. The qualified CMDE provider and QSP must determine how to adapt the evaluation, treatment recommendations, and ITP to the culture, language, and values of the child and family. A language interpreter must be provided consistent with section 256B.0625, subdivision 18a. Providers must have a limited English proficiency (LEP) plan in compliance with title VI of the Civil Rights Act. Communication and language assistance

must comply with national standards for linguistically appropriate services (CLAS), as published by the United States Department of Health and Human Services.

Subd. 4. **Diagnosis.** (a) A diagnosis of ASD or a related condition must:

(1) be based upon current DSM criteria including direct observations of the child and ~~reports~~ information from ~~parents~~ the child's legal representative or primary caregivers; ~~and~~

(2) be completed by either (i) a licensed physician or advanced practice registered nurse or (ii) a mental health professional; and

(3) meet the requirements of Minnesota Rules, part 9505.0372, subpart 1, items B and C.

(b) Additional ~~diagnostic~~ assessment information may be considered to complete a diagnostic assessment including ~~from~~ specialized tests administered through special education evaluations and licensed school personnel, and from professionals licensed in the fields of medicine, speech and language, psychology, occupational therapy, and physical therapy. A diagnostic assessment may include treatment recommendations.

Subd. 5. ~~**Diagnostic assessment**~~ **Comprehensive multidisciplinary evaluation (CMDE).** (a) The following information and assessments must be performed, reviewed, and relied upon for the eligibility determination, treatment and services recommendations, and treatment plan development for the child:

~~(1)~~ an assessment of the child's developmental skills, functional behavior, needs, and capacities based on direct observation of the child, which must be administered by a licensed mental health professional, must include medical or assessment information from the child's physician or advanced practice registered nurse, and may also include observations from family members, school personnel, child care providers, or other caregivers, as well as any medical or assessment information from other licensed professionals such as rehabilitation therapists, licensed school personnel, or mental health professionals~~; and~~

~~(2) an assessment of parental or caregiver capacity to participate in therapy including the type and level of parental or caregiver involvement and training recommended~~.

A CMDE must be completed to determine the medical necessity of EIDBI services.

(b) The CMDE must include and document the child's legal representative's or caregiver's preferences for involvement in the child's treatment that is culturally and linguistically appropriate as required under subdivision 3a.

Subd. 5a. **CMDE provider qualification requirements.** A qualified CMDE provider must:

(1) be a licensed physician or advanced practice registered nurse or a mental health professional or a mental health practitioner who meets the requirements of a clinical trainee as defined in Minnesota Rules, part 9505.0371, subpart 5, item C;

(2) have at least 2,000 hours of clinical experience in the evaluation and treatment of children with ASD or equivalent documented coursework at the graduate level by an accredited university in the following content areas: ASD diagnosis, ASD treatment strategies, and child development;

(3) be able to diagnose, evaluate, or provide treatment within the provider's scope of practice and professional license; and

(4) have knowledge and provide information about the range of current EIDBI treatment modalities recognized by the commissioner.

Subd. 6. **Individual treatment plan (ITP).** (a) The qualified EIDBI professional who integrates and coordinates child and family information from the CMDE and ITP progress evaluation monitoring process to develop the ITP must develop and monitor the ITP.

(b) The ITP must be individualized, person-centered, and culturally and linguistically appropriate, as required under subdivision 3a. The ITP must specify the medically necessary treatment and services, including baseline data, primary goals and target objectives, ITP progress evaluation results and goal mastery data, and any significant changes in the child's condition or family circumstances. Each child's ~~treatment plan~~ ITP must be~~:~~

~~(1)~~ based on the diagnostic assessment and CMDE summary information specified in subdivisions 4 and 5~~;~~

~~(2) coordinated with medically necessary occupational, physical, and speech and language therapies, special education, and other services the child and family are receiving;~~

~~(3) family-centered;~~

~~(4) culturally sensitive; and~~

~~(5) individualized based on the child's developmental status and the child's and family's identified needs~~.

~~(b)~~ (c) The ~~treatment plan~~ ITP must specify the primary treatment goals and target objectives, including baseline measures and projected dates of accomplishment. The ITP must include:

~~(1) child's goals which are developmentally appropriate, functional, and generalizable;~~

~~(2) treatment modality;~~

~~(3) treatment intensity;~~

~~(4) setting; and~~

~~(5) level and type of parental or caregiver involvement.~~

(1) the treatment method that shall be used to meet the goals and objectives, including:

(i) frequency, intensity, location, and duration of each service provided;

(ii) level of parent or caregiver training and counseling;

(iii) any changes or modifications to the physical and social environments necessary when the services are provided;

(iv) any specialized equipment and materials required;

(v) techniques that support and are consistent with the child's communication mode and learning style; and

(vi) the name of the QSP; and

(2) the discharge criteria that shall be used and a defined transition plan to assist the child and the child's legal representative to transition to other services. The transition plan shall include:

(i) protocols for changing service when medically necessary;

(ii) how the transition will occur;

(iii) the time allowed to make the transition. Up to 30 days of continued service is allowed while the transition plan is being developed. Services during this plan development period shall be consistent with the ITP. The plan development period begins when the child or the child's legal representative receives notice of termination of EIDBI and ends when EIDBI is terminated; and

(iv) a description of how the parent or guardian will be informed of and involved in the transition.

~~(c)~~ (d) Implementation of the ~~treatment~~ ITP must be supervised by a qualified supervising professional ~~with expertise and training in autism and child development who is a licensed physician, advanced practice registered nurse, or mental health professional~~ (QSP).

~~(d)~~ (e) The ~~treatment plan~~ ITP must be submitted to the commissioner for approval in a manner determined by the commissioner for this purpose.

~~(e) Services authorized must be consistent with the child's approved treatment plan.~~

(f) Services included in the ~~treatment plan~~ ITP must meet all applicable requirements for medical necessity and coverage.

Subd. 6a. **Coordination with other benefits.** (a) Services provided under this section are not intended to replace services provided in school or other settings. Each child's CMDE must document that EIDBI services coordinate with, but do not include or replace, special education and related services defined in the child's individualized education plan

(IEP), or individualized family service plan (IFSP), when the service is available under the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) through a local education agency. This provision does not preclude EIDBI treatment during school hours.

(b) The commissioner shall integrate medical authorization procedures for this benefit with authorization procedures for other health and mental health services and home and community-based services to ensure that the child receives services that are the most appropriate and effective in meeting the child's needs. Programs for birth to three years of age and additional resources shall also coordinate with EIDBI services. Resources for individuals over the age of 18 must also be coordinated with the services in this section.

Subd. 7. ~~**Ongoing eligibility**~~ **ITP progress evaluation monitoring.** (a) An ~~independent~~ ITP progress evaluation ~~conducted by a licensed mental health professional with expertise and training in autism spectrum disorder and child development~~ must be completed after each six months of treatment, or more frequently as determined by the ~~commissioner~~ qualified CMDE provider, to determine if progress is being made toward ~~achieving~~ targeted functional and generalizable goals ~~and meeting functional goals contained~~ specified in the ~~treatment plan~~ ITP. Based on the results of ITP progress evaluation, the ITP must be adjusted as needed and must document that the child continues to meet medical necessity for EIDBI or is referred to other services.

(b) The ITP progress evaluation must include:

(1) ~~the treating provider's report;~~

~~(2) parental or caregiver~~ input from the child's caregiver or the child's legal representative;

~~(3)~~ (2) an ~~independent~~ observation of the child ~~which can be~~ that is performed by ~~the child's~~ a QSP or a level I or level II treatment provider and may include observation information from licensed special education staff or other licensed health care providers;

(3) documentation of current level of performance on primary treatment goal domains including when goals and objectives are achieved, changed, or discontinued;

(4) any significant changes in the child's condition or family circumstances;

~~(4)~~ (5) any treatment plan modifications and the rationale for any changes made including treatment modality, intensity, frequency, and duration; and

~~(5)~~ (6) recommendations for continued treatment ~~services~~.

(c) ITP progress ~~evaluations~~ evaluation must be submitted to the commissioner and the child or legal representative in a manner determined by the commissioner for ~~this purpose~~ the reauthorization of EIDBI services.

(d) A child who continues to ~~achieve generalizable goals and~~ make reasonable progress toward treatment goals as specified in the ~~treatment plan~~ ITP is eligible to continue receiving ~~this benefit~~ EIDBI services.

(e) A child's treatment shall continue during the ITP progress evaluation using the process determined under ~~subdivision 8, clause (8)~~ this subdivision. Treatment may continue during an appeal pursuant to section 256.045.

Subd. 8. **Refining the benefit with stakeholders.** The commissioner must ~~develop the implementation~~ refine the details of the benefit in consultation with stakeholders and consider recommendations from ~~the Health Services Advisory Council,~~ the Department of Human Services ~~Autism Spectrum Disorder~~ Early Intensive Developmental and Behavioral Intervention Benefit Advisory Council, ~~the Legislative Autism Spectrum Disorder Task Force,~~ the EIDBI learning collaborative, and the ASD Interagency Task Force of the Departments of Health, Education, Employment and Economic Development, and Human Services. ~~The commissioner must release these details for a 30-day public comment period prior to submission to the federal government for approval.~~ The ~~implementation~~ details must include, but are not limited to, the following components:

(1) a definition of the qualifications, standards, and roles of the treatment team, including recommendations after stakeholder consultation on whether board-certified behavior analysts and other ~~types of~~ professionals certified in other treatment approaches recognized by the Department of Human Services or trained in autism spectrum disorder and child development should be added as ~~mental health or other~~ professionals ~~for~~ qualified to provide EIDBI treatment supervision or other functions under medical assistance;

(2) ~~development of initial,~~ refinement of uniform parameters for comprehensive multidisciplinary ~~diagnostic assessment information~~ evaluation and ~~progress evaluation~~ ongoing ITP progress evaluation monitoring standards;

(3) the design of an effective and consistent process for assessing ~~parent~~ the child's legal representative's and ~~caregiver capacity~~ caregiver's preferences and options to participate in the child's early intervention treatment and efficacy of methods ~~of involving the parents~~ to involve and educate the child's legal representative and caregivers in the treatment of the child;

(4) formulation of a collaborative process in which professionals have opportunities to collectively inform provider standards and qualifications; standards for a comprehensive~~,~~ multidisciplinary ~~diagnostic assessment~~ evaluation; medical necessity determination; efficacy of treatment apparatus, including modality, intensity, frequency, and duration; and ~~progress evaluation~~ progress-monitoring processes ~~and standards~~ to support quality improvement of ~~early intensive intervention~~ EIDBI services;

(5) coordination of this benefit and its interaction with other services provided by the Departments of Human Services, Health, Employment and Economic Development, and Education;

(6) evaluation, on an ongoing basis, of ~~research regarding the~~ program EIDBI outcomes and efficacy of treatment ~~modalities~~ methods provided to children under this benefit; and

(7) as provided under subdivision 18, determination of the availability of ~~licensed physicians, nurse practitioners, and mental health professionals~~ qualified EIDBI professionals with necessary expertise and training in autism spectrum disorder and related conditions throughout the state to assess whether there are sufficient professionals ~~to require involvement of both a physician or nurse practitioner and a mental health professional~~ to provide timely access and prevent delay in the ~~diagnosis and~~ CMDE and treatment of ~~young children, so as to implement subdivision 4, and to ensure treatment is effective, timely, and accessible; and~~ ASD and related conditions.

~~(8) development of the process for the progress evaluation that will be used to determine the ongoing eligibility, including necessary documentation, timelines, and responsibilities of all parties.~~

Subd. 9. **Revision of treatment options.** (a) The commissioner may revise covered treatment options as needed based on outcome data and other evidence. EIDBI treatment methods approved by the Department of Human Services must:

(1) cause no harm to the individual child or family;

(2) be provided in an individualized manner to meet the varied needs of each child and family;

(3) be developmentally appropriate and highly structured, with well-defined goals and objectives that provide a strategic direction for treatment;

(4) be regularly evaluated and adjusted as needed;

(5) be based in recognized principles of developmental and behavioral science;

(6) utilize sound practices that are replicable across providers and maintain the fidelity of the specific approach;

(7) demonstrate an evidentiary basis;

(8) have goals and objectives that are measurable, achievable, and regularly evaluated to ensure that adequate progress is being made;

(9) be provided intensively with a high adult-to-child ratio; and

(10) include active child and legal representative participation in decision-making, knowledge and capacity building, and developing and implementing the child's ITP.

(b) Before ~~the changes~~ revisions in Department of Human Services recognized treatment modalities become effective, the commissioner must provide public notice of the changes, the reasons for the change, and a 30-day public comment period to those who request notice through an electronic list accessible to the public on the department's Web site.

Subd. 10. **Coordination between agencies.** The commissioners of human services and education must develop the capacity to coordinate services and information including diagnostic, functional, developmental, medical, and educational assessments; service delivery; and progress evaluations across health and education sectors.

Subd. 11. **Federal approval of the autism benefit.** (a) This section shall apply to state plan services under title XIX of the Social Security Act when federal approval is granted under a 1915(i) waiver or other authority which allows children eligible for medical assistance through the TEFRA option under section 256B.055, subdivision 12, to qualify and includes children eligible for medical assistance in families over 150 percent of the federal poverty guidelines.

(b) The commissioner may use the federal authority for a Medicaid state plan amendment under Early and Periodic Screening Diagnosis and Treatment (EPSDT), United States Code, title 42, section 1396D(R)(5), or other Medicaid provision for any aspect or type of treatment covered in this section if new federal guidance is helpful in achieving one or more of the purposes of this section in a cost-effective manner. Notwithstanding subdivisions 2 and 3, any treatment services submitted for federal approval under EPSDT shall include appropriate medical criteria to qualify for the service and shall cover children through age 20.

Subd. 12. **Autism benefit; training provided.** After approval of the autism early intensive intervention benefit under this section by the Centers for Medicare and Medicaid Services, the commissioner shall provide statewide training on the benefit for culturally and linguistically diverse communities. Training for autism service providers on culturally appropriate practices must be online, accessible, and available in multiple languages. The training for families, lead agencies, advocates, and other interested parties must provide information about the benefit and how to access it.

Subd. 13. **Covered services.** (a) The services described in paragraphs (b) to (i) are eligible for reimbursement by medical assistance under this section.

(b) EIDBI interventions are a variety of individualized, intensive treatment methods approved by the department that are based in behavioral and developmental science consistent with best practices on effectiveness. Services must address the participant's medically necessary treatment goals and be provided by a qualified supervising

professional or a level I, level II, or level III treatment provider. Services are targeted to develop, enhance, or maintain the individual developmental skills of a child with ASD and related conditions to improve functional communication, social or interpersonal interaction, behavioral challenges and self-regulation, cognition, learning and play, self-care, safety, and level of support needed. EIDBI interventions include, but are not limited to:

(1) applied behavioral analysis (ABA);

(2) developmental individual-difference relationship-based model (DIR/Floortime);

(3) early start Denver model (ESDM);

(4) PLAY project; or

(5) relationship development intervention (RDI).

A provider may use one or more of the treatment interventions in clauses (1) to (5) as the primary modality for treatment as a covered service, or several treatment interventions in combination as the primary modality of treatment, as approved by the commissioner. Additional treatment interventions may be used upon approval by the commissioner. A provider that identifies and provides assurance of qualifications for a single specific treatment modality must document the required qualifications to meet fidelity to the specific model.

(c) EIDBI intervention observation and direction is the clinical direction and oversight by a QSP or a level I or level II treatment provider regarding provision of EIDBI services to a child, including developmental and behavioral techniques, progress measurement, data collection, function of behaviors, and generalization of acquired skills for the direct benefit of a child. EIDBI intervention observation and direction informs any modifications of the methods to support the accomplishment of outcomes in the ITP. Observation and direction provides a real-time response to EIDBI interventions to maximize the benefit to the child.

(d) CMDE is a comprehensive evaluation of the child's developmental status to determine medical necessity for EIDBI services and meets the requirements of subdivision 5. The services must be provided by a qualified CMDE provider.

(e) ITP development and monitoring is development of the initial, annual, and progress monitoring of ITPs. This service documents, provides oversight and on-going evaluation of child treatment and progress on targeted goals and objectives, and integrates and coordinates child and family information from the CMDE and progress monitoring evaluations. The ITP must meet the requirements of subdivision 6. ITP progress evaluation monitoring must meet the requirements of subdivision 7. This service must be reviewed and completed by a QSP, and may include input from a level I or level II treatment provider.

(f) Family caregiver training and counseling is specialized training and education a family or primary caregiver receives to understand their child's developmental status and

help with their child's needs and development. This service must be provided by a QSP or a level I or level II treatment provider.

(g) A coordinated care conference is a voluntary face-to-face meeting with the child and family to review the CMDE or progress monitoring results and to coordinate and integrate services across providers and service-delivery systems to develop the ITP. This service must be provided by a QSP and may include the CMDE provider or the level I or level II treatment provider.

(h) Travel time is allowable billing for traveling to and from the recipient's home, school, a community setting, or place of service outside of an EIDBI center, clinic, or office from a specified location to provide face-to-face EIDBI intervention, observation and direction, or family caregiver training and counseling. EIDBI recipients must have an ITP specifying the reasons the provider must travel to the recipient's home, a community setting, or place of service outside of an EIDBI center, clinic, or office.

(i) Medical assistance covers medically necessary EIDBI services and consultations delivered by a licensed health care provider via telemedicine in the same manner as if the service or consultation was delivered in person. Coverage is limited to three telemedicine services per enrollee per calendar week.

Subd. 14. **Service recipient rights.** A child or the child's legal representative has the right to:

(1) have their rights protected as defined under the health care bill of rights under section 144.651;

(2) designate an advocate of the child's or the child's legal representative's choice to be present in all aspects of the child's and family's services at the request of the child or the child's legal representative;

(3) be informed of the agency policy on assigning staff to individual children;

(4) receive the opportunity to observe the child while receiving services;

(5) receive services in a manner that respects and takes into consideration the child's and the legal representative's culture, values, religion, and preferences in accordance with subdivision 3a;

(6) be free from mechanical restraint or seclusion using locked doors except in emergencies as defined in section 245D.02, subdivision 8a;

(7) be under the supervision of a responsible adult at all times;

(8) receive notification from the agency within 24 hours if the child is injured while receiving services, including what occurred and how agency staff responded to the injury;

(9) request a voluntary coordinated care conference; and

(10) request an independent CMDE provider of the child's or legal representative's choice.

Subd. 15. **EIDBI provider qualifications.** (a) A level I treatment provider must be employed by an EIDBI agency and:

(1) have at least 2,000 hours of supervised clinical experience or training in examining or treating children with ASD or equivalent documented coursework at the graduate level by an accredited university in ASD diagnostics, ASD developmental and behavioral treatment strategies, and typical child development or an equivalent combination of documented coursework or hours of experience; and

(2) have or be at least one of the following:

(i) a master's degree in behavioral health or child development or allied fields, including but not limited to mental health, special education, social work, psychology, speech pathology, or occupational therapy from an accredited college or university;

(ii) a bachelor's degree in a behavioral health or child development field from an accredited college or university and advanced certification in a treatment method recognized by the Department of Human Services; or

(iii) a board-certified assistant behavior analyst with 4,000 hours of supervised clinical experience including meeting all registration, supervision, and continuing education requirements of the certification.

(b) A level II treatment provider must be employed by an EIDBI provider agency and be either:

(1) a person who:

(i) has a bachelor's degree from an accredited college or university in a behavioral or child development science or allied field including but not limited to mental health, special education, social work, psychology, speech pathology, or occupational therapy; and

(ii) has at least 1,000 hours of clinical experience or training in examining or treating children with ASD or equivalent documented coursework at the graduate level by an accredited university in ASD diagnostics, ASD developmental and behavioral treatment strategies, and typical child development or a combination of coursework or hours of experience, or certification as a board-certified assistant behavior analyst from the Behavior Analyst Certification Board or is a registered behavior technician as defined by the Behavior Analyst Certification Board or is certified in one of the other treatment modalities recognized by the Department of Human Services;

(2) a person who:

(i) has an associate's degree in a behavioral or child development science or allied field including but not limited to mental health, special education, social work, psychology, speech pathology, or occupational therapy from an accredited college or university; and

(ii) has at least 2,000 hours of supervised clinical experience in delivering treatment to children with ASD. Hours worked as a behavioral aide or level III treatment provider may be included in the required hours of experience;

(3) a person who has at least 4,000 hours of supervised clinical experience in delivering treatment to children with ASD. Hours worked as a mental health behavioral aide or developmental or level III treatment provider may be included in the required hours of experience;

(4) a person who is a graduate student in a behavioral science, child development science, or allied field and is receiving clinical supervision by a qualified supervising professional affiliated with an agency to meet the clinical training requirements for experience and training with children with ASD; or

(5) a person who is at least 18 years old and who:

(i) is fluent in the non-English language spoken in the child's home or works with a tribal entity that represents the child's culture;

(ii) meets level III EIDBI training requirements; and

(iii) receives observation and direction from a qualified supervising professional or qualified level I treatment provider at least once a week until 1,000 hours of supervised clinical experience is met.

(c) A level III treatment provider must be employed by an EIDBI provider agency, have completed the level III training requirement, be at least 18 years old, and have at least one of the following:

(1) a high school diploma or general equivalency diploma (GED);

(2) fluency in the non-English language spoken in the child's home or works with a tribal entity that represents the child's culture; or

(3) one year of experience as a primary PCA, community health worker, waiver service provider, or special education assistant to a child with ASD within the previous five years.

(d) A qualified supervising professional must be employed by an EIDBI agency and be:

(1) a licensed mental health professional who has at least 2,000 hours of supervised clinical experience or training in examining or treating children with ASD or equivalent documented coursework at the graduate level by an accredited university in ASD

diagnostics, ASD developmental and behavioral treatment strategies, and typical child development; or

(2) a developmental or behavioral pediatrician who has at least 2,000 hours of supervised clinical experience or training in the examining or treating of children with ASD or related conditions or equivalent documented coursework at the graduate level by an accredited university in the areas of ASD diagnostics, ASD developmental and behavioral treatment strategies, and typical child development.

Subd. 16. **Agency responsibilities.** (a) The agency must:

(1) exercise and protect the service recipient's rights;

(2) offer services that are person-centered and culturally and linguistically appropriate as required under subdivision 3a;

(3) allow people to make informed decisions concerning CMDE, treatment recommendations, alternatives considered, and possible risks of services;

(4) have a written policy that identifies steps to resolve issues collaboratively when possible;

(5) except for emergency situations, provide adequate notice of transition, subject to staff availability, of transition from EIDBI services prior to implementing a transition plan with the family;

(6) provide notice as soon as possible when issues arise about provision of EIDBI services;

(7) provide the legal representative with prompt notification if the child is injured while being served by the agency. An incident report must be completed by the agency staff member in charge of the child. Copies of all incident and injury reports must remain on file at the agency for at least one year. An incident is when any of the following occur:

(i) an illness, accident, or injury which requires first aid treatment;

(ii) a bump or blow to the head; or

(iii) an unusual or unexpected event which jeopardizes the safety of children or staff including a child leaving the agency unattended; and

(8) prior to starting services, provide the child or the child's legal representative a plain-spoken description of the treatment method or methods that the child shall receive, including the staffing certification levels and training of the staff who shall provide the treatment or treatments.

(b) When delivering the ITP, and annually thereafter, agencies must provide the child or the child's legal representative with:

(1) a written copy of the child's rights and agency responsibilities;

(2) a verbal explanation of rights and responsibilities;

(3) reasonable accommodations to provide the information in other formats or languages as needed to facilitate understanding of the rights; and

(4) documentation in the child's file of the date that the child or the child's legal representative received a copy and explanation of the client's rights and agency responsibilities.

Subd. 17. **EIDBI agency qualifications, general requirements, and duties.** (a) EIDBI agencies delivering services under this section shall:

(1) enroll as a medical assistance Minnesota health care programs provider according to Minnesota Rules, part 9505.0195, and meet all applicable provider standards and requirements;

(2) demonstrate compliance with federal and state laws for EIDBI;

(3) verify and maintain records of all services provided to the child or the child's legal representative as required under Minnesota Rules, parts 9505.2175 and 9505.2197;

(4) not have had a lead agency contract or provider agreement discontinued due to a conviction of fraud, or not have had an owner, board member, or manager fail a state or FBI-based criminal background check or appear on the list of excluded individuals or entities maintained by the federal Office of Inspector General while enrolled or seeking enrollment as a Minnesota health care programs provider;

(5) have established business practices that include written policies and procedures, internal controls, and a system that demonstrates the organization's ability to deliver quality EIDBI services;

(6) have an office located in Minnesota; and

(7) conduct a criminal background check on individuals who have direct contact with the child or the legal representative.

(b) EIDBI agencies shall:

(1) report maltreatment as required under sections 626.556 and 626.557;

(2) provide the child or the child's legal representative with a copy of the service-related rights under subdivision 14 at the start of services;

(3) comply with any data requests from the department consistent with the Minnesota Government Data Practices Act, section 256B.064 and section 256B.27; and

(4) provide training for all agency staff on the Maltreatment of Minors Act and the Vulnerable Adult Protection Act requirements and responsibilities, including mandated and voluntary reporting, nonretaliation, and agency policy for all staff on how to report suspected abuse and neglect.

Subd. 18. **Provider shortage; authority for exceptions.** (a) In consultation with the Early Intensive Developmental and Behavioral Intervention Advisory Council, including

agencies, professionals, parents of children with ASD, and advocacy organizations, the commissioner shall determine if a shortage of qualified EIDBI providers exists. For the purposes of this subdivision, "shortage of qualified EIDBI providers" means a lack of availability of providers who meet the EIDBI provider qualification requirements under subdivision 15 that results in the delay of access to timely services under this section, or that significantly impairs the ability of a provider agency to have sufficient qualified providers to meet the requirements of this section. The commissioner shall consider geographic factors when determining the prevalence of a shortage. The commissioner may determine that a shortage exists only in a specific region of the state, multiple regions of the state, or statewide. The commissioner shall also consider availability of various types of treatment methods covered under this section.

(b) If the commissioner determines that a shortage of qualified providers exists under paragraph (a), the commissioner, in consultation with the EIDBI Advisory Council and stakeholders, must establish processes and criteria for granting exceptions. The commissioner may grant exceptions to any of the following requirements, but only if an exception would not compromise child safety nor diminish the quality and effectiveness of the treatment provided:

(1) EIDBI provider qualifications under this section;

(2) medical assistance provider enrollment requirements under Minnesota Rules, part 9505.0195; or

(3) applicable provider or agency standards or requirements.

(c) If the commissioner, in consultation with the EIDBI Advisory Council and stakeholders, determines that a shortage no longer exists, the commissioner must submit a notice that a shortage no longer exists to the chairs and ranking minority members of the senate and the house of representatives committees with jurisdiction over health and human services. The commissioner must post the notice for public comment for 30 days. The commissioner shall consider all public comments before the commissioner makes a final determination regarding the termination and timeline for termination of the commissioner's authority to grant exceptions under this subdivision. Until the shortage ends, the commissioner shall provide an update annually to the chairs and ranking minority members of the house of representatives and senate committees with jurisdiction over health and human services on the status of the provider shortage and exception process.

EFFECTIVE DATE. Subdivisions 1, 5a, 13, and 18, are effective the day following final enactment. Subdivisions 2 to 3a, 5, 6 to 9, and 14 to 17, are effective August 1, 2016. Subdivision 4 is effective January 1, 2017.

Sec. 5. Minnesota Statutes 2015 Supplement, section 256B.441, subdivision 30, is amended to read:

Subd. 30. **Median total care-related cost per diem and other operating per diem determined.** (a) The commissioner shall determine the median total care-related per diem to be used in subdivision 50 and the median other operating per diem to be used in subdivision 51 using the cost reports from nursing facilities in Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington Counties.

(b) The median total care-related per diem shall be equal to the median ~~direct care cost~~ total care-related per diem for a RUG's weight of 1.00 for facilities located in the counties listed in paragraph (a).

(c) The median other operating per diem shall be equal to the median other operating per diem for facilities located in the counties listed in paragraph (a). The other operating per diem shall be the sum of each facility's administrative costs, dietary costs, housekeeping costs, laundry costs, and maintenance and plant operations costs divided by each facility's resident days.

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

Sec. 6. Minnesota Statutes 2015 Supplement, section 256B.441, subdivision 66, is amended to read:

Subd. 66. **Nursing facilities in border cities.** (a) Rate increases under this section for a facility located in Breckenridge are effective for the rate year beginning January 1, 2016, and annually thereafter~~;~~. Rate increases under this section for a facility located in Moorhead are effective for the rate year beginning January 1, 2020, and annually thereafter.

(b) Operating payment rates of a nonprofit nursing facility that exists on January 1, 2015, is located anywhere within the boundaries of the city of Breckenridge or Moorhead, and is reimbursed under this section, section 256B.431, or section 256B.434, shall be adjusted to be equal to the median RUG's rates, including comparable rate components as determined by the commissioner, for the equivalent RUG's weight of the nonprofit nursing facility or facilities located in an adjacent city in another state and in cities contiguous to the adjacent city. The commissioner must make the comparison required under this subdivision on October 1 of each year. The adjustment under this subdivision applies to the rates effective on the following January 1.

(c) The Minnesota facility's operating payment rate with a weight of 1.0 shall be computed by dividing the adjacent city's nursing facilities median operating payment rate with a weight of 1.02 by 1.02. ~~If the adjustments under this subdivision result in a rate that exceeds the limits in subdivisions 50 and 51 in a given rate year, the facility's rate shall~~

~~not be subject to those limits for that rate year.~~ If a facility's rate is increased under this subdivision, the facility is not subject to the total care-related limit in subdivision 50 and is not limited to the other operating price established in subdivision 51. This subdivision shall apply only if it results in a higher operating payment rate than would otherwise be determined under this section, section 256B.431, or section 256B.434.

Sec. 7. Minnesota Statutes 2014, section 256B.4912, is amended by adding a subdivision to read:

Subd. 11. **Annual data submission.** (a) In a manner determined by the commissioner, home and community-based services waiver providers enrolled under this section shall submit data to the commissioner on the following:

(1) wages of workers;

(2) benefits paid;

(3) staff retention rates;

(4) amount of overtime paid;

(5) amount of travel time paid;

(6) vacancy rates; and

(7) other data elements determined by the commissioner.

(b) The commissioner may adjust reporting requirements for some individual self-employed workers.

(c) This subdivision also applies to providers of personal care assistance services under section 256B.0625, subdivision 19a; community first services and supports under section 256B.85; consumer support grants under section 256.476; nursing services and home health services under section 256B.0625, subdivision 6a; home care nursing services under section 256B.0625, subdivision 7; intermediate care facilities for persons with developmental disabilities under section 256B.501; and day training and habilitation providers serving residents of intermediate care facilities for persons with developmental disabilities under section 256B.501.

(d) This data shall be submitted annually each calendar year on a date specified by the commissioner. The commissioner shall give providers at least 30 calendar days to submit the data. Failure to submit the data requested may result in delays to medical assistance reimbursement.

(e) Individually identifiable data submitted to the commissioner in this section are considered private data on individuals, as defined by section 13.02, subdivision 12.

(f) The commissioner shall analyze data annually for workforce assessments and its impact on service access.

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

Sec. 8. Minnesota Statutes 2015 Supplement, section 256B.4913, subdivision 4a, is amended to read:

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

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

(1) for a day service recipient who was not authorized to receive these waiver services prior to January 1, 2014; added a new service or services on or after January 1, 2014; or changed providers on or after January 1, 2014, the historical rate must be the weighted average authorized rate for ~~the~~ each provider number in the county of service, effective December 1, 2013; or

(2) for a unit-based service with programming or a unit-based service without programming recipient who was not authorized to receive these waiver services prior to January 1, 2014; added a new service or services on or after January 1, 2014; or changed providers on or after January 1, 2014, the historical rate must be the weighted average authorized rate for each provider number in the county of service, effective December 1, 2013; or

(3) for residential service recipients who change providers on or after January 1, 2014, the historical rate must be set by each lead agency within their ~~county~~ aggregate budget using their respective methodology for residential services effective December 1, 2013, for determining the provider rate for a similarly situated recipient being served by that provider.

(c) The commissioner shall adjust individual reimbursement rates determined under this section so that the unit rate is no higher or lower than:

(1) 0.5 percent from the historical rate for the implementation period;

(2) 0.5 percent from the rate in effect in clause (1), for the 12-month period immediately following the time period of clause (1);

(3) 0.5 percent from the rate in effect in clause (2), for the 12-month period immediately following the time period of clause (2);

(4) 1.0 percent from the rate in effect in clause (3), for the 12-month period immediately following the time period of clause (3);

(5) 1.0 percent from the rate in effect in clause (4), for the 12-month period immediately following the time period of clause (4); and

(6) no adjustment to the rate in effect in clause (5) for the 12-month period immediately following the time period of clause (5). During this banding rate period, the commissioner shall not enforce any rate decrease or increase that would otherwise result from the end of the banding period. The commissioner shall, upon enactment, seek federal approval for the addition of this banding period.

(d) The commissioner shall review all changes to rates that were in effect on December 1, 2013, to verify that the rates in effect produce the equivalent level of spending and service unit utilization on an annual basis as those in effect on October 31, 2013.

(e) By December 31, 2014, the commissioner shall complete the review in paragraph (d), adjust rates to provide equivalent annual spending, and make appropriate adjustments.

(f) During the banding period, the Medicaid Management Information System (MMIS) service agreement rate must be adjusted to account for change in an individual's need. The commissioner shall adjust the Medicaid Management Information System (MMIS) service agreement rate by:

(1) calculating a service rate under section 256B.4914, subdivision 6, 7, 8, or 9, for the individual with variables reflecting the level of service in effect on December 1, 2013;

(2) calculating a service rate under section 256B.4914, subdivision 6, 7, 8, or 9, for the individual with variables reflecting the updated level of service at the time of application; and

(3) adding to or subtracting from the Medicaid Management Information System (MMIS) service agreement rate, the difference between the values in clauses (1) and (2).

(g) This subdivision must not apply to rates for recipients served by providers new to a given county after January 1, 2014. Providers of personal supports services who also acted as fiscal support entities must be treated as new providers as of January 1, 2014.

Sec. 9. Minnesota Statutes 2015 Supplement, section 256B.4914, subdivision 10, is amended to read:

Subd. 10. **Updating payment values and additional information.** (a) From January 1, 2014, through December 31, 2017, the commissioner shall develop and implement uniform procedures to refine terms and adjust values used to calculate payment rates in this section.

(b) No later than July 1, 2014, the commissioner shall, within available resources, begin to conduct research and gather data and information from existing state systems or other outside sources on the following items:

(1) differences in the underlying cost to provide services and care across the state; and

(2) mileage, vehicle type, lift requirements, incidents of individual and shared rides, and units of transportation for all day services, which must be collected from providers using the rate management worksheet and entered into the rates management system; and

(3) the distinct underlying costs for services provided by a license holder under sections 245D.05, 245D.06, 245D.07, 245D.071, 245D.081, and 245D.09, and for services provided by a license holder certified under section 245D.33.

(c) Using a statistically valid set of rates management system data, the commissioner, in consultation with stakeholders, shall analyze for each service the average difference in the rate on December 31, 2013, and the framework rate at the individual, provider, lead agency, and state levels. The commissioner shall issue semiannual reports to the stakeholders on the difference in rates by service and by ~~county~~ lead agency during the banding period under section 256B.4913, subdivision 4a. The commissioner shall issue the first report by October 1, 2014.

(d) No later than July 1, 2014, the commissioner, in consultation with stakeholders, shall begin the review and evaluation of the following values already in subdivisions 6 to 9, or issues that impact all services, including, but not limited to:

(1) values for transportation rates for day services;

(2) values for transportation rates in residential services;

(3) values for services where monitoring technology replaces staff time;

(4) values for indirect services;

(5) values for nursing;

(6) component values for independent living skills;

(7) component values for family foster care that reflect licensing requirements;

(8) adjustments to other components to replace the budget neutrality factor;

(9) remote monitoring technology for nonresidential services;

(10) values for basic and intensive services in residential services;

(11) values for the facility use rate in day services, and the weightings used in the day service ratios and adjustments to those weightings;

(12) values for workers' compensation as part of employee-related expenses;

(13) values for unemployment insurance as part of employee-related expenses;

(14) a component value to reflect costs for individuals with rates previously adjusted for the inclusion of group residential housing rate 3 costs, only for any individual enrolled as of December 31, 2013; and

(15) any changes in state or federal law with an impact on the underlying cost of providing home and community-based services.

(e) The commissioner shall report to the chairs and the ranking minority members of the legislative committees and divisions with jurisdiction over health and human services policy and finance with the information and data gathered under paragraphs (b) to (d) on the following dates:

(1) January 15, 2015, with preliminary results and data;

(2) January 15, 2016, with a status implementation update, and additional data and summary information;

(3) January 15, 2017, with the full report; and

(4) January 15, 2019, with another full report, and a full report once every four years thereafter.

(f) Based on the commissioner's evaluation of the information and data collected in paragraphs (b) to (d), the commissioner shall make recommendations to the legislature by January 15, 2015, to address any issues identified during the first year of implementation. After January 15, 2015, the commissioner may make recommendations to the legislature to address potential issues.

(g) The commissioner shall implement a regional adjustment factor to all rate calculations in subdivisions 6 to 9, effective no later than January 1, 2015. Prior to implementation, the commissioner shall consult with stakeholders on the methodology to calculate the adjustment.

(h) The commissioner shall provide a public notice via LISTSERV in October of each year beginning October 1, 2014, containing information detailing legislatively approved changes in:

(1) calculation values including derived wage rates and related employee and administrative factors;

(2) service utilization;

(3) ~~county and tribal~~ lead agency allocation changes; and

(4) information on adjustments made to calculation values and the timing of those adjustments.

The information in this notice must be effective January 1 of the following year.

(i) No later than July 1, 2016, the commissioner shall develop and implement, in consultation with stakeholders, a methodology sufficient to determine the shared staffing

levels necessary to meet, at a minimum, health and welfare needs of individuals who will be living together in shared residential settings, and the required shared staffing activities described in subdivision 2, paragraph (l). This determination methodology must ensure staffing levels are adaptable to meet the needs and desired outcomes for current and prospective residents in shared residential settings.

(j) When the available shared staffing hours in a residential setting are insufficient to meet the needs of an individual who enrolled in residential services after January 1, 2014, or insufficient to meet the needs of an individual with a service agreement adjustment described in section 256B.4913, subdivision 4a, paragraph (f), then individual staffing hours shall be used.

Sec. 10. Minnesota Statutes 2014, section 256B.4914, subdivision 11, is amended to read:

Subd. 11. **Payment implementation.** Upon implementation of the payment methodologies under this section, those payment rates supersede rates established in ~~county~~ lead agency contracts for recipients receiving waiver services under section 256B.092 or 256B.49.

Sec. 11. Minnesota Statutes 2015 Supplement, section 256B.4914, subdivision 14, is amended to read:

Subd. 14. **Exceptions.** (a) In a format prescribed by the commissioner, lead agencies must identify individuals with exceptional needs that cannot be met under the disability waiver rate system. The commissioner shall use that information to evaluate and, if necessary, approve an alternative payment rate for those individuals. Whether granted, denied, or modified, the commissioner shall respond to all exception requests in writing. The commissioner shall include in the written response the basis for the action and provide notification of the right to appeal under paragraph (h).

(b) Lead agencies must act on an exception request within 30 days and notify the initiator of the request of their recommendation in writing. A lead agency shall submit all exception requests along with its recommendation to the commissioner.

(c) An application for a rate exception may be submitted for the following criteria:

(1) an individual has service needs that cannot be met through additional units of service;

(2) an individual's rate determined under subdivisions 6, 7, 8, and 9 is so insufficient that it has resulted in an individual receiving a notice of discharge from the individual's provider; ~~or~~

(3) an individual's service needs, including behavioral changes, require a level of service which necessitates a change in provider or which requires the current provider to propose service changes beyond those currently authorized.; or

(4) an individual's service needs cannot be met through a weighted county average rate as defined in 256B.4913, subdivision 4a.

(d) Exception requests must include the following information:

(1) the service needs required by each individual that are not accounted for in subdivisions 6, 7, 8, and 9;

(2) the service rate requested and the difference from the rate determined in subdivisions 6, 7, 8, and 9;

(3) a basis for the underlying costs used for the rate exception and any accompanying documentation; and

(4) any contingencies for approval.

(e) Approved rate exceptions shall be managed within lead agency allocations under sections 256B.092 and 256B.49.

(f) Individual disability waiver recipients, an interested party, or the license holder that would receive the rate exception increase may request that a lead agency submit an exception request. A lead agency that denies such a request shall notify the individual waiver recipient, interested party, or license holder of its decision and the reasons for denying the request in writing no later than 30 days after the request has been made and shall submit its denial to the commissioner in accordance with paragraph (b). The reasons for the denial must be based on the failure to meet the criteria in paragraph (c).

(g) The commissioner shall determine whether to approve or deny an exception request no more than 30 days after receiving the request. If the commissioner denies the request, the commissioner shall notify the lead agency and the individual disability waiver recipient, the interested party, and the license holder in writing of the reasons for the denial.

(h) The individual disability waiver recipient may appeal any denial of an exception request by either the lead agency or the commissioner, pursuant to sections 256.045 and 256.0451. When the denial of an exception request results in the proposed demission of a waiver recipient from a residential or day habilitation program, the commissioner shall issue a temporary stay of demission, when requested by the disability waiver recipient, consistent with the provisions of section 256.045, subdivisions 4a and 6, paragraph (c). The temporary stay shall remain in effect until the lead agency can provide an informed choice of appropriate, alternative services to the disability waiver.

(i) Providers may petition lead agencies to update values that were entered incorrectly or erroneously into the rate management system, based on past service level discussions and determination in subdivision 4, without applying for a rate exception.

(j) The starting date for the rate exception will be the later of the date of the recipient's change in support or the date of the request to the lead agency for an exception.

(k) The commissioner shall track all exception requests received and their dispositions. The commissioner shall issue quarterly public exceptions statistical reports, including the number of exception requests received and the numbers granted, denied, withdrawn, and pending. The report shall include the average amount of time required to process exceptions.

(l) No later than January 15, 2016, the commissioner shall provide research findings on the estimated fiscal impact, the primary cost drivers, and common population characteristics of recipients with needs that cannot be met by the framework rates.

(m) No later than July 1, 2016, the commissioner shall develop and implement, in consultation with stakeholders, a process to determine eligibility for rate exceptions for individuals with rates determined under the methodology in section 256B.4913, subdivision 4a. Determination of eligibility for an exception will occur as annual service renewals are completed.

(n) Approved rate exceptions will be implemented at such time that the individual's rate is no longer banded and remain in effect in all cases until an individual's needs change as defined in paragraph (c).

Sec. 12. Minnesota Statutes 2015 Supplement, section 256B.4914, subdivision 15, is amended to read:

Subd. 15. **~~County or tribal~~ Lead agency allocations.** (a) Upon implementation of the disability waiver rates management system on January 1, 2014, the commissioner shall establish a method of tracking and reporting the fiscal impact of the disability waiver rates management system on individual lead agencies.

(b) Beginning January 1, 2014, the commissioner shall make annual adjustments to lead agencies' home and community-based waivered service budget allocations to adjust for rate differences and the resulting impact on ~~county~~ lead agency allocations upon implementation of the disability waiver rates system.

(c) Lead agencies exceeding their allocations shall be subject to the provisions under sections 256B.0916, subdivision 11, and 256B.49, subdivision 26.

Sec. 13. **PROVIDER RATE AND GRANT INCREASES EFFECTIVE JULY 1, 2016.**

(a) The commissioner of human services shall increase reimbursement rates, grants, allocations, individual limits, and rate limits, as applicable, by 2.72 percent for the rate period beginning July 1, 2016, for services rendered on or after that date. County or tribal contracts for services specified in this section must be amended to pass through with these rate increases within 60 days of the effective date.

(b) The rate changes described in this section must be provided to:

(1) the following services within the home and community-based waiver for persons with developmental disabilities under Minnesota Statutes, section 256B.092: extended personal care, personal support, chore, respite care services except for crisis respite services, homemaker cleaning services, and consumer-directed community supports budgets;

(2) the following services within the community access for disability inclusion waiver under Minnesota Statutes, section 256B.49: extended personal care, chore, respite care services, homemaker cleaning services, and consumer-directed community supports budgets;

(3) the following services within the community alternative care waiver under Minnesota Statutes, section 256B.49: extended personal care, chore, respite care services, homemaker cleaning services, and consumer-directed community supports budgets;

(4) the following services within the brain injury waiver under Minnesota Statutes, section 256B.49: extended personal care, chore, respite care services, homemaker cleaning services, and consumer-directed community supports budgets;

(5) the following services within the elderly waiver under Minnesota Statutes, section 256B.0915: extended personal care, companion, chore, respite care services, homemaker cleaning services, and consumer-directed community supports budgets;

(6) the following services within the alternative care program under Minnesota Statutes, section 256B.0913: personal care, companion, chore, respite care services, homemaker cleaning services, and consumer-directed community supports budgets;

(7) personal care services and qualified professional supervision of personal care services under Minnesota Statutes, section 256B.0625, subdivision 6a or 19a; and

(8) consumer support grants under Minnesota Statutes, section 256.476.

(c) A managed care plan or county-based purchasing plan receiving state payments for the services in paragraph (b) must include the increases in paragraph (a) in payments to providers. To implement the rate increase in this section, capitation rates paid by the commissioner to managed care organizations under Minnesota Statutes, section 256B.69,

shall reflect a 2.72 percent increase for the specified services provided on or after July 1, 2016.

(d) Counties and tribes shall increase the budget for each recipient of consumer-directed community supports by the amounts in paragraph (a) on the effective dates in paragraph (a).

(e) To implement the provisions of this section, the commissioner shall increase applicable service rates in the disability waiver payment system authorized in Minnesota Statutes, sections 256B.4913 and 256B.4914.

(f) A provider that receives a rate adjustment under paragraph (a) shall use 90 percent of the additional revenue to increase compensation-related costs for employees directly employed by the program on or after July 1, 2016, except:

(1) persons employed in the central office of a corporation or entity that has an ownership interest in the provider or exercises control over the provider; and

(2) persons paid by the provider under a management contract.

(g) Compensation-related costs include:

(1) wages and salaries, including overtime and travel time;

(2) the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, workers' compensation, and mileage reimbursement;

(3) the employer's share of health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, pensions, and contributions to employee retirement accounts; and

(4) other employee benefits provided, such as training of employees, as specified in the distribution plan and required under paragraph (i) and approved by the commissioner.

(h) Nothing in this subdivision prevents a provider as an employer from allocating the increase in revenues across the eligible compensation-related costs listed in paragraph (g).

(i) For a provider that has employees who are represented by an exclusive bargaining representative, the provider shall obtain a letter of acceptance of the distribution plan required under paragraph (j), for the members of the bargaining unit, signed by the exclusive bargaining agent. Upon receipt of the letter of acceptance, the provider shall be deemed to have met all the requirements of this section for the members of the bargaining unit. Upon request, the provider shall produce a letter of acceptance for the commissioner.

(j) A provider that receives a rate adjustment under paragraph (a), that is subject to paragraph (f), shall prepare and, upon request, submit to the commissioner a distribution plan that specifies the amount of money that is subject to the requirements of paragraph (f) the provider expects to receive, including the amount of money that will be distributed to increase compensation for employees. The distribution plan must also include the

provider's policy for scheduling overtime. The provider's policy must not limit the scheduling of overtime hours where an individual's service needs are unmet without a worker exceeding 40 hours per week of work. The provider's overtime scheduling policy must provide for a process that reliably and expeditiously provides services to recipients.

(k) Within six months of the effective date of the rate adjustment, the provider shall post the distribution plan required under paragraph (j) for a period of at least six weeks in an area of the provider's operation to which all eligible employees have access and shall provide instructions for employees who do not believe they received the wage and other compensation-related increases specified in the distribution plan. The instructions must include a mailing address, e-mail address, and telephone number that the employees may use to contact the commissioner or the commissioner's representative.

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

Sec. 14. **INSTRUCTION TO THE COMMISSIONER.**

The commissioner shall amend the medical assistance state plan for the EIDBI benefit, authorized under Minnesota Statutes, section 256B.0949, to reference relevant statutory sections. When duplicative of statutory language, the commissioner shall remove the language from the state plan.

Sec. 15. **REVISOR'S INSTRUCTION.**

The revisor of statutes shall codify Minnesota Laws 2015, chapter 71, article 7, section 55, as Minnesota Statutes, section 256B.0921.

ARTICLE 5

HEALTH CARE

Section 1. Minnesota Statutes 2015 Supplement, section 16A.724, subdivision 2, is amended to read:

Subd. 2. **Transfers.** (a) Notwithstanding section 295.581, to the extent available resources in the health care access fund exceed expenditures in that fund, effective for the biennium beginning July 1, 2007, the commissioner of management and budget shall transfer the excess funds from the health care access fund to the general fund on June 30 of each year, provided that the amount transferred in fiscal year 2016 shall not exceed $48,000,000, the amount in fiscal year 2017 shall not exceed $170,000,000, and the amount in any fiscal biennium thereafter shall not exceed ~~$96,000,000~~ $244,000,000.

The purpose of this transfer is to meet the rate increase required under Laws 2003, First Special Session chapter 14, article 13C, section 2, subdivision 6.

(b) For fiscal years 2006 to 2011, MinnesotaCare shall be a forecasted program, and, if necessary, the commissioner shall reduce these transfers from the health care access fund to the general fund to meet annual MinnesotaCare expenditures or, if necessary, transfer sufficient funds from the general fund to the health care access fund to meet annual MinnesotaCare expenditures.

Sec. 2. Minnesota Statutes 2014, section 62J.497, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** For the purposes of this section, the following terms have the meanings given.

(a) "Backward compatible" means that the newer version of a data transmission standard would retain, at a minimum, the full functionality of the versions previously adopted, and would permit the successful completion of the applicable transactions with entities that continue to use the older versions.

(b) "Dispense" or "dispensing" has the meaning given in section 151.01, subdivision 30. Dispensing does not include the direct administering of a controlled substance to a patient by a licensed health care professional.

(c) "Dispenser" means a person authorized by law to dispense a controlled substance, pursuant to a valid prescription.

(d) "Electronic media" has the meaning given under Code of Federal Regulations, title 45, part 160.103.

(e) "E-prescribing" means the transmission using electronic media of prescription or prescription-related information between a prescriber, dispenser, pharmacy benefit manager, or group purchaser, either directly or through an intermediary, including an e-prescribing network. E-prescribing includes, but is not limited to, two-way transmissions between the point of care and the dispenser and two-way transmissions related to eligibility, formulary, and medication history information.

(f) "Electronic prescription drug program" means a program that provides for e-prescribing.

(g) "Group purchaser" has the meaning given in section 62J.03, subdivision 6.

(h) "HL7 messages" means a standard approved by the standards development organization known as Health Level Seven.

(i) "National Provider Identifier" or "NPI" means the identifier described under Code of Federal Regulations, title 45, part 162.406.

(j) "NCPDP" means the National Council for Prescription Drug Programs, Inc.

(k) "NCPDP Formulary and Benefits Standard" means the National Council for Prescription Drug Programs Formulary and Benefits Standard, Implementation Guide, Version 1, Release 0, October 2005.

(l) "NCPDP SCRIPT Standard" means the National Council for Prescription Drug Programs Prescriber/Pharmacist Interface SCRIPT Standard, Implementation Guide Version 8, Release 1 (Version 8.1), October 2005, or the most recent standard adopted by the Centers for Medicare and Medicaid Services for e-prescribing under Medicare Part D as required by section 1860D-4(e)(4)(D) of the Social Security Act, and regulations adopted under it. The standards shall be implemented according to the Centers for Medicare and Medicaid Services schedule for compliance. Subsequently released versions of the NCPDP SCRIPT Standard may be used, provided that the new version of the standard is backward compatible to the current version adopted by the Centers for Medicare and Medicaid Services.

(m) "Pharmacy" has the meaning given in section 151.01, subdivision 2.

(n) "Prescriber" means a licensed health care practitioner, other than a veterinarian, as defined in section 151.01, subdivision 23.

(o) "Prescription-related information" means information regarding eligibility for drug benefits, medication history, or related health or drug information.

(p) "Provider" or "health care provider" has the meaning given in section 62J.03, subdivision 8.

(q) "Utilization review organization" has the meaning given in section 62M.02, subdivision 21.

Sec. 3. Minnesota Statutes 2014, section 62J.497, subdivision 3, is amended to read:

Subd. 3. **Standards for electronic prescribing.** (a) Prescribers and dispensers must use the NCPDP SCRIPT Standard for the communication of a prescription or prescription-related information. The NCPDP SCRIPT Standard shall be used to conduct the following transactions:

(1) get message transaction;

(2) status response transaction;

(3) error response transaction;

(4) new prescription transaction;

(5) prescription change request transaction;

(6) prescription change response transaction;

(7) refill prescription request transaction;

(8) refill prescription response transaction;

(9) verification transaction;

(10) password change transaction;

(11) cancel prescription request transaction; and

(12) cancel prescription response transaction.

(b) Providers, group purchasers, prescribers, and dispensers must use the NCPDP SCRIPT Standard for communicating and transmitting medication history information.

(c) Providers, group purchasers, prescribers, and dispensers must use the NCPDP Formulary and Benefits Standard for communicating and transmitting formulary and benefit information.

(d) Group purchaser, other than workers' compensation plans and the medical component of automobile insurance coverage, and utilization review organizations must develop processes to ensure that prescribers can obtain information about covered drugs from the same class or classes as a drug originally prescribed but denied. This process must allow communication to the prescriber via telephone, or for the medical assistance fee-for-service program under chapter 256B via a public Web site.

~~(d)~~ (e) Providers, group purchasers, prescribers, and dispensers must use the national provider identifier to identify a health care provider in e-prescribing or prescription-related transactions when a health care provider's identifier is required.

~~(e)~~ (f) Providers, group purchasers, prescribers, and dispensers must communicate eligibility information and conduct health care eligibility benefit inquiry and response transactions according to the requirements of section 62J.536.

Sec. 4. Minnesota Statutes 2014, section 62M.02, is amended by adding a subdivision to read:

Subd. 10a. **Drug.** "Drug" has the meaning given in section 151.01, subdivision 5.

Sec. 5. Minnesota Statutes 2014, section 62M.02, is amended by adding a subdivision to read:

Subd. 11a. **Formulary.** "Formulary" has the meaning given in section 62Q.83, subdivision 1.

Sec. 6. Minnesota Statutes 2014, section 62M.02, subdivision 12, is amended to read:

Subd. 12. **Health benefit plan.** "Health benefit plan" means a policy, contract, or certificate issued by a health plan company for the coverage of medical, dental, prescription drug, or hospital benefits. A health benefit plan does not include coverage that is:

(1) limited to disability or income protection coverage;

(2) automobile medical payment coverage;

(3) supplemental to liability insurance;

(4) designed solely to provide payments on a per diem, fixed indemnity, or nonexpense incurred basis;

(5) credit accident and health insurance issued under chapter 62B;

(6) blanket accident and sickness insurance as defined in section 62A.11;

(7) accident only coverage issued by a licensed and tested insurance agent; or

(8) workers' compensation.

Sec. 7. Minnesota Statutes 2014, section 62M.02, subdivision 14, is amended to read:

Subd. 14. **Outpatient services.** "Outpatient services" means procedures or services performed on a basis other than as an inpatient, and includes obstetrical, psychiatric, chemical dependency, dental, prescription drug, and chiropractic services.

Sec. 8. Minnesota Statutes 2014, section 62M.02, is amended by adding a subdivision to read:

Subd. 14b. **Prescription.** "Prescription" has the meaning given in section 151.01, subdivision 16a.

Sec. 9. Minnesota Statutes 2014, section 62M.02, is amended by adding a subdivision to read:

Subd. 14c. **Prescription drug order.** "Prescription drug order" has the meaning given in section 151.01, subdivision 16.

Sec. 10. Minnesota Statutes 2014, section 62M.02, subdivision 15, is amended to read:

Subd. 15. **Prior authorization.** "Prior authorization" means utilization review conducted prior to the delivery of a service, including an outpatient service. Prior authorization includes, but is not limited to, preadmission review, pretreatment review, quantity limits, step therapy, utilization, and case management. Prior authorization also includes any utilization review organization's requirement that an enrollee or provider notify the utilization review organization prior to providing a service, including an outpatient service. Reviews performed for emergency medical assistance benefits, medical assistance waivered services, or the Minnesota restricted recipient program are not prior authorization.

Sec. 11. Minnesota Statutes 2014, section 62M.02, subdivision 17, is amended to read:

Subd. 17. **Provider.** "Provider" means a licensed health care facility, physician, pharmacist, or other health care professional that delivers health care services to an enrollee.

Sec. 12. Minnesota Statutes 2014, section 62M.02, is amended by adding a subdivision to read:

Subd. 18a. **Quantity limit.** "Quantity limit" means a limit on the number of doses of a prescription drug that are covered during a specific time period.

Sec. 13. Minnesota Statutes 2014, section 62M.02, is amended by adding a subdivision to read:

Subd. 19a. **Step therapy.** "Step therapy" means clinical practice or other evidence-based protocols or requirements that specify the sequence in which different prescription drugs for a given medical condition are to be used by an enrollee before a drug prescribed by a provider is covered. Step therapy does not include a requirement for an enrollee to use a generic or biosimilar product considered by the Food and Drug Administration to be therapeutically equivalent and interchangeable to a branded product, provided the generic or biosimilar product has not previously been tried by the patient.

Sec. 14. Minnesota Statutes 2014, section 62M.05, subdivision 3a, is amended to read:

Subd. 3a. **Standard review determination.** (a) Notwithstanding subdivision 3b, an initial determination on all requests for utilization review, except a determination related to prescription drugs, must be communicated to the provider and enrollee in accordance with this subdivision within ten business days of the request, provided that all information reasonably necessary to make a determination on the request has been made available to the utilization review organization.

(b) An initial determination for utilization review on all prescription drug requests must be communicated to the provider and enrollee in accordance with this subdivision within five business days of the request, provided that all information reasonably necessary to make a determination on the request has been made available to the utilization review organization.

~~(b)~~ (c) When an initial determination is made to certify, notification must be provided promptly by telephone to the provider. The utilization review organization shall send written notification to the provider or shall maintain an audit trail of the determination and telephone notification. For purposes of this subdivision, "audit trail" includes documentation of the telephone notification, including the date; the name of the person spoken to; the enrollee; the service, procedure, or admission certified; and the date

of the service, procedure, or admission. If the utilization review organization indicates certification by use of a number, the number must be called the "certification number." For purposes of this subdivision, notification may also be made by facsimile to a verified number or by electronic mail to a secure electronic mailbox. These electronic forms of notification satisfy the "audit trail" requirement of this paragraph.

~~(c)~~ (d) When an initial determination is made not to certify, notification must be provided by telephone, by facsimile to a verified number, or by electronic mail to a secure electronic mailbox within one working day after making the determination to the attending health care professional and hospital as applicable. Written notification must also be sent to the hospital as applicable and attending health care professional if notification occurred by telephone. For purposes of this subdivision, notification may be made by facsimile to a verified number or by electronic mail to a secure electronic mailbox. Written notification must be sent to the enrollee and may be sent by United States mail, facsimile to a verified number, or by electronic mail to a secure mailbox. The written notification must include the principal reason or reasons for the determination and the process for initiating an appeal of the determination. Upon request, the utilization review organization shall provide the provider or enrollee with the criteria used to determine the necessity, appropriateness, and efficacy of the health care service and identify the database, professional treatment parameter, or other basis for the criteria. Reasons for a determination not to certify may include, among other things, the lack of adequate information to certify after a reasonable attempt has been made to contact the provider or enrollee.

~~(d)~~ (e) When an initial determination is made not to certify, the written notification must inform the enrollee and the attending health care professional of the right to submit an appeal to the internal appeal process described in section 62M.06 and the procedure for initiating the internal appeal. The written notice shall be provided in a culturally and linguistically appropriate manner consistent with the provisions of the Affordable Care Act as defined under section 62A.011, subdivision 1a.

Sec. 15. Minnesota Statutes 2014, section 62M.05, subdivision 3b, is amended to read:

Subd. 3b. **Expedited review determination.** (a) An expedited initial determination must be utilized if the attending health care professional believes that an expedited determination is warranted.

(b) Notification of an expedited initial determination to either certify or not to certify, except a determination related to prescription drugs, must be provided to the hospital, the attending health care professional, and the enrollee as expeditiously as the enrollee's medical condition requires, but no later than 72 hours from the initial request.

When an expedited initial determination is made not to certify, the utilization review organization must also notify the enrollee and the attending health care professional of the right to submit an appeal to the expedited internal appeal as described in section 62M.06 and the procedure for initiating an internal expedited appeal.

(c) Notification of an expedited initial determination to either certify or not to certify on all prescription drug requests must be provided to the hospital, the attending health care professional, and the enrollee as expeditiously as the enrollee's medical condition requires, but no later than 36 hours from the initial request, provided that all the information reasonably necessary to make a determination has been made available to the utilization review organization. For state public health care programs administered under section 256B.69 and chapter 256L, notification must be provided to the hospital, attending health care provider, or the enrollee as expeditiously as the enrollee's condition requires, but no later than 36 hours from the initial request, provided that all the information reasonably necessary to make a determination has been made available to the utilization review organization. When an expedited initial determination is made not to certify, the utilization review organization must also notify the enrollee and the attending health care professional of the right to submit an appeal to the expedited internal appeal as described in section 62M.06, and the procedure for initiating an internal expedited appeal.

Sec. 16. Minnesota Statutes 2014, section 62M.06, subdivision 2, is amended to read:

Subd. 2. **Expedited appeal.** (a) When an initial determination not to certify a health care service is made prior to or during an ongoing service requiring review and the attending health care professional believes that the determination warrants an expedited appeal, the utilization review organization must ensure that the enrollee and the attending health care professional have an opportunity to appeal the determination over the telephone on an expedited basis. In such an appeal, the utilization review organization must ensure reasonable access to its consulting physician or health care provider.

(b) The utilization review organization shall notify the enrollee and attending health care professional by telephone of its determination, except for determinations related to prescription drugs, on the expedited appeal as expeditiously as the enrollee's medical condition requires, but no later than 72 hours after receiving the expedited appeal. The utilization review organization shall notify the enrollee and attending health care professional by telephone of its determination on the expedited appeal of a prescription drug request as expeditiously as the enrollee's medical condition requires, but no later than 36 hours after receiving the expedited appeal.

(c) If the determination not to certify is not reversed through the expedited appeal, the utilization review organization must include in its notification the right to submit the appeal to the external appeal process described in section 62Q.73 and the procedure for initiating the process. This information must be provided in writing to the enrollee and the attending health care professional as soon as practical.

Sec. 17. Minnesota Statutes 2014, section 62M.06, subdivision 3, is amended to read:

Subd. 3. **Standard appeal.** The utilization review organization must establish procedures for appeals to be made either in writing or by telephone.

(a) A utilization review organization shall notify in writing the enrollee, attending health care professional, and claims administrator of its determination on the appeal, except for determinations related to prescription drugs, within 30 days upon receipt of the notice of appeal. If the utilization review organization cannot make a determination within 30 days due to circumstances outside the control of the utilization review organization, the utilization review organization may take up to 14 additional days to notify the enrollee, attending health care professional, and claims administrator of its determination. If the utilization review organization takes any additional days beyond the initial 30-day period to make its determination, it must inform the enrollee, attending health care professional, and claims administrator, in advance, of the extension and the reasons for the extension.

(b) A utilization review organization shall notify in writing the enrollee, attending health care professional, and claims administrator of its determination on the appeal on a prescription drug within 15 days upon receipt of the notice of appeal. If the utilization review organization cannot make a determination on a prescription drug within 15 days due to circumstances outside the control of the utilization review organization, the utilization review organization may take up to ten additional days to notify the enrollee, attending health care professional, and claims administrator of its determination. If the utilization review organization takes any additional days beyond the initial 15-day period to make its determination, it must inform the enrollee, attending health care professional, and claims administrator, in advance, of the extension and the reasons for the extension.

~~(b)~~ (c) The documentation required by the utilization review organization may include copies of part or all of the medical record and a written statement from the attending health care professional.

~~(c)~~ (d) Prior to upholding the initial determination not to certify for clinical reasons, the utilization review organization shall conduct a review of the documentation by a physician who did not make the initial determination not to certify.

~~(d)~~ (e) The process established by a utilization review organization may include defining a period within which an appeal must be filed to be considered. The time period must be communicated to the enrollee and attending health care professional when the initial determination is made.

~~(e)~~ (f) An attending health care professional or enrollee who has been unsuccessful in an attempt to reverse a determination not to certify shall, consistent with section 72A.285, be provided the following:

(1) a complete summary of the review findings;

(2) qualifications of the reviewers, including any license, certification, or specialty designation; and

(3) the relationship between the enrollee's diagnosis and the review criteria used as the basis for the decision, including the specific rationale for the reviewer's decision.

~~(f)~~ (g) In cases of appeal to reverse a determination not to certify for clinical reasons, the utilization review organization must ensure that a physician of the utilization review organization's choice in the same or a similar specialty as typically manages the medical condition, procedure, or treatment under discussion is reasonably available to review the case.

~~(g)~~ (h) If the initial determination is not reversed on appeal, the utilization review organization must include in its notification the right to submit the appeal to the external review process described in section 62Q.73 and the procedure for initiating the external process.

Sec. 18. Minnesota Statutes 2014, section 62M.07, is amended to read:

62M.07 PRIOR AUTHORIZATION OF SERVICES.

(a) Utilization review organizations conducting prior authorization of services must have written standards that meet at a minimum the following requirements:

(1) written procedures and criteria used to determine whether care is appropriate, reasonable, or medically necessary;

(2) a system for providing prompt notification of its determinations to enrollees and providers and for notifying the provider, enrollee, or enrollee's designee of appeal procedures under clause (4);

(3) compliance with section 62M.05, subdivisions 3a and 3b, regarding time frames for approving and disapproving prior authorization requests;

(4) written procedures for appeals of denials of prior authorization which specify the responsibilities of the enrollee and provider, and which meet the requirements of sections 62M.06 and 72A.285, regarding release of summary review findings; and

(5) procedures to ensure confidentiality of patient-specific information, consistent with applicable law.

(b) No utilization review organization, health plan company, or claims administrator may conduct or require prior authorization of emergency confinement or emergency treatment. The enrollee or the enrollee's authorized representative may be required to notify the health plan company, claims administrator, or utilization review organization as soon after the beginning of the emergency confinement or emergency treatment as reasonably possible.

(c) If prior authorization for a health care service is required, the utilization review organization, health plan company, or claim administrator must allow providers to submit requests for prior authorization of the health care services without unreasonable delay by telephone, facsimile, or voice mail or through an electronic mechanism 24 hours a day, seven days a week. This paragraph does not apply to dental service covered under MinnesotaCare, general assistance medical care, or medical assistance.

(d) Any authorization for a prescription drug must remain valid for the duration of an enrollee's contract term, or for the benefits offered under section 256B.69 or chapter 256L, the prior authorization must remain valid for the duration of the enrollee's enrollment or one year, whichever is shorter, provided the drug continues to be prescribed for a patient with a condition that requires ongoing medication therapy, provided the drug has not otherwise been deemed unsafe by the Food and Drug Administration, has not been withdrawn by the manufacturer or the Food and Drug Administration, there is no evidence of the enrollee's abuse or misuse of the prescription drug, or provided no independent source of research, clinical guidelines, or evidence-based standards has issued drug-specific warnings or recommended changes in drug usage. This does not apply to individuals assigned to the restricted recipient program under Minnesota Rules, parts 9505.2160 to 9505.2245.

(e) No utilization review organization, health plan company, or claims administrator may impose step therapy requirements for the following drug classes:

(1) immunosuppressants;

(2) antidepressants;

(3) antipsychotics;

(4) anticonvulsants;

(5) antiretrovirals; or

(6) antineoplastics.

(f) No utilization review organization, health plan company, or claims administrator may impose step therapy requirements for enrollees currently taking a prescription drug for which the patient satisfied a previous step therapy requirement, as substantiated from

available claims data or provider documentation. This provision does not apply to a patient who has initiated treatment for a condition with samples provided by a prescriber and provided that any step therapy requirements subsequently applied are consistent with evidence-based prescribing practices.

Sec. 19. Minnesota Statutes 2014, section 62M.09, subdivision 3, is amended to read:

Subd. 3. **Physician reviewer involvement.** (a) A physician must review all cases in which the utilization review organization has concluded that a determination not to certify for clinical reasons is appropriate.

(b) The physician conducting the review must be licensed in this state. ~~This paragraph does not apply to reviews conducted in connection with policies issued by a health plan company that is assessed less than three percent of the total amount assessed by the Minnesota Comprehensive Health Association.~~

(c) The physician should be reasonably available by telephone to discuss the determination with the attending health care professional.

(d) This subdivision does not apply to outpatient mental health or substance abuse services governed by subdivision 3a.

Sec. 20. Minnesota Statutes 2014, section 62M.11, is amended to read:

62M.11 COMPLAINTS TO COMMERCE OR HEALTH.

Notwithstanding the provisions of sections 62M.01 to 62M.16, an enrollee or provider may file a complaint regarding compliance with the requirements of this chapter or regarding a determination not to certify directly to the commissioner responsible for regulating the utilization review organization.

Sec. 21. Minnesota Statutes 2014, section 62Q.81, subdivision 4, is amended to read:

Subd. 4. **Essential health benefits; definition.** For purposes of this section, "essential health benefits" has the meaning given under section 1302(b) of the Affordable Care Act and includes:

(1) ambulatory patient services;

(2) emergency services;

(3) hospitalization;

(4) laboratory services;

(5) maternity and newborn care;

(6) mental health and substance use disorder services, including behavioral health treatment;

(7) pediatric services, including oral and vision care;

(8) prescription drugs;

(9) preventive and wellness services and chronic disease management;

(10) rehabilitative and habilitative services and devices, including services for autism spectrum disorder treatment specified pursuant to section 62A.3094; and

(11) additional essential health benefits included in the EHB-benchmark plan, as defined under the Affordable Care Act.

EFFECTIVE DATE. This section is effective upon a formal determination from the Centers of Medicare and Medicaid Services that the inclusion of the autism spectrum disorder treatment services under Minnesota Statutes, section 62Q.81, subdivision 4, clause (10), as a rehabilitative and habilitative service is not a new state mandate and the state is not required to cover the cost for the services described under Minnesota Statutes, section 62A.3094. Upon a formal determination, this section is effective for health plans issued or renewed on or after January 1 of the next coverage year.

Sec. 22. **[62Q.83] PRESCRIPTION DRUG BENEFIT TRANSPARENCY AND MANAGEMENT.**

Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have the meaning given them.

(b) "Drug" has the meaning given in section 151.01, subdivision 5.

(c) "Enrollee contract year" means the 12-month term during which benefits associated with health plan company products are in effect. For managed care plans and county-based purchasing plans under section 256B.69 and chapter 256L, it means a calendar year beginning January through December.

(d) "Formulary" means a list of prescription drugs that have been developed by clinical and pharmacy experts and represents the health plan company's medically appropriate and cost-effective prescription drugs approved for use.

(e) "Health plan company" has the meaning given in section 62Q.01, subdivision 4, and includes an entity that performs pharmacy benefits management for the health plan company. For purposes of this definition, "pharmacy benefits management" means the administration or management of prescription drug benefits provided by the health plan company for the benefit of its enrollees and may include, but is not limited to, procurement of prescription drugs, clinical formulary development and management services, claims processing, and rebate contracting and administration.

(f) "Prescription" has the meaning given in section 151.01, subdivision 16a.

Subd. 2. **Prescription drug benefit disclosure.** (a) A health plan company that provides prescription drug benefit coverage and uses a formulary must make its formulary and related benefit information available by electronic means and, upon request, in writing, at least 30 days prior to annual renewal dates.

(b) Formularies must be organized and disclosed consistent with the most recent version of the United States Pharmacopeia's (USP) Model Guidelines.

(c) For each item or category of items on the formulary, the specific enrollee benefit terms must be identified, including enrollee cost-sharing and expected out-of-pocket costs.

Subd. 3. **Formulary changes.** (a) Once a formulary has been established, a health plan company may, at any time during the enrollee's contract year:

(1) expand its formulary by adding drugs to the formulary;

(2) reduce co-payments or coinsurance; or

(3) move a drug to a benefit category that reduces an enrollee's cost.

(b) A health plan company may remove a brand name drug from its formulary or place a brand name drug in a benefit category that increases an enrollee's cost only upon the addition to the formulary of a generic or multisource brand name drug rated as therapeutically equivalent according to the FDA Orange Book or a biologic drug rated as interchangeable according to the FDA Purple Book, at a lower cost to the enrollee, and upon at least a 60-day notice to prescribers, pharmacists, and affected enrollees.

(c) A health plan company may change utilization review requirements or move drugs to a benefit category that increases an enrollee's cost during the enrollee's contract year upon at least a 60-day notice to prescribers, pharmacists, and affected enrollees, provided that these changes do not apply to enrollees who are currently taking the drugs affected by these changes for the duration of the enrollee's contract year.

(d) A health plan company may remove any drugs from its formulary that have been deemed unsafe by the Food and Drug Administration, that have been withdrawn by either the Food and Drug Administration or the product manufacturer, or where an independent source of research, clinical guidelines, or evidence-based standards has issued drug-specific warnings or recommended changes in drug usage.

Subd. 4. **Transition process.** (a) A health plan company must establish and maintain a transition process to prevent gaps in prescription drug coverage for both new and continuing enrollees with ongoing prescription drug needs who are affected by changes in formulary drug availability.

(b) The transition process must provide coverage for at least 60 days.

(c) Any enrollee cost-sharing applied must be based on the defined prescription drug benefit terms and must be consistent with any cost-sharing that the health plan company would charge for nonformulary drugs approved under a medication exceptions process.

(d) A health plan company must ensure that written notice is provided to each affected enrollee and prescriber within three business days after adjudication of the transition coverage.

Subd. 5. **Medication exceptions process.** (a) Each health plan company must establish and maintain a medication exceptions process that allows enrollees, providers, or an enrollee's authorized representative to request and obtain coverage approval in the following situations:

(1) there is no acceptable clinical alternative listed on the formulary to treat the enrollee's disease or medical condition;

(2) the prescription listed on the formulary has been ineffective in the treatment of an enrollee's disease or medical condition or, based on clinical and scientific evidence and the relevant physical or mental characteristics of the enrollee, is likely to be ineffective or adversely affect the drug's effectiveness or the enrollee's medication compliance; or

(3) the number of doses that are available under a dose restriction has been ineffective in the treatment of the enrollee's disease or medical condition or, based on clinical and scientific evidence and the relevant physical or mental characteristics of the enrollee, is likely to be ineffective or adversely affect the drug's effectiveness or the enrollee's medication compliance.

(b) An approved medication exceptions request must remain valid for the duration of an enrollee's contract term, provided the medication continues to be prescribed for the same condition, and provided the medication has not otherwise been withdrawn by the manufacturer or the Food and Drug Administration.

(c) The medication exceptions process must comply with the requirements of chapter 62M.

Sec. 23. **[62V.041] GOVERNANCE OF THE SHARED ELIGIBILITY SYSTEM.**

Subdivision 1. **Definition; shared eligibility system.** "Shared eligibility system" means the system that supports eligibility determinations using a modified adjusted gross income methodology for medical assistance under section 256B.056, subdivision 1a, paragraph (b), clause (1), MinnesotaCare under chapter 256L, and qualified health plan enrollment under section 62V.05, subdivision 5, paragraph (c).

Subd. 2. **Executive steering committee.** The shared eligibility system shall be governed and administered by a seven-member executive steering committee. The steering

committee shall consist of two members appointed by the commissioner of human services, two members appointed by the board, two members appointed by the commissioner of MN.IT, and one county representative appointed by the commissioner of human services. The commissioner of human services shall designate one of the members appointed by the commissioner of human services to serve as chair of the steering committee.

Subd. 3. **Duties.** (a) The steering committee shall establish an overall governance structure for the shared eligibility system, and shall be responsible for the overall governance of the system, including setting goals and priorities, allocating the system's resources, and making major system decisions.

(b) The steering committee shall adopt bylaws, policies, and interagency agreements necessary to administer the shared eligibility system.

Subd. 4. **Decision making.** The steering committee, to the extent feasible, shall operate under a consensus model. The steering committee shall make decisions that give particular attention to parts of the system with the largest enrollments and the greatest risks.

Subd. 5. **Administrative structure.** MN.IT services shall be responsible for the design, build, maintenance, operation, and upgrade of the information technology for the shared eligibility system. MN.IT services shall carry out its responsibilities under the governance of the executive steering committee and this section.

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

Sec. 24. Minnesota Statutes 2014, section 62V.05, subdivision 2, is amended to read:

Subd. 2. **Operations funding.** (a) Prior to January 1, 2015, MNsure shall retain or collect up to 1.5 percent of total premiums for individual and small group market health plans and dental plans sold through MNsure to fund the cash reserves of MNsure, but the amount collected shall not exceed a dollar amount equal to 25 percent of the funds collected under section 62E.11, subdivision 6, for calendar year 2012.

(b) Beginning January 1, 2015, through December 31, 2015, MNsure shall retain or collect up to 3.5 percent of total premiums for individual and small group market health plans and dental plans sold through MNsure to fund the operations of MNsure, but the amount collected shall not exceed a dollar amount equal to 50 percent of the funds collected under section 62E.11, subdivision 6, for calendar year 2012.

(c) Beginning January 1, 2016, through December 31, 2017, MNsure shall retain or collect up to 3.5 percent of total premiums for individual and small group market health plans and dental plans sold through MNsure to fund the operations of MNsure, but the amount collected may never exceed a dollar amount greater than 100 percent of the funds collected under section 62E.11, subdivision 6, for calendar year 2012.

(d) Beginning January 1, 2018, MNsure shall retain or collect up to 1.5 percent of total premiums for individual health plans and dental plans sold to Minnesota residents through MNsure and outside of MNsure to fund the operations of MNsure. The amount collected shall not exceed a dollar amount greater than 100 percent of the funds collected under section 62E.11, subdivision 6, for calendar year 2012.

~~(d)~~ (e) For fiscal years 2014 and 2015, the commissioner of management and budget is authorized to provide cash flow assistance of up to $20,000,000 from the special revenue fund or the statutory general fund under section 16A.671, subdivision 3, paragraph (a), to MNsure. Any funds provided under this paragraph shall be repaid, with interest, by June 30, 2015.

~~(e)~~ (f) Funding for the operations of MNsure shall cover any compensation provided to navigators participating in the navigator program.

Sec. 25. Minnesota Statutes 2014, section 256B.04, subdivision 14, is amended to read:

Subd. 14. **Competitive bidding.** (a) When determined to be effective, economical, and feasible, the commissioner may utilize volume purchase through competitive bidding and negotiation under the provisions of chapter 16C, to provide items under the medical assistance program including but not limited to the following:

(1) eyeglasses;

(2) oxygen. The commissioner shall provide for oxygen needed in an emergency situation on a short-term basis, until the vendor can obtain the necessary supply from the contract dealer;

(3) hearing aids and supplies; and

(4) durable medical equipment, including but not limited to:

(i) hospital beds;

(ii) commodes;

(iii) glide-about chairs;

(iv) patient lift apparatus;

(v) wheelchairs and accessories;

(vi) oxygen administration equipment;

(vii) respiratory therapy equipment;

(viii) electronic diagnostic, therapeutic and life-support systems; and

(ix) allergen-reducing products as described in section 256B.0625, subdivision 65, paragraph (c), clause (3);

(5) nonemergency medical transportation level of need determinations, disbursement of public transportation passes and tokens, and volunteer and recipient mileage and parking reimbursements; and

(6) drugs.

(b) Rate changes and recipient cost-sharing under this chapter and chapters 256D and 256L do not affect contract payments under this subdivision unless specifically identified.

(c) The commissioner may not utilize volume purchase through competitive bidding and negotiation for special transportation services under the provisions of chapter 16C.

Sec. 26. Minnesota Statutes 2014, section 256B.057, is amended by adding a subdivision to read:

Subd. 12a. **Presumptive eligibility determinations made by federally qualified health centers.** The commissioner shall establish a process to qualify federally qualified health centers, as defined in section 145.9269, subdivision 1, that are participating providers under the medical assistance program to determine presumptive eligibility for medical assistance for applicants who are pregnant women or children under the age of two, and have a basis of eligibility using the modified adjusted gross income methodology as defined in section 256B.056, subdivision 1a, paragraph (b), clause (1).

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

Sec. 27. Minnesota Statutes 2014, section 256B.059, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** (a) For purposes of this section and sections 256B.058 and 256B.0595, the terms defined in this subdivision have the meanings given them.

(b) "Community spouse" means the spouse of an institutionalized spouse.

~~(c) "Spousal share" means one-half of the total value of all assets, to the extent that either the institutionalized spouse or the community spouse had an ownership interest at the time of the first continuous period of institutionalization.~~

~~(d)~~ (c) "Assets otherwise available to the community spouse" means assets individually or jointly owned by the community spouse, other than assets excluded by subdivision 5, paragraph (c).

~~(e)~~ (d) "Community spouse asset allowance" is the value of assets that can be transferred under subdivision 3.

~~(f)~~ (e) "Institutionalized spouse" means a person who is:

(1) in a hospital, nursing facility, or intermediate care facility for persons with developmental disabilities, or receiving home and community-based services under

section 256B.0915, and is expected to remain in the facility or institution or receive the home and community-based services for at least 30 consecutive days; and

(2) married to a person who is not in a hospital, nursing facility, or intermediate care facility for persons with developmental disabilities, and is not receiving home and community-based services under section 256B.0915, 256B.092, or 256B.49.

~~(g)~~ (f) "For the sole benefit of" means no other individual or entity can benefit in any way from the assets or income at the time of a transfer or at any time in the future.

~~(h)~~ (g) "Continuous period of institutionalization" means a 30-consecutive-day period of time in which a person is expected to stay in a medical or long-term care facility, or receive home and community-based services that would qualify for coverage under the elderly waiver (EW) or alternative care (AC) programs. For a stay in a facility, the 30-consecutive-day period begins on the date of entry into a medical or long-term care facility. For receipt of home and community-based services, the 30-consecutive-day period begins on the date that the following conditions are met:

(1) the person is receiving services that meet the nursing facility level of care determined by a long-term care consultation;

(2) the person has received the long-term care consultation within the past 60 days;

(3) the services are paid by the EW program under section 256B.0915 or the AC program under section 256B.0913 or would qualify for payment under the EW or AC programs if the person were otherwise eligible for either program, and but for the receipt of such services the person would have resided in a nursing facility; and

(4) the services are provided by a licensed provider qualified to provide home and community-based services.

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

Sec. 28. Minnesota Statutes 2014, section 256B.059, subdivision 2, is amended to read:

Subd. 2. **Assessment of ~~spousal share~~ marital assets.** ~~At the beginning of the first continuous period of institutionalization of a person beginning on or after October 1, 1989, at the request of either the institutionalized spouse or the community spouse, or~~ Upon application for medical assistance benefits for an institutionalized spouse, the total value of assets in which either the institutionalized spouse or the community spouse ~~had~~ have an interest ~~at the time of the first period of institutionalization of 30 days or more~~ shall be assessed and ~~documented and the spousal share shall be assessed and documented~~ the community spouse asset allowance calculated as required in subdivision 3.

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

Sec. 29. Minnesota Statutes 2014, section 256B.059, subdivision 3, is amended to read:

Subd. 3. **Community spouse asset allowance.** An institutionalized spouse may transfer assets to the community spouse for the sole benefit of the community spouse. Except for increased amounts allowable under subdivision 4, the maximum amount of assets allowed to be transferred is the amount which, when added to the assets otherwise available to the community spouse, is ~~as follows~~ the greater of:

~~(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; and~~

~~(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.~~

(1) $119,220 subject to an annual adjustment on January 1, 2017, and every January 1 thereafter, equal to the percentage increase in the Consumer Price Index for All Urban Consumers (all items; United States city average) between the two previous Septembers; or

(2) the amount required by court order to be paid to the community spouse.

If the assets available to the community spouse are already at the limit permissible under this section, or the higher limit attributable to increases under subdivision 4, no assets may be transferred from the institutionalized spouse to the community spouse. The transfer must be made as soon as practicable after the date the institutionalized spouse is determined eligible for medical assistance, or within the amount of time needed for any court order required for the transfer. ~~On January 1, 1994, and every January 1 thereafter, the limits in this subdivision shall be adjusted by the same percentage change in the Consumer Price Index for All Urban Consumers (all items; United States city average) between the two previous Septembers. These adjustments shall also be applied to the limits in subdivision 5.~~

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

Sec. 30. Minnesota Statutes 2015 Supplement, 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~~ for an institutionalized spouse, 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:~~ available to the community spouse under subdivision 3.

~~(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. 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, and during the continuous period of ~~institutionalization~~ enrollment, 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.

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

Sec. 31. Minnesota Statutes 2014, section 256B.059, is amended by adding a subdivision to read:

Subd. 6. **Temporary application.** (a) During the period in which rules against spousal impoverishment are temporarily applied according to section 2404 of the Patient Protection Affordable Care Act, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, this section applies to an institutionalized spouse:

(1) applying for home and community-based waivers under sections 256B.092, 256B.093, and 256B.49 on or after June 1, 2016;

(2) enrolled in home and community-based waivers under sections 256B.092, 256B.093, and 256B.49 before June 1, 2016; or

(3) applying for services under section 256B.85 upon the effective date of that section.

(b) During the applicable period of paragraph (a), the definition of "institutionalized spouse" in subdivision 1, paragraph (f), also includes an institutionalized spouse referenced in paragraph (a).

EFFECTIVE DATE. (a) Minnesota Statutes, section 256B.059 subdivision 6, paragraph (a), clauses (1) and (3), and paragraph (b) are effective June 1, 2016. Minnesota Statutes, section 256B.059 subdivision 6, paragraph (a), clause (2), is effective March 1, 2017.

(b) Minnesota Statutes, section 256B.059 subdivision 6, paragraph (a), clauses (1) and (2), expire upon notification to the commissioner of human services that the Center for Medicare and Medicaid Services has approved the continuation of the deeming rules in effect on May 31, 2016, for the treatment of the asset of a community spouse. The commissioner of human services shall notify the revisor of statutes when notice is received.

Sec. 32. Minnesota Statutes 2014, section 256B.06, subdivision 4, is amended to read:

Subd. 4. **Citizenship requirements.** (a) Eligibility for medical assistance is limited to citizens of the United States, qualified noncitizens as defined in this subdivision, and other persons residing lawfully in the United States. 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) "Qualified noncitizen" means a person who meets one of the following immigration criteria:

(1) admitted for lawful permanent residence according to United States Code, title 8;

(2) admitted to the United States as a refugee according to United States Code, title 8, section 1157;

(3) granted asylum according to United States Code, title 8, section 1158;

(4) granted withholding of deportation according to United States Code, title 8, section 1253(h);

(5) paroled for a period of at least one year according to United States Code, title 8, section 1182(d)(5);

(6) granted conditional entrant status according to United States Code, title 8, section 1153(a)(7);

(7) determined to be a battered noncitizen by the United States Attorney General according to the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, title V of the Omnibus Consolidated Appropriations Bill, Public Law 104-200;

(8) is a child of a noncitizen determined to be a battered noncitizen by the United States Attorney General according to the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, title V, of the Omnibus Consolidated Appropriations Bill, Public Law 104-200; or

(9) determined to be a Cuban or Haitian entrant as defined in section 501(e) of Public Law 96-422, the Refugee Education Assistance Act of 1980.

(c) All qualified noncitizens who were residing in the United States before August 22, 1996, who otherwise meet the eligibility requirements of this chapter, are eligible for medical assistance with federal financial participation.

(d) Beginning December 1, 1996, qualified noncitizens who entered the United States on or after August 22, 1996, and who otherwise meet the eligibility requirements of this chapter are eligible for medical assistance with federal participation for five years if they meet one of the following criteria:

(1) refugees admitted to the United States according to United States Code, title 8, section 1157;

(2) persons granted asylum according to United States Code, title 8, section 1158;

(3) persons granted withholding of deportation according to United States Code, title 8, section 1253(h);

(4) veterans of the United States armed forces with an honorable discharge for a reason other than noncitizen status, their spouses and unmarried minor dependent children; or

(5) persons on active duty in the United States armed forces, other than for training, their spouses and unmarried minor dependent children.

Beginning July 1, 2010, children and pregnant women who are noncitizens described in paragraph (b) or who are lawfully present in the United States as defined in Code of Federal Regulations, title 8, section 103.12, and who otherwise meet eligibility requirements of this chapter, are eligible for medical assistance with federal financial participation as provided by the federal Children's Health Insurance Program Reauthorization Act of 2009, Public Law 111-3.

(e) Nonimmigrants who otherwise meet the eligibility requirements of this chapter are eligible for the benefits as provided in paragraphs (f) to (h). For purposes of this subdivision, a "nonimmigrant" is a person in one of the classes listed in United States Code, title 8, section 1101(a)(15).

(f) Payment shall also be made for care and services that are furnished to noncitizens, regardless of immigration status, who otherwise meet the eligibility requirements of this chapter, if such care and services are necessary for the treatment of an emergency medical condition.

(g) For purposes of this subdivision, the term "emergency medical condition" means a medical condition that meets the requirements of United States Code, title 42, section 1396b(v).

(h)(1) Notwithstanding paragraph (g), services that are necessary for the treatment of an emergency medical condition are limited to the following:

(i) services delivered in an emergency room or by an ambulance service licensed under chapter 144E that are directly related to the treatment of an emergency medical condition;

(ii) services delivered in an inpatient hospital setting following admission from an emergency room or clinic for an acute emergency condition; and

(iii) follow-up services that are directly related to the original service provided to treat the emergency medical condition and are covered by the global payment made to the provider.

(2) Services for the treatment of emergency medical conditions do not include:

(i) services delivered in an emergency room or inpatient setting to treat a nonemergency condition;

(ii) organ transplants, stem cell transplants, and related care;

(iii) services for routine prenatal care;

(iv) continuing care, including long-term care, nursing facility services, home health care, adult day care, day training, or supportive living services;

(v) elective surgery;

(vi) outpatient prescription drugs, unless the drugs are administered or dispensed as part of an emergency room visit;

(vii) preventative health care and family planning services;

(viii) rehabilitation services;

(ix) physical, occupational, or speech therapy;

(x) transportation services;

(xi) case management;

(xii) prosthetics, orthotics, durable medical equipment, or medical supplies;

(xiii) dental services;

(xiv) hospice care;

(xv) audiology services and hearing aids;

(xvi) podiatry services;

(xvii) chiropractic services;

(xviii) immunizations;

(xix) vision services and eyeglasses;

(xx) waiver services;

(xxi) individualized education programs; or

(xxii) chemical dependency treatment.

(i) Pregnant noncitizens who are ineligible for federally funded medical assistance because of immigration status, are not covered by a group health plan or health insurance coverage according to Code of Federal Regulations, title 42, section 457.310, and who otherwise meet the eligibility requirements of this chapter, are eligible for medical assistance through the period of pregnancy, including labor and delivery, and 60 days postpartum, to the extent federal funds are available under title XXI of the Social Security Act, and the state children's health insurance program.

(j) Beginning October 1, 2003, persons who are receiving care and rehabilitation services from a nonprofit center established to serve victims of torture and are otherwise ineligible for medical assistance under this chapter are eligible for medical assistance without federal financial participation. These individuals are eligible only for the period during which they are receiving services from the center. Individuals eligible under this paragraph shall not be required to participate in prepaid medical assistance. The nonprofit center referenced under this paragraph may establish itself as a provider of mental health

targeted case management services through a county contract under section 256.0112, subdivision 6. If the nonprofit center is unable to secure a contract with a lead county in its service area, then, notwithstanding the requirements of section 256B.0625, subdivision 20, the commissioner may negotiate a contract with the nonprofit center for provision of mental health targeted case management services. When serving clients who are not the financial responsibility of their contracted lead county, the nonprofit center must gain the concurrence of the county of financial responsibility prior to providing mental health targeted case management services for those clients.

(k) Notwithstanding paragraph (h), clause (2), the following services are covered as emergency medical conditions under paragraph (f) except where coverage is prohibited under federal law:

(1) dialysis services provided in a hospital or freestanding dialysis facility; ~~and~~

(2) surgery and the administration of chemotherapy, radiation, and related services necessary to treat cancer if the recipient has a cancer diagnosis that is not in remission and requires surgery, chemotherapy, or radiation treatment; and

(3) kidney transplant if the person has been diagnosed with end stage renal disease, is currently receiving dialysis services, and is a potential candidate for a kidney transplant.

(l) Effective July 1, 2013, recipients of emergency medical assistance under this subdivision are eligible for coverage of the elderly waiver services provided under section 256B.0915, and coverage of rehabilitative services provided in a nursing facility. The age limit for elderly waiver services does not apply. In order to qualify for coverage, a recipient of emergency medical assistance is subject to the assessment and reassessment requirements of section 256B.0911. Initial and continued enrollment under this paragraph is subject to the limits of available funding.

Sec. 33. Minnesota Statutes 2014, section 256B.0625, is amended by adding a subdivision to read:

Subd. 9c. **Oral health assessments.** Medical assistance covers oral health assessments that meet the requirements of this subdivision. An oral health assessment must use the risk factors established by the commissioner of human services and be conducted by a licensed dental provider in collaborative practice under section 150A.10, subdivision 1a; 150A.105; or 150A.106, to identify possible signs of oral or systemic disease, malformation, or injury and the need for referral for diagnosis and treatment. Oral health assessments are limited to once per patient per year and must be conducted in a community setting. The provider performing the assessment must document that a formal arrangement with a licensed dentist for patient referral and follow-up is in place and is being utilized.

The patient referral and follow-up arrangement must allow patients receiving an assessment under this subdivision to receive follow-up services in a timely manner and establish an ongoing relationship with a dental provider that is available to serve as the patient's dental home. If the commissioner determines from an analysis of claims or other information that the referral and follow-up arrangement is not reasonably effective in ensuring that patients receive follow-up services, the commissioner may disqualify the treating provider or the pay-to provider from receiving payment for assessments under this subdivision.

Sec. 34. Minnesota Statutes 2015 Supplement, section 256B.0625, subdivision 17a, is amended to read:

Subd. 17a. **Payment for ambulance services.** (a) Medical assistance covers ambulance services. Providers shall bill ambulance services according to Medicare criteria. Nonemergency ambulance services shall not be paid as emergencies. Effective for services rendered on or after July 1, 2001, medical assistance payments for ambulance services shall be paid at the Medicare reimbursement rate or at the medical assistance payment rate in effect on July 1, 2000, whichever is greater.

(b) Effective for services provided on or after July 1, 2016, medical assistance payment rates for ambulance services identified in this paragraph are increased by five percent. Capitation payments made to managed care plans and county-based purchasing plans for ambulance services provided on or after January 1, 2017, shall be increased to reflect this rate increase, and shall require the plans to pass on the full amount of the increase in the form of higher reimbursement rates to the ambulance service providers identified in this paragraph. The increased rate described in this paragraph applies to ambulance service providers whose base of operations as defined in section 144E.10 is located:

(1) outside the metropolitan counties listed in section 473.121, subdivision 4, and outside the cities of Duluth, Mankato, Moorhead, St. Cloud, and Rochester; or

(2) within a municipality with a population of less than 1,000.

Sec. 35. Minnesota Statutes 2014, section 256B.0625, subdivision 30, is amended to read:

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

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

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

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

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

(f) Effective January 1, 2001, each federally qualified health center and rural health clinic may elect to be paid either under the prospective payment system established in United States Code, title 42, section 1396a(aa), or under an alternative payment methodology consistent with the requirements of United States Code, title 42, section 1396a(aa), and approved by the Centers for Medicare and Medicaid Services. The

alternative payment methodology shall be 100 percent of cost as determined according to Medicare cost principles.

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

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

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

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

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

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

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

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

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

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

(i) For clinic services provided prior to January 1, 2015, the commissioner shall calculate and pay monthly the proposed managed care supplemental payments to clinics, and clinics shall conduct a timely review of the payment calculation data in order to finalize all supplemental payments in accordance with federal law. Any issues arising from a clinic's review must be reported to the commissioner by January 1, 2017. Upon final agreement between the commissioner and a clinic on issues identified under this subdivision, and in accordance with United States Code, title 42, section 1396a(bb), no supplemental payments for managed care plan or county-based purchasing plan claims for services provided prior to January 1, 2015, shall be made after June 30, 2017. If the commissioner and clinics are unable to resolve issues under this subdivision, the parties shall submit the dispute to the arbitration process under section 14.57.

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

Sec. 36. Minnesota Statutes 2015 Supplement, section 256B.0625, subdivision 31, is amended to read:

Subd. 31. **Medical supplies and equipment.** (a) Medical assistance covers medical supplies and equipment. Separate payment outside of the facility's payment rate shall be made for wheelchairs and wheelchair accessories for recipients who are residents of intermediate care facilities for the developmentally disabled. Reimbursement for wheelchairs and wheelchair accessories for ICF/DD recipients shall be subject to the same conditions and limitations as coverage for recipients who do not reside in institutions. A wheelchair purchased outside of the facility's payment rate is the property of the recipient.

(b) Vendors of durable medical equipment, prosthetics, orthotics, or medical supplies must enroll as a Medicare provider.

(c) When necessary to ensure access to durable medical equipment, prosthetics, orthotics, or medical supplies, the commissioner may exempt a vendor from the Medicare enrollment requirement if:

(1) the vendor supplies only one type of durable medical equipment, prosthetic, orthotic, or medical supply;

(2) the vendor serves ten or fewer medical assistance recipients per year;

(3) the commissioner finds that other vendors are not available to provide same or similar durable medical equipment, prosthetics, orthotics, or medical supplies; and

(4) the vendor complies with all screening requirements in this chapter and Code of Federal Regulations, title 42, part 455. The commissioner may also exempt a vendor from the Medicare enrollment requirement if the vendor is accredited by a Centers for Medicare and Medicaid Services approved national accreditation organization as complying with the Medicare program's supplier and quality standards and the vendor serves primarily pediatric patients.

(d) Durable medical equipment means a device or equipment that:

(1) can withstand repeated use;

(2) is generally not useful in the absence of an illness, injury, or disability; and

(3) is provided to correct or accommodate a physiological disorder or physical condition or is generally used primarily for a medical purpose.

(e) Electronic tablets may be considered durable medical equipment if the electronic tablet will be used as an augmentative and alternative communication system as defined under subdivision 31a, paragraph (a). To be covered by medical assistance, the device must be locked in order to prevent use not related to communication.

(f) Notwithstanding the requirement in paragraph (e) that an electronic tablet must be locked to prevent use not as an augmentative communication device, a recipient of waiver services may use an electronic tablet for a use not related to communication when the recipient has been authorized under the waiver to receive one or more additional applications that can be loaded onto the electronic tablet, such that allowing the additional use prevents the purchase of a separate electronic tablet with waiver funds.

(g) Allergen-reducing products provided according to subdivision 65, paragraph (c), clause (3), shall be considered durable medical equipment.

EFFECTIVE DATE. This section is effective upon federal approval, but not before January 1, 2017. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 37. Minnesota Statutes 2014, section 256B.0625, subdivision 34, is amended to read:

Subd. 34. **Indian health services facilities.** (a) Medical assistance payments and MinnesotaCare payments to facilities of the Indian health service and facilities operated by a tribe or tribal organization under funding authorized by United States Code, title 25, sections 450f to 450n, or title III of the Indian Self-Determination and Education Assistance Act, Public Law 93-638, for enrollees who are eligible for federal financial participation, shall be at the option of the facility in accordance with the rate published by the United States Assistant Secretary for Health under the authority of United States Code, title 42, sections 248(a) and 249(b). ~~General assistance medical care payments to facilities of the Indian health services and facilities operated by a tribe or tribal organization for the provision of outpatient medical care services billed after June 30, 1990, must be in accordance with the general assistance medical care rates paid for the same services when provided in a facility other than a facility of the Indian health service or a facility operated by a tribe or tribal organization.~~ MinnesotaCare payments for enrollees who are not eligible for federal financial participation at facilities of the Indian health service and facilities operated by a tribe or tribal organization for the provision of outpatient medical

services must be in accordance with the medical assistance rates paid for the same services when provided in a facility other than a facility of the Indian health service or a facility operated by a tribe or tribal organization.

(b) Effective upon federal approval, the medical assistance payments to a dually certified facility as defined in subdivision 30, paragraph (j), shall be the encounter rate described in paragraph (a) or a rate that is substantially equivalent for services provided to American Indians and Alaskan Native populations. The rate established under this paragraph for dually certified facilities shall not apply to MinnesotaCare payments.

Sec. 38. Minnesota Statutes 2015 Supplement, section 256B.0625, subdivision 58, is amended to read:

Subd. 58. **Early and periodic screening, diagnosis, and treatment services.** (a) 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 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.

(b) Effective for services provided on or after July 1, 2016, payment for a complete EPSDT screening shall be increased by five percent. Effective January 1, 2017, capitation payments made to managed care plans and county-based purchasing plans shall be increased to reflect this increase and the commissioner shall require the plans to pass on the full amount of the increase in the form of higher payment rates to the providers. This increase does not apply to federally qualified health centers, rural health centers, and Indian health services.

Sec. 39. Minnesota Statutes 2014, section 256B.0625, is amended by adding a subdivision to read:

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

(b) A CEMT may provide a posthospital discharge visit when ordered by a treating physician. The posthospital discharge visit includes:

(1) verbal or visual reminders of discharge orders;

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

(3) medication access confirmation;

(4) food access confirmation; and

(5) identification of home hazards.

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

(1) medication access confirmation;

(2) food access confirmation; and

(3) identification of home hazards.

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

EFFECTIVE DATE. This section is effective January 1, 2017, or upon federal approval, whichever is later.

Sec. 40. Minnesota Statutes 2014, section 256B.0625, is amended by adding a subdivision to read:

Subd. 65. **Enhanced asthma care services.** (a) Medical assistance covers enhanced asthma care services and related products for children with poorly controlled asthma to be provided in the children's homes. To be eligible for services and products under this subdivision, a child must:

(1) be under 21 years of age;

(2) have poorly controlled asthma;

(3) have, at least one time in the past year, received health care for the child's asthma from a hospital emergency department or been hospitalized for the treatment of asthma; and

(4) receive a referral for asthma care services and products covered under this subdivision from a treating health care provider.

(b) Covered asthma care services and products include:

(1) a home assessment for asthma triggers provided by an enrolled healthy homes specialist currently credentialed by the National Environmental Health Association;

(2) targeted asthma education services in the child's home by an enrolled asthma educator certified by the National Asthma Educator Certification Board. Asthma education services provided under this clause include education on self-management, avoiding asthma triggers, identifying worsening asthma symptoms, and medication uses and techniques; and

(3) allergen-reducing products recommended for the child by the healthy homes specialist or the certified asthma educator based on the documented allergies for that child and proven to reduce asthma triggers identified in the child's home assessment, including:

(i) encasements for mattresses, box springs, and pillows;

(ii) a HEPA vacuum cleaner, filters, and bags;

(iii) a dehumidifier and filters;

(iv) single-room air cleaners and filters;

(v) nontoxic pest control systems, including traps and starter packages of food storage containers;

(vi) a damp mopping system;

(vii) if the child does not have access to a bed, a waterproof hospital-grade mattress; and

(viii) furnace filters, for homeowners only.

(c) A child is limited to one home assessment and one visit by a certified asthma educator to provide education on the use and maintenance of the products listed in paragraph (b), clause (3). A child may receive an additional home assessment if the child moves to a new home: (1) develops a new asthma trigger, including tobacco smoke; or (2) the child's health care provider documents a new allergy for the child, including an allergy to mold, pests, pets, or dust mites.

(d) The commissioner shall determine the frequency that a child may receive a product listed in paragraph (a), clause (3), based on the reasonable expected lifetime of the product.

EFFECTIVE DATE. This section is effective upon federal approval, but not before January 1, 2017. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 41. Minnesota Statutes 2014, section 256B.15, subdivision 1, is amended to read:

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

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

(2) the provisions of subdivisions 1c to 1k expanding the interests included in an estate for purposes of recovery under this section give effect to the provisions of United

States Code, title 42, section 1396p, governing recoveries, but do not give rise to any express or implied liens in favor of any other parties not named in these provisions;

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

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

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

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

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

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

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

Sec. 42. Minnesota Statutes 2014, section 256B.15, subdivision 1a, is amended to read:

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

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

(1) the person's probate estate;

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

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

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

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

(c) For the purpose of this section and recovery in a surviving spouse's estate for medical assistance paid for a predeceased spouse, the estate must consist of all of the legal title and interests the deceased individual's predeceased spouse had in jointly owned or

marital property at the time of the spouse's death, as defined in subdivision 2b, and the proceeds of those interests, that passed to the deceased individual or another individual, a survivor, an heir, or an assign of the predeceased spouse through a joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement. A deceased recipient who, at death, owned the property jointly with the surviving spouse shall have an interest in the entire property.

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

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

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

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

(3) the person received general assistance medical care services under chapter 256D.~~;~~ or

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

(f) The claim shall be considered an expense of the last illness of the decedent for the purpose of section 524.3-805. Notwithstanding any law or rule to the contrary, a state or county agency with a claim under this section must be a creditor under section 524.6-307. Any statute of limitations that purports to limit any county agency or the state agency, or both, to recover for medical assistance granted hereunder shall not apply to any claim made hereunder for reimbursement for any medical assistance granted hereunder. Notice of the claim shall be given to all heirs and devisees of the decedent, and to other persons with an ownership interest in the real property owned by the decedent at the time of the decedent's death, whose identity can be ascertained with reasonable diligence. The

notice must include procedures and instructions for making an application for a hardship waiver under subdivision 5; time frames for submitting an application and determination; and information regarding appeal rights and procedures. Counties are entitled to one-half of the nonfederal share of medical assistance collections from estates that are directly attributable to county effort. Counties are entitled to ten percent of the collections for alternative care directly attributable to county effort.

EFFECTIVE DATE. This section is effective upon federal approval and applies to services rendered on or after January 1, 2014, and to claims not paid prior to July 1, 2016.

Sec. 43. Minnesota Statutes 2014, section 256B.15, subdivision 2, is amended to read:

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

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

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

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

The claim shall not include interest. For the purposes of this section, "home and community-based services" has the same meaning it has when used in United States Code, title 42, section 1396p, subsection (b), paragraph (1), subparagraph (B), clause (i).

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

the predeceased recipient spouse. Claims for alternative care shall be net of all premiums paid under section 256B.0913, subdivision 12, on or after July 1, 2003, and shall be limited to services provided on or after July 1, 2003. Claims against marital property shall be limited to claims against recipients who died on or after July 1, 2009.

EFFECTIVE DATE. This section is effective upon federal approval and applies to services rendered on or after January 1, 2014, and to claims not paid prior to July 1, 2016.

Sec. 44. Minnesota Statutes 2014, section 256B.69, subdivision 6, is amended to read:

Subd. 6. **Service delivery.** (a) Each demonstration provider shall be responsible for the health care coordination for eligible individuals. Demonstration providers:

(1) shall authorize and arrange for the provision of all needed health services including but not limited to the full range of services listed in sections 256B.02, subdivision 8, and 256B.0625 in order to ensure appropriate health care is delivered to enrollees. Notwithstanding section 256B.0621, demonstration providers that provide nursing home and community-based services under this section shall provide relocation service coordination to enrolled persons age 65 and over;

(2) shall accept the prospective, per capita payment from the commissioner in return for the provision of comprehensive and coordinated health care services for eligible individuals enrolled in the program;

(3) may contract with other health care and social service practitioners to provide services to enrollees; and

(4) shall institute recipient grievance procedures according to the method established by the project, utilizing applicable requirements of chapter 62D. Disputes not resolved through this process shall be appealable to the commissioner as provided in subdivision 11.

(b) Demonstration providers must comply with the standards for claims settlement under section 72A.201, subdivisions 4, 5, 7, and 8, when contracting with other health care and social service practitioners to provide services to enrollees. A demonstration provider must pay a clean claim, as defined in Code of Federal Regulations, title 42, section 447.45(b), within 30 business days of the date of acceptance of the claim.

(c) Managed care plans and county-based purchasing plans must comply with chapter 62M and section 62Q.83.

Sec. 45. Minnesota Statutes 2015 Supplement, section 256B.76, subdivision 1, is amended to read:

Subdivision 1. **Physician reimbursement.** (a) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for physician services as follows:

(1) payment for level one Centers for Medicare and Medicaid Services' common procedural coding system codes titled "office and other outpatient services," "preventive medicine new and established patient," "delivery, antepartum, and postpartum care," "critical care," cesarean delivery and pharmacologic management provided to psychiatric patients, and level three codes for enhanced services for prenatal high risk, shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992. If the rate on any procedure code within these categories is different than the rate that would have been paid under the methodology in section 256B.74, subdivision 2, then the larger rate shall be paid;

(2) payments for all other services shall be paid at the lower of (i) submitted charges, or (ii) 15.4 percent above the rate in effect on June 30, 1992; and

(3) all physician 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 except that payment rates for home health agency services shall be the rates in effect on September 30, 1992.

(b) Effective for services rendered on or after January 1, 2000, payment rates for physician and professional services shall be increased by three percent over the rates in effect on December 31, 1999, except for home health agency and family planning agency services. The increases in this paragraph shall be implemented January 1, 2000, for managed care.

(c) Effective for services rendered on or after July 1, 2009, payment rates for physician and professional services shall be reduced by five percent, except that for the period July 1, 2009, through June 30, 2010, payment rates shall be reduced by 6.5 percent for the medical assistance and general assistance medical care programs, over the rates in effect on June 30, 2009. This reduction and the reductions in paragraph (d) do not apply to office or other outpatient visits, preventive medicine visits and family planning visits billed by physicians, advanced practice nurses, or physician assistants in a family planning agency or in one of the following primary care practices: general practice, general internal medicine, general pediatrics, general geriatrics, and family medicine. This reduction and the reductions in paragraph (d) do not apply to federally qualified health centers, rural health centers, and Indian health services. Effective October 1, 2009, payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment reduction described in this paragraph.

(d) Effective for services rendered on or after July 1, 2010, payment rates for physician and professional services shall be reduced an additional seven percent over the five percent reduction in rates described in paragraph (c). This additional reduction does not apply to physical therapy services, occupational therapy services, and speech pathology and related services provided on or after July 1, 2010. This additional reduction does not apply to physician services billed by a psychiatrist or an advanced practice nurse with a specialty in mental health. Effective October 1, 2010, payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment reduction described in this paragraph.

(e) Effective for services rendered on or after September 1, 2011, through June 30, 2013, payment rates for physician and professional services shall be reduced three percent from the rates in effect on August 31, 2011. This reduction does not apply to physical therapy services, occupational therapy services, and speech pathology and related services.

(f) Effective for services rendered on or after September 1, 2014, payment rates for physician and professional services, including physical therapy, occupational therapy, speech pathology, and mental health services shall be increased by five percent from the rates in effect on August 31, 2014. In calculating this rate increase, the commissioner shall not include in the base rate for August 31, 2014, the rate increase provided under section 256B.76, subdivision 7. This increase does not apply to federally qualified health centers, rural health centers, and Indian health services. Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

(g) Effective for services rendered on or after July 1, 2015, payment rates for physical therapy, occupational therapy, and speech pathology and related services provided by a hospital meeting the criteria specified in section 62Q.19, subdivision 1, paragraph (a), clause (4), shall be increased by 90 percent from the rates in effect on June 30, 2015. Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

(h) Effective for services provided on or after July 1, 2016, payment rates for primary care services that were eligible for the rate increase in 2013 and 2014 under section 1902(a)(13)(c) of the Social Security Act shall be increased by five percent when that service is provided by a provider meeting one of the following criteria:

(1) a physician certified in the specialties of family medicine, general internal medicine, pediatric medicine, or obstetric and gynecological medicine; or

(2) a physician assistant, advanced practice registered nurse, or physician other than a psychiatrist, for whom at least 60 percent of the services for which the provider

received payment under medical assistance and MinnesotaCare were for primary care evaluation and management services or vaccine administration services under the Vaccines for Children program. The commissioner shall periodically validate the eligibility of providers who attest to meeting the criteria established under this clause.

Effective January 1, 2017, capitation payments made to managed care plans and county-based purchasing plans shall be increased to reflect this increase, and the commissioner shall require the plans to pass on the full amount of the increase in the form of higher payment rates to eligible providers. This increase does not apply to federally qualified health centers, rural health centers, and Indian health services.

Sec. 46. Minnesota Statutes 2015 Supplement, 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) 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) 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.

(k) Effective for services rendered on or after July 1, 2015, through December 31, 2016, the commissioner shall increase payment rates for services furnished by dental providers located outside of the seven-county metropolitan area by the maximum percentage possible above the rates in effect on June 30, 2015, while remaining within the limits of funding appropriated for this purpose. 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, 2016, through December 31, 2016, payments to managed care plans and county-based purchasing plans under sections 256B.69 and 256B.692 shall reflect the payment increase described in this paragraph. The commissioner shall require managed care and county-based purchasing plans to pass on the full amount of the increase, in the form of higher payment rates to dental providers located outside of the seven-county metropolitan area.

(l) Effective for services provided on or after January 1, 2017, the commissioner shall increase payment rates by 9.65 percent for dental services provided outside of the seven-county metropolitan area. This increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, or Indian health services. Effective January 1, 2017, payments to managed care plans and county-based purchasing plans under sections 256B.69 and 256B.692, shall reflect the payment increase described in this paragraph. The commissioner shall require managed

care and county-based purchasing plans to pass on the full amount of the increase in the form of higher payment rates to dental providers for the dental services that are identified for the rate increase in this paragraph.

(m) Effective for services provided on or after July 1, 2016, payment rates for preventive dental services shall be increased by five percent. Effective January 1, 2017, capitation payments made to managed care plans and county-based purchasing plans shall be increased to reflect this increase, and the commissioner shall require the plans to pass on the full amount of the increase in the form of higher payment rates for these services. This increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, and Indian health services.

Sec. 47. Minnesota Statutes 2015 Supplement, 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~~ 2016, the commissioner shall increase reimbursement by ~~35~~ 37.5 percent above the reimbursement rate that would otherwise be paid to the critical access dental provider, except as specified under paragraph (b). 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 July 1, 2016, by a dental clinic or dental group that meets the critical access dental provider designation under paragraph (d), clause (4), and is owned and operated by a health maintenance organization licensed under chapter 62D, the commissioner shall increase reimbursement by 35 percent above the reimbursement rate that would otherwise be paid to the critical access provider.

~~(b)~~ (c) Critical access dental payments made under paragraph (a) or (b) for dental services provided by a critical access dental provider to an enrollee of a managed care plan or county-based purchasing plan must not reflect any capitated payments or cost-based payments from the managed care plan or county-based purchasing plan. The managed care plan or county-based purchasing plan must base the additional critical access dental payment on the amount that would have been paid for that service had the dental provider been paid according to the managed care plan or county-based purchasing plan's fee schedule that applies to dental providers that are not paid under a capitated payment or cost-based payment.

(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~~ hospital-based dental clinics owned and operated ~~hospital-based dental clinics~~ by a city, county, or former state hospital as defined in section 62Q.19, subdivision 1, paragraph (a), clause (4);

(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~~ the seven-county metropolitan area and 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; ~~and~~ or

~~(iii) 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.~~

(ii) the dentist's office is located outside the seven-county metropolitan area and more than 25 percent of the dentist's patient encounters per year are with patients who are uninsured or covered by medical assistance or MinnesotaCare.

Sec. 48. Minnesota Statutes 2014, section 256B.761, is amended to read:

256B.761 REIMBURSEMENT FOR MENTAL HEALTH SERVICES.

(a) Effective for services rendered on or after July 1, 2001, payment for medication management provided to psychiatric patients, outpatient mental health services, day treatment services, home-based mental health services, and family community support services shall be paid at the lower of (1) submitted charges, or (2) 75.6 percent of the 50th percentile of 1999 charges.

(b) Effective July 1, 2001, the medical assistance rates for outpatient mental health services provided by an entity that operates: (1) a Medicare-certified comprehensive outpatient rehabilitation facility; and (2) a facility that was certified prior to January 1, 1993, with at least 33 percent of the clients receiving rehabilitation services in the most recent calendar year who are medical assistance recipients, will be increased by 38 percent, when those services are provided within the comprehensive outpatient rehabilitation facility and provided to residents of nursing facilities owned by the entity.

(c) The commissioner shall establish three levels of payment for mental health diagnostic assessment, based on three levels of complexity. The aggregate payment under the tiered rates must not exceed the projected aggregate payments for mental health diagnostic assessment under the previous single rate. The new rate structure is effective January 1, 2011, or upon federal approval, whichever is later.

(d) In addition to rate increases otherwise provided, the commissioner may restructure coverage policy and rates to improve access to adult rehabilitative mental health services under section 256B.0623 and related mental health support services under section 256B.021, subdivision 4, paragraph (f), clause (2). For state fiscal years 2015 and 2016, the projected state share of increased costs due to this paragraph is transferred from adult mental health grants under sections 245.4661 and 256E.12. The transfer for fiscal year 2016 is a permanent base adjustment for subsequent fiscal years. Payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the rate changes described in this paragraph.

(e) Effective for services provided on or after July 1, 2016, payments for outpatient mental health services shall be increased by five percent. Effective January 1, 2017, capitation payments made to managed care plans and county-based purchasing plans shall be increased to reflect this increase, and the commissioner shall require the plans to pass on the full amount of the increase in the form of higher payment rates for these services. This increase is not applicable to federally qualified health centers, rural health centers, Indian health services, other cost-based rates, rates that are negotiated with the county, or rates that are established by the federal government.

Sec. 49. **[256B.7625] REIMBURSEMENT FOR EVIDENCE-BASED PUBLIC HEALTH NURSE HOME VISITS.**

Effective for services provided on or after January 1, 2017, prenatal and postpartum follow-up home visits provided by public health nurses using evidence-based models shall be paid $140 per visit. Evidence-based postpartum follow-up home visits must be administered by home visiting programs that meet the United States Department of Health and Human Services criteria for evidence-based models and identified by the commissioner of health as eligible services under the Maternal, Infant, and Early Childhood Home Visiting program. Home visits shall be targeted toward pregnant women and mothers with children up to three years of age. Effective January 1, 2017, capitation payments made to managed care plans and county-based purchasing plans shall be increased to reflect this increase and the commissioner shall require the plans to pass on the full amount of the increase in the form of higher payment rates to the providers.

Sec. 50. Minnesota Statutes 2015 Supplement, section 256B.766, is amended to read:

256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.

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

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

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

(d) Effective for services provided on or after September 1, 2011, through June 30, 2013, total payments for ambulatory surgery centers facility fees, medical supplies and durable medical equipment not subject to a volume purchase contract, prosthetics and orthotics, renal dialysis services, laboratory services, public health nursing services,

physical therapy services, occupational therapy services, speech therapy services, eyeglasses not subject to a volume purchase contract, hearing aids not subject to a volume purchase contract, and anesthesia services shall be reduced by three percent from the rates in effect on August 31, 2011.

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

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

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

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

(i) Effective July 1, 2015, the ~~medical assistance payment rate for durable medical equipment, prosthetics, orthotics, or supplies shall be restored to the January 1, 2008, medical assistance fee schedule, updated to include subsequent rate increases in the Medicare and medical assistance fee schedules, and including~~ following categories of durable medical equipment shall be individually priced items ~~for the following categories~~: enteral nutrition and supplies, customized and other specialized tracheostomy tubes and supplies, electric patient lifts, and durable medical equipment repair and service. This paragraph does not apply to medical supplies and durable medical equipment subject to

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

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

(1) payment rates for durable medical equipment, prosthetics, orthotics, or supplies that were subject to the Medicare 2008 competitive bid shall be increased by 9.5 percent; and

(2) payment rates for durable medical equipment, prosthetics, orthotics, or supplies on the medical assistance fee schedule, whether or not subject to the Medicare 2008 competitive bid, shall be increased by 2.94 percent, with this increase being applied after calculation of any increased payment rate under clause (1).

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

Sec. 51. Minnesota Statutes 2014, section 256L.01, subdivision 1a, is amended to read:

Subd. 1a. **Child.** "Child" means an individual under 21 years of age~~, including the unborn child of a pregnant woman, an emancipated minor, and an emancipated minor's spouse~~.

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

Sec. 52. Minnesota Statutes 2015 Supplement, 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~~ current income, or if income fluctuates month to month, the income for the 12-month eligibility period.

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

Sec. 53. Minnesota Statutes 2015 Supplement, 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 $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 for recipients with incomes not exceeding 200 percent of the federal poverty guidelines. The commissioner shall increase co-payments for covered services in a manner sufficient to reduce the actuarial value of the benefit to 87 percent for recipients with incomes greater than 200 percent but not exceeding 250 percent of the federal poverty guidelines. The

commissioner shall increase co-payments for covered services in a manner sufficient to reduce the actuarial value of the benefit to 80 percent for recipients with incomes greater than 250 percent but not exceeding 275 percent of the federal poverty guidelines. The cost-sharing changes 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. This section is effective January 1, 2018, or upon the effective date of federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 54. Minnesota Statutes 2014, section 256L.04, subdivision 1, is amended to read:

Subdivision 1. **Families with children.** Families with children with family income above 133 percent of the federal poverty guidelines and equal to or less than ~~200~~ 275 percent of the federal poverty guidelines for the applicable family size shall be eligible for MinnesotaCare according to this section. All other provisions of sections 256L.01 to 256L.18 shall apply unless otherwise specified. Children under age 19 with family income at or below ~~200~~ 275 percent of the federal poverty guidelines and who are ineligible for medical assistance by sole reason of the application of federal household composition rules for medical assistance are eligible for MinnesotaCare.

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

Sec. 55. 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 by 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. 56. Minnesota Statutes 2014, section 256L.04, subdivision 2, is amended to read:

Subd. 2. **Third-party liability, paternity, and other medical support.** ~~(a) To be eligible for MinnesotaCare,~~ Individuals and families ~~must~~ may cooperate with the state agency to identify potentially liable third-party payers and assist the state in obtaining third-party payments. "Cooperation" includes, but is not limited to, complying with the notice requirements in section 256B.056, subdivision 9, identifying any third party who may be liable for care and services provided under MinnesotaCare to the enrollee, providing relevant information to assist the state in pursuing a potentially liable third party, and completing forms necessary to recover third-party payments.

~~(b) A parent, guardian, relative caretaker, or child enrolled in the MinnesotaCare program must cooperate with the Department of Human Services and the local agency in establishing the paternity of an enrolled child and in obtaining medical care support and payments for the child and any other person for whom the person can legally assign rights, in accordance with applicable laws and rules governing the medical assistance program. A child shall not be ineligible for or disenrolled from the MinnesotaCare program solely because the child's parent, relative caretaker, or guardian fails to cooperate in establishing paternity or obtaining medical support.~~

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

Sec. 57. Minnesota Statutes 2014, section 256L.04, subdivision 7, is amended to read:

Subd. 7. **Single adults and households with no children.** The definition of eligible persons includes all individuals and families with no children who have incomes that are above 133 percent and equal to or less than ~~200~~ 275 percent of the federal poverty guidelines for the applicable family size.

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

Sec. 58. Minnesota Statutes 2015 Supplement, 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 annually ~~on January~~ each July 1 as ~~provided~~ described in ~~Code of Federal Regulations, title 26, section 1.36B-1(h)~~ section 256B.056, subdivision 1c.

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

Sec. 59. Minnesota Statutes 2015 Supplement, section 256L.05, subdivision 3a, is amended to read:

Subd. 3a. **Redetermination of eligibility.** (a) An enrollee's eligibility must be redetermined on an annual basis, in accordance with Code of Federal Regulations, title 42, section 435.916(a). ~~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.~~ The 12-month eligibility period begins the month of application. Beginning July 1, 2017, the commissioner shall adjust the eligibility period for enrollees to implement renewals throughout the year according to guidance from the Centers for Medicare and Medicaid Services.

(b) Each new period of eligibility must take into account any changes in circumstances that impact eligibility and premium amount. Coverage begins as provided in section 256L.06.

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

Sec. 60. Minnesota Statutes 2015 Supplement, 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 may not reenroll prior to the first day of the month following the payment of an amount equal to two months' premiums.

(e) The commissioner shall forgive the past-due premium for persons disenrolled under paragraph (d) prior to issuing a premium invoice for the fourth month following disenrollment.

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

Sec. 61. Minnesota Statutes 2014, section 256L.07, subdivision 1, is amended to read:

Subdivision 1. **General requirements.** Individuals enrolled in MinnesotaCare under section 256L.04, subdivision 1, and individuals enrolled in MinnesotaCare under section 256L.04, subdivision 7, whose income increases above ~~200 percent of the federal poverty guidelines~~ the maximum income eligibility limit in section 256L.04, subdivision 1 or 7, are no longer eligible for the program and shall be disenrolled by the commissioner. For persons disenrolled under this subdivision, MinnesotaCare coverage terminates the last day of the calendar month ~~following the month~~ in which the commissioner ~~determines that~~ sends advance notice in accordance with Code of Federal Regulations, title 42, section 431.211, that indicates the income of a family or individual exceeds program income limits.

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

Sec. 62. Minnesota Statutes 2014, section 256L.11, subdivision 7, is amended to read:

Subd. 7. **Critical access dental providers.** Effective for dental services provided to MinnesotaCare enrollees on or after ~~January 1, 2007, through August 31, 2011~~ July 1, 2016, 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~~ 32.5 percent above the payment rate that would otherwise be paid to the provider, except for a dental clinic or dental group described in section 256B.76, subdivision 4, paragraph (b), in which 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.

Sec. 63. Minnesota Statutes 2015 Supplement, section 256L.15, subdivision 1, is amended to read:

Subdivision 1. **Premium determination for MinnesotaCare.** (a) Families with children and individuals shall pay a premium determined according to subdivision 2.

(b) Members of the military and their families who meet the eligibility criteria for MinnesotaCare upon eligibility approval made within 24 months following the end of the member's tour of active duty shall have their premiums paid by the commissioner. The effective date of coverage for an individual or family who meets the criteria of this paragraph shall be the first day of the month following the month in which eligibility is approved. This exemption applies for 12 months.

(c) Beginning July 1, 2009, American Indians enrolled in MinnesotaCare and their families shall have their premiums waived by the commissioner in accordance with section 5006 of the American Recovery and Reinvestment Act of 2009, Public Law 111-5. An individual must ~~document~~ indicate status as an American Indian, as defined under Code of Federal Regulations, title 42, section 447.50, to qualify for the waiver of premiums. The commissioner shall accept attestation of an individual's status as an American Indian as verification until the United States Department of Health and Human Services approves an electronic data source for this purpose.

(d) For premiums effective August 1, 2015, and after, the commissioner, after consulting with the chairs and ranking minority members of the legislative committees with jurisdiction over human services, shall increase premiums under subdivision 2 for recipients based on June 2015 program enrollment. Premium increases shall be sufficient to increase projected revenue to the fund described in section 16A.724 by at least $27,800,000 for the biennium ending June 30, 2017. The commissioner shall publish the revised premium scale on the Department of Human Services Web site and in the State Register no later than June 15, 2015. The revised premium scale applies to all premiums on or after August 1, 2015, in place of the scale under subdivision 2.

(e) By July 1, 2015, the commissioner shall provide the chairs and ranking minority members of the legislative committees with jurisdiction over human services the revised premium scale effective August 1, 2015, and statutory language to codify the revised premium schedule.

(f) Premium changes authorized under paragraph (d) must only apply to enrollees not otherwise excluded from paying premiums under state or federal law. Premium changes authorized under paragraph (d) must satisfy the requirements for premiums for the Basic Health Program under title 42 of Code of Federal Regulations, section 600.505.

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

Sec. 64. Minnesota Statutes 2015 Supplement, section 256L.15, subdivision 2, is amended to read:

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

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

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

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

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

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

Federal Poverty Guideline Greater than or Equal to	**Less than**	**Individual Premium Amount**
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%	$29
160%	170%	$33

170%	180%	$38
180%	190%	$43
190%		$50

(e) The commissioner shall extend the premium scale specified in paragraph (d) to include individuals with incomes greater than 200 percent but not exceeding 275 percent of the federal poverty guidelines, such that individuals with incomes at 201 percent of the federal poverty guidelines shall pay 4.09 percent of income, individuals with incomes at 251 percent of the federal poverty guidelines shall pay 7.26 percent of income, and individuals with incomes at 275 percent of the federal poverty guidelines shall pay 8.83 percent of income. The commissioner shall set other premium amounts in a proportional manner using evenly spaced income steps.

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

Sec. 65. **FEDERAL WAIVER.**

Subdivision 1. **Waiver goals.** (a) The commissioner of human services, in consultation with the commissioners of health and commerce, and the executive director of MNsure, shall seek the necessary federal waiver authority from the United States Department of Health and Human Services to design and operate a seamless and sustainable health coverage continuum that reduces barriers to care, eases the transition across the continuum for consumers, and ensures access to comprehensive and affordable health care coverage. The waiver request shall include all proposals described in this section and the commissioner shall seek authority to secure all federal funding available to meet the proposals as described under this section. This includes available Medicaid funding and all premium tax credits and cost-sharing subsidies available under United States Code, title 26, section 36B, and United States Code, title 42, section 18071, as applicable to each proposal.

(b) The waiver request must incorporate:

(1) the alignment of eligibility, benefits, and enrollment requirements across insurance affordability programs, including, a common income methodology, 12 months of continuous eligibility for families and children enrolled in medical assistance, consistent household composition rules, and a common definition of "American Indian;"

(2) multipayer alignment across the health care coverage continuum that promotes health equity, including consistent payment methodologies across payers and products and

similar coverage and contracting requirements across insurance affordability programs or product options; and

(3) innovative reforms to promote cost-neutrality and sustainability, including prospective and outcome-based payment for collaborative organizations and primary care providers.

(c) In developing this federal waiver, the commissioner shall coordinate with the appropriate state agencies and consult with stakeholder groups and consumers. The commissioner shall work with the commissioner of health for the purpose of analyzing the differences in the utilization of services and provider payment rates across markets. The commissioner may prioritize through separate waiver submissions the proposals described in paragraph (b) and in subdivisions 3, 4, and 5, to the extent necessary to ensure conformity with the federal waiver application requirements.

(d) The commissioner is authorized to seek any available waivers or federal approvals to accomplish the goals and proposals under this section prior to January 1, 2018.

Subd. 2. **Expansion of the MinnesotaCare program.** (a) As part of the waiver under subdivision 1, the commissioner shall seek authority to:

(1) expand MinnesotaCare to include persons with incomes up to 275 percent of federal poverty guidelines under section 1332 of the Affordable Care Act;

(2) modify MinnesotaCare premiums and cost-sharing to smooth affordability cliffs between insurance affordability programs; and

(3) receive for all MinnesotaCare enrollees, including, but not limited to, those with incomes at or below 275 percent of the federal poverty guidelines, the full amount of advanced premium tax credits, and cost-sharing reductions that these individuals would have otherwise received if they obtained qualified health plan coverage through MNsure.

(b) The commissioner shall notify the chairs and ranking minority members of the legislative committees with jurisdiction over health care finances when federal approval is obtained for this proposal.

(c) Upon federal approval, the commissioner is authorized to accept and expend federal funds that support the purpose of this subdivision.

Subd. 3. **Access to employer health coverage.** The commissioner shall include in the waiver request under subdivision 1 the ability for individuals who have access to health coverage through a spouse's or parent's employer that is deemed minimum essential coverage under Code of Federal Regulations, title 26, section 1.36B-2, and the portion of the annual premium the employee pays for employee and dependent coverage exceeds the required contribution percentage as described in Code of Federal Regulations, title 26, section 1.36B-2, to:

(1) enroll in the MinnesotaCare program if all eligibility requirements are met, except for Minnesota Statutes, section 256L.07, subdivision 2, paragraph (a); and

(2) be eligible for advanced premium tax credits and cost-sharing credits under Code of Federal Regulations, title 26, section 1.36B-2, as applicable to their household income when purchasing a qualified health plan through MNsure, for individuals whose income is above the maximum income eligibility limit under Minnesota Statutes, section 256L.04, subdivision 1 or 7, but less than 400 percent of federal poverty guidelines.

Subd. 4. **MinnesotaCare public option.** (a) The commissioner shall include as part of the waiver request under subdivision 1, the authority to establish a public option that allows individuals with income above the maximum income eligibility limit under Minnesota Statutes, section 256L.04, subdivision 1 or 7, and who otherwise meet the MinnesotaCare eligibility requirements to purchase coverage through MinnesotaCare instead of purchasing a qualified health plan through MNsure, or an individual health plan offered outside of MNsure. The MinnesotaCare public option shall coordinate the administration of the public option with the MinnesotaCare program to maximize efficiency and improve the continuity of care. The commissioner shall seek to implement mechanisms to ensure the long-term financial sustainability of MinnesotaCare and mitigate any adverse financial impacts to MNsure. These mechanisms must address issues related to minimizing adverse selection; the state's financial risk and contribution; and impacts to premiums in the individual and group insurance market both inside and outside of MNsure, to health care provider payment rates, and to the financial stability of urban, rural, and safety net providers.

(b) The commissioner shall also seek federal authority for individuals who qualify for the purchase option to use advanced tax credits and cost-sharing credits, if eligible, to purchase the public option and to permit the public option to be offered through MNsure to be compared with qualified health plans.

(c) The public option shall include, at a minimum, the following:

(1) establishment of an annual per enrollee premium rate similar to the average rate paid by the state to managed care plan contractors under Minnesota Statutes, section 256L.12;

(2) establishment of a benefit set equal to the benefits covered under MinnesotaCare under Minnesota Statutes, section 256L.03;

(3) limiting annual enrollment to the same annual open enrollment periods established for MNsure;

(4) ability of the commissioner to adjust the purchase option's actuarial value to a value no lower than 87 percent;

(5) reimbursement mechanisms for addressing potential reductions in funding for MNsure operations; and

(6) reimbursement mechanisms for addressing potential increased cost to the MinnesotaCare program under Minnesota Statutes, chapter 256L.

(d) In preparing the actuarial analysis necessary for this portion of the waiver request, the commissioner may coordinate with the University of Minnesota School of Public Health.

Subd. 5. **Alternative open enrollment.** (a) The commissioner, in consultation with the commissioners of commerce and health, shall include in the waiver request under subdivision 1, the necessary approval to replace the annual open enrollment period in the individual health market required under the Affordable Care Act with an alternative open enrollment period for qualified health plans offered through MNsure and individual health plans offered outside of MNsure. The alternative open enrollment period must be of equal length as the existing annual open enrollment period and must not begin before the federal individual tax filing deadline.

(b) The enrollment period described in paragraph (a) shall be limited to a specific period of time. Special open enrollment periods as defined under the Affordable Care Act shall continue to apply.

Subd. 6. **Report.** On March 1, 2017, the commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance on the progress of receiving a federal waiver, including the results of actuarial analyses on the broader impact to the health insurance market required for waiver submission and recommendations on necessary statutory changes, including the expected fiscal impact to the state.

Subd. 7. **Implementation.** Implementation of the proposals contained in the waiver request under this section shall be contingent upon necessary federal approval, and subsequent statutory changes and state financial contributions, except for subdivision 2, which shall be effective January 1, 2018, or upon federal approval, whichever is later.

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

Sec. 66. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; NOTICE.**

For all individuals that received medical assistance nonlong term care services on or after July 1, 2014, the commissioner of human services must provide notice of the 2016 amendments to Minnesota Statutes, section 256B.15, subdivisions 1a and 2. The notice must be provided within 90 days from the date of enactment.

Sec. 67. **REPEALER.**

(a) Minnesota Statutes 2014, section 256B.059, subdivision 1a, is repealed.

(b) Minnesota Statutes 2014, sections 256L.04, subdivisions 2a and 8; 256L.22; 256L.24; 256L.26; and 256L.28, are repealed.

EFFECTIVE DATE. Paragraph (a) is effective June 1, 2016. Paragraph (b) is effective the day following final enactment.

ARTICLE 6

HEALTH DEPARTMENT

Section 1. Minnesota Statutes 2014, section 13.3805, is amended by adding a subdivision to read:

Subd. 5. **Radon testing and mitigation data.** Data maintained by the Department of Health that identify the address of a radon testing or mitigation site, and the name, address, e-mail address, and telephone number of residents and residential property owners of a radon testing or mitigation site, are private data on individuals or nonpublic data.

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

Sec. 2. Minnesota Statutes 2014, section 13.3806, subdivision 22, is amended to read:

Subd. 22. **Medical use of cannabis data.** Data collected under the registry program authorized under sections 152.22 to 152.37 are governed by sections 152.25, subdivision 1; 152.27, subdivision 8; 152.28, subdivision 2; and 152.37, subdivision 3.

Sec. 3. Minnesota Statutes 2014, section 62D.04, subdivision 1, is amended to read:

Subdivision 1. **Application review.** Upon receipt of an application for a certificate of authority, the commissioner of health shall determine whether the applicant for a certificate of authority has:

(a) demonstrated the willingness and potential ability to assure that health care services will be provided in such a manner as to enhance and assure both the availability and accessibility of adequate personnel and facilities;

(b) arrangements for an ongoing evaluation of the quality of health care, including a peer review process;

(c) a procedure to develop, compile, evaluate, and report statistics relating to the cost of its operations, the pattern of utilization of its services, the quality, availability and accessibility of its services, and such other matters as may be reasonably required by regulation of the commissioner of health;

(d) reasonable provisions for emergency and out of area health care services;

(e) demonstrated that it is financially responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees. In making this determination, the commissioner of health shall require the amount of initial net worth required in section 62D.042, compliance with the risk-based capital standards under sections 60A.50 to 60A.592, the deposit required in section 62D.041, and in addition shall consider:

(1) the financial soundness of its arrangements for health care services and the proposed schedule of charges used in connection therewith;

(2) arrangements which will guarantee for a reasonable period of time the continued availability or payment of the cost of health care services in the event of discontinuance of the health maintenance organization; and

(3) agreements with providers for the provision of health care services;

(f) demonstrated that it will assume full financial risk on a prospective basis for the provision of comprehensive health maintenance services, including hospital care; provided, however, that the requirement in this paragraph shall not prohibit the following:

(1) a health maintenance organization from obtaining insurance or making other arrangements (i) for the cost of providing to any enrollee comprehensive health maintenance services, the aggregate value of which exceeds $5,000 in any year, (ii) for the cost of providing comprehensive health care services to its members on a nonelective emergency basis, or while they are outside the area served by the organization, or (iii) for not more than 95 percent of the amount by which the health maintenance organization's costs for any of its fiscal years exceed 105 percent of its income for such fiscal years; and

(2) a health maintenance organization from having a provision in a group health maintenance contract allowing an adjustment of premiums paid based upon the actual health services utilization of the enrollees covered under the contract, except that at no time during the life of the contract shall the contract holder fully self-insure the financial risk of health care services delivered under the contract. Risk sharing arrangements shall be subject to the requirements of sections 62D.01 to 62D.30;

(g) demonstrated that it has made provisions for and adopted a conflict of interest policy applicable to all members of the board of directors and the principal officers of the health maintenance organization. The conflict of interest policy shall include the procedures described in section 317A.255, subdivisions 1 and 2. However, the commissioner is not precluded from finding that a particular transaction is an unreasonable expense as described in section 62D.19 even if the directors follow the required procedures; and

(h) otherwise met the requirements of sections 62D.01 to 62D.30.

Sec. 4. Minnesota Statutes 2014, section 62D.08, subdivision 3, is amended to read:

Subd. 3. **Report requirements.** Such report shall be on forms prescribed by the commissioner of health, and shall include:

(a) a financial statement of the organization, including its balance sheet and receipts and disbursements for the preceding year certified by an independent certified public accountant, reflecting at least (1) all prepayment and other payments received for health care services rendered, (2) expenditures to all providers, by classes or groups of providers, and insurance companies or nonprofit health service plan corporations engaged to fulfill obligations arising out of the health maintenance contract, (3) expenditures for capital improvements, or additions thereto, including but not limited to construction, renovation or purchase of facilities and capital equipment, and (4) a supplementary statement of assets, liabilities, premium revenue, and expenditures for risk sharing business under section 62D.04, subdivision 1, on forms prescribed by the commissioner;

(b) the number of new enrollees enrolled during the year, the number of group enrollees and the number of individual enrollees as of the end of the year and the number of enrollees terminated during the year;

(c) a summary of information compiled pursuant to section 62D.04, subdivision 1, clause (c), in such form as may be required by the commissioner of health;

(d) a report of the names and addresses of all persons set forth in section 62D.03, subdivision 4, clause (c), who were associated with the health maintenance organization or the major participating entity during the preceding year, and the amount of wages, expense reimbursements, or other payments to such individuals for services to the health maintenance organization or the major participating entity, as those services relate to the health maintenance organization, including a full disclosure of all financial arrangements during the preceding year required to be disclosed pursuant to section 62D.03, subdivision 4, clause (d);

(e) a separate report addressing health maintenance contracts sold to individuals covered by Medicare, title XVIII of the Social Security Act, as amended, including the information required under section 62D.30, subdivision 6; ~~and~~

(f) data on the number of complaints received and the category of each complaint as defined by the commissioner. The categories must include, but are not limited to, access, communication and behavior, health plan administration, facilities and environment, coordination of care, and technical competence and appropriateness. The commissioner must define complaint categories to be used by each health maintenance organization by July 1, 2017, and the categories must be used by each health maintenance organization beginning calendar year 2018; and

~~(f)~~ (g) such other information relating to the performance of the health maintenance organization as is reasonably necessary to enable the commissioner of health to carry out the duties under sections 62D.01 to 62D.30.

Sec. 5. **[62D.115] QUALITY OF CARE COMPLAINTS.**

Subdivision 1. **Quality of care complaint.** For purposes of this section, "quality of care complaint" means an expressed dissatisfaction regarding health care services resulting in potential or actual harm to an enrollee. Quality of care complaints may include, but are not limited to, concerns related to provider and staff competence, clinical appropriateness of services, communications, behavior, facility and environmental considerations, or other factors that could impact the quality of health care services.

Subd. 2. **Quality of care complaint investigation.** Each health maintenance organization shall develop and implement policies and procedures for the receipt, investigation, and resolution of quality of care complaints. The policy and procedures must be in writing and must meet the requirements in paragraphs (a) to (g).

(a) A health maintenance organization's definition for quality of care complaints must include the concerns identified in subdivision 1.

(b) A health maintenance organization must classify each quality of care complaint received by severity level as defined by the commissioner and must have investigation procedures for each level of severity.

(c) Any complaint with an allegation regarding quality of care or service must be investigated by the health maintenance organization and the health maintenance organization must document the investigation process, including documentation that the complaint was received and investigated, and that each allegation was addressed. The investigation record must include all related documents, correspondence, summaries, discussions, consultations, and conferences held in relation to the investigation of the quality of care complaint in accordance with subdivision 4.

(d) The resolution of a complaint must be supported by evidence and may include a corrective action plan or a formal response from a provider to the health maintenance organization if a formal response was submitted to the health maintenance organization.

(e) Medical director review shall be conducted as part of the investigation process when there is potential for patient harm.

(f) Each quality of care complaint received by a health maintenance organization must be tracked and trended by the health maintenance organization according to provider type and the following type of quality of care issue: behavior, facility, environmental, or technical competence.

(g) The commissioner shall define the quality of care complaints severity levels by July 1, 2017.

Subd. 3. **Reporting.** (a) Quality of care complaints must be reported as part of the requirements under section 62D.08, subdivision 3.

(b) All quality of care complaints received by a health maintenance organization that meet the highest level of severity as defined by the commissioner under subdivision 2 must be reported to the commissioner within ten calendar days of receipt of the complaint. The commissioner shall investigate each quality of care complaint received under this paragraph and may contract with experts in health care or medical practice to assist with the investigation. The commissioner's investigative process shall include the notification and investigation requirements described in section 214.103 to the extent applicable. The commissioner shall furnish to the person who made the complaint a written description of the commissioner's investigative process and any action taken by the commissioner relating to the complaint, including whether the complaint was referred to the Office of Health Facility Complaints or a health-related licensing board. If the commissioner takes corrective action or requires the health maintenance organization to make any corrective measures of any kind, the nature of the complaint and the action or measures required to be taken are public data.

(c) The commissioner shall forward any quality of care complaint received by a health maintenance organization under this subdivision or received directly from an enrollee of a health maintenance organization that involves the delivery of health care services by a health care provider or facility to the relevant health-related licensing board or state agency for further investigation. Prior to forwarding a complaint to the appropriate board or agency, the commissioner shall obtain the enrollee's consent.

Subd. 4. **Right to external quality of care review.** (a) An enrollee or an individual acting on behalf of an enrollee who files with the commissioner a quality of care complaint that involves a health maintenance organization may submit a written request to the commissioner for an external quality of care review. The enrollee must request an external review within six months from the date of the adverse event that led to the quality of care complaint.

(b) If the enrollee requests an external quality of care review, the health maintenance organization must participate in the external review. The cost of the external quality of care review shall be borne by the health maintenance organization.

Subd. 5. **Contract.** (a) Pursuant to a request for proposal, the commissioner shall contract with at least three organizations or business entities to provide independent external quality of care reviews submitted for external review.

(b) The request for proposal must require that the entity demonstrate:

(1) no conflicts of interest in that it is not owned, a subsidiary of, or affiliated with a health maintenance organization, utilization review organization, or a trade organization of health care providers;

(2) an expertise in dispute resolution;

(3) an expertise in health-related law;

(4) an ability to conduct reviews using a variety of alternative dispute resolution procedures depending upon the nature of the dispute;

(5) an ability to maintain written records, for at least three years, regarding reviews conducted and provide data to the commissioners of health and commerce upon request on reviews conducted;

(6) an ability to ensure confidentiality of medical records and other enrollee information;

(7) accreditation by nationally recognized private accrediting organization;

(8) the ability to provide an expedited external review process; and

(9) expertise in clinical medical care and the provision of clinically appropriate medical care to patients.

(c) The contract shall ensure that the fees for the services rendered by the entity in connection with the review are reasonable.

Subd. 6. **Process.** (a) Upon receiving a request for an external quality of care review, the commissioner shall randomly assign the review to one of the external review entities under contract in accordance with subdivision 5. The assigned external review entity must provide immediate notice of the review to the enrollee and to the health maintenance organization. Within ten business days of receiving notice of the review, the health maintenance organization and the enrollee must provide the assigned external review entity with any information that the enrollee wishes to be considered. Each party shall be provided an opportunity to present its version of the facts and arguments. The assigned external review entity must furnish to the health maintenance organization any additional information submitted by the enrollee within one business day of receipt. An enrollee may be assisted or represented by a person of the enrollee's choice.

(b) As part of the external quality of care review process, any aspect of an external review involving the quality of clinical care must be performed by a health care professional with expertise in the medical issue being reviewed.

(c) An external quality of care review shall be made as soon as practical but in no case later than 45 days after receiving the request for an external quality of care review

and must promptly send written notice of the decision and the reasons for it to the enrollee, the health maintenance organization, and the commissioner.

(d) The external review entity and the clinical reviewer assigned must not have a material professional, familial, or financial conflict of interest with:

(1) the health maintenance organization that is the subject of the external quality of care review;

(2) the enrollee, or any parties related to the enrollee, whose treatment is the subject of the external quality of care review;

(3) any officer, director, or management employee of the health maintenance organization;

(4) a plan administrator, plan fiduciaries, or plan employees;

(5) the health care provider, the health care provider's group, or practice association recommending treatment that is the subject of the external quality of care review;

(6) the facility at which the recommended treatment would be provided; or

(7) the developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended.

(e) An expedited external review must be provided upon the enrollee's request after receiving:

(1) clinical care that involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the enrollee or would jeopardize the enrollee's ability to regain maximum function and the enrollee has simultaneously requested an expedited internal appeal; or

(2) clinical care that concerns an admission, availability of care, continued stay, or health care service for which the enrollee received emergency services but has not been discharged from a facility.

(f) The external review entity must make its expedited determination and any recommendations for actions to ameliorate the effects of adverse clinical care as expeditiously as possible but within no more than 72 hours after the receipt of the request for expedited review and notify the enrollee, the health maintenance organization, and the commissioner of health of the determination.

(g) If the external review entity's notification is not in writing, the external quality of care review entity must provide written confirmation of the determination within 48 hours of the notification.

Subd. 7. **Records; data practices.** Each health maintenance organization shall maintain records of all quality of care complaints and their resolution and retain those records for five years. Notwithstanding section 145.64, the records must be made available

to the commissioner upon request. Records provided to the commissioner under this subdivision are confidential data on individuals or protected nonpublic data as defined in section 13.02, subdivision 3 or 13.

Subd. 8. **Exception.** This section does not apply to quality of care complaints received by a health maintenance organization from an enrollee who is covered under a public health care program administered by the commissioner of human services under chapter 256B or 256L.

Sec. 6. Minnesota Statutes 2014, section 62J.495, subdivision 4, is amended to read:

Subd. 4. **Coordination with national HIT activities.** (a) The commissioner, in consultation with the e-Health Advisory Committee, shall update the statewide implementation plan required under subdivision 2 and released June 2008, to be consistent with the updated Federal HIT Strategic Plan released by the Office of the National Coordinator in accordance with section 3001 of the HITECH Act. The statewide plan shall meet the requirements for a plan required under section 3013 of the HITECH Act.

(b) The commissioner, in consultation with the e-Health Advisory Committee, shall work to ensure coordination between state, regional, and national efforts to support and accelerate efforts to effectively use health information technology to improve the quality and coordination of health care and the continuity of patient care among health care providers, to reduce medical errors, to improve population health, to reduce health disparities, and to reduce chronic disease. The commissioner's coordination efforts shall include but not be limited to:

(1) assisting in the development and support of health information technology regional extension centers established under section 3012(c) of the HITECH Act to provide technical assistance and disseminate best practices; ~~and~~

(2) providing supplemental information to the best practices gathered by regional centers to ensure that the information is relayed in a meaningful way to the Minnesota health care community~~.~~;

(3) providing financial and technical support to Minnesota health care providers to encourage implementation of admission, discharge and transfer alerts, and care summary document exchange transactions and to evaluate the impact of health information technology on cost and quality of care;

(4) providing educational resources and technical assistance to health care providers and patients related to state and national privacy, security, and consent laws governing clinical health information. In carrying out these activities, the commissioner's technical assistance does not constitute legal advice;

(5) assessing Minnesota's legal, financial, and regulatory framework for health information exchange, and making recommendations for modifications that would strengthen the ability of Minnesota health care providers to securely exchange data in compliance with patient preferences and in a way that is efficient and financially sustainable; and

(6) seeking public input on both patient impact and costs associated with requirements related to patient consent for release of health records for the purposes of treatment, payment, and health care operations, as required in section 144.293, subdivision 2. The commissioner shall provide a report to the legislature on the findings of this public input process no later than February 1, 2017.

(c) The commissioner, in consultation with the e-Health Advisory Committee, shall monitor national activity related to health information technology and shall coordinate statewide input on policy development. The commissioner shall coordinate statewide responses to proposed federal health information technology regulations in order to ensure that the needs of the Minnesota health care community are adequately and efficiently addressed in the proposed regulations. The commissioner's responses may include, but are not limited to:

(1) reviewing and evaluating any standard, implementation specification, or certification criteria proposed by the national HIT standards committee;

(2) reviewing and evaluating policy proposed by the national HIT policy committee relating to the implementation of a nationwide health information technology infrastructure;

(3) monitoring and responding to activity related to the development of quality measures and other measures as required by section 4101 of the HITECH Act. Any response related to quality measures shall consider and address the quality efforts required under chapter 62U; and

(4) monitoring and responding to national activity related to privacy, security, and data stewardship of electronic health information and individually identifiable health information.

(d) To the extent that the state is either required or allowed to apply, or designate an entity to apply for or carry out activities and programs under section 3013 of the HITECH Act, the commissioner of health, in consultation with the e-Health Advisory Committee and the commissioner of human services, shall be the lead applicant or sole designating authority. The commissioner shall make such designations consistent with the goals and objectives of sections 62J.495 to 62J.497 and 62J.50 to 62J.61.

(e) The commissioner of human services shall apply for funding necessary to administer the incentive payments to providers authorized under title IV of the American Recovery and Reinvestment Act.

(f) The commissioner shall include in the report to the legislature information on the activities of this subdivision and provide recommendations on any relevant policy changes that should be considered in Minnesota.

Sec. 7. Minnesota Statutes 2014, section 62J.496, subdivision 1, is amended to read:

Subdivision 1. **Account establishment.** (a) An account is established to:

(1) finance the purchase of certified electronic health records or qualified electronic health records as defined in section 62J.495, subdivision 1a;

(2) enhance the utilization of electronic health record technology, which may include costs associated with upgrading the technology to meet the criteria necessary to be a certified electronic health record or a qualified electronic health record;

(3) train personnel in the use of electronic health record technology; and

(4) improve the secure electronic exchange of health information.

(b) Amounts deposited in the account, including any grant funds obtained through federal or other sources, loan repayments, and interest earned on the amounts shall be used only for awarding loans or loan guarantees, as a source of reserve and security for leveraged loans, for activities authorized in section 62J.495, subdivision 4, or for the administration of the account.

(c) The commissioner may accept contributions to the account from private sector entities subject to the following provisions:

(1) the contributing entity may not specify the recipient or recipients of any loan issued under this subdivision;

(2) the commissioner shall make public the identity of any private contributor to the loan fund, as well as the amount of the contribution provided;

(3) the commissioner may issue letters of commendation or make other awards that have no financial value to any such entity; and

(4) a contributing entity may not specify that the recipient or recipients of any loan use specific products or services, nor may the contributing entity imply that a contribution is an endorsement of any specific product or service.

(d) The commissioner may use the loan funds to reimburse private sector entities for any contribution made to the loan fund. Reimbursement to private entities may not exceed the principle amount contributed to the loan fund.

(e) The commissioner may use funds deposited in the account to guarantee, or purchase insurance for, a local obligation if the guarantee or purchase would improve credit market access or reduce the interest rate applicable to the obligation involved.

(f) The commissioner may use funds deposited in the account as a source of revenue or security for the payment of principal and interest on revenue or general obligation bonds issued by the state if the proceeds of the sale of the bonds will be deposited into the loan fund.

Sec. 8. Minnesota Statutes 2015 Supplement, section 62U.04, subdivision 11, is amended to read:

Subd. 11. **Restricted uses of the all-payer claims data.** (a) Notwithstanding subdivision 4, paragraph (b), and subdivision 5, paragraph (b), the commissioner or the commissioner's designee shall only use the data submitted under subdivisions 4 and 5 for the following purposes:

(1) to evaluate the performance of the health care home program as authorized under sections 256B.0751, subdivision 6, and 256B.0752, subdivision 2;

(2) to study, in collaboration with the reducing avoidable readmissions effectively (RARE) campaign, hospital readmission trends and rates;

(3) to analyze variations in health care costs, quality, utilization, and illness burden based on geographical areas or populations;

(4) to evaluate the state innovation model (SIM) testing grant received by the Departments of Health and Human Services, including the analysis of health care cost, quality, and utilization baseline and trend information for targeted populations and communities; and

(5) to compile one or more public use files of summary data or tables that must:

(i) be available to the public for no or minimal cost by March 1, 2016, and available by Web-based electronic data download by June 30, 2019;

(ii) not identify individual patients, payers, or providers;

(iii) be updated by the commissioner, at least annually, with the most current data available;

(iv) contain clear and conspicuous explanations of the characteristics of the data, such as the dates of the data contained in the files, the absence of costs of care for uninsured patients or nonresidents, and other disclaimers that provide appropriate context; and

(v) not lead to the collection of additional data elements beyond what is authorized under this section as of June 30, 2015.

(b) The commissioner may publish the results of the authorized uses identified in paragraph (a) so long as the data released publicly do not contain information or descriptions in which the identity of individual hospitals, clinics, or other providers may be discerned.

(c) Nothing in this subdivision shall be construed to prohibit the commissioner from using the data collected under subdivision 4 to complete the state-based risk adjustment system assessment due to the legislature on October 1, 2015.

(d) The commissioner or the commissioner's designee may use the data submitted under subdivisions 4 and 5 for the purpose described in paragraph (a), clause (3), until July 1, ~~2016~~ 2019.

(e) The commissioner shall consult with the all-payer claims database work group established under subdivision 12 regarding the technical considerations necessary to create the public use files of summary data described in paragraph (a), clause (5).

(f) The commissioner shall develop a community input process to advise the commissioner in the identification of high priority analyses to be conducted pursuant to paragraph (a), clause (3), and in the creation of additional public use files of summary data described in paragraph (a), clause (5).

Sec. 9. **[144.0615] STATEWIDE SCHOOL-BASED SEALANT GRANT PROGRAM.**

(a) The commissioner of health shall develop a statewide coordinated dental sealant program to improve access to preventive dental services for school-aged children. The program shall focus on developing the data tools necessary to identify the public schools in the state with students ages six to nine who are in the greatest need of preventive dental care based on the percentage of students who are low-income and who are either enrolled in a public health care program or uninsured, and have no access to a school-based sealant program. In creating this program, the commissioner shall develop an implementation plan that identifies statewide needs, establishes outcome measures, and provides an evaluation process based on the outcome measures established.

(b) The commissioner shall award grants to nonprofit organizations to provide school-based sealant programs. The grants shall be available to expand existing school-based sealant programs and to create new programs in schools that have been identified as underserved high-risk schools.

(c) By March 15, 2018, the commissioner shall submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over health care, describing the implementation plan, including the data tools developed, the outcome

measures, the number of grants awarded, and the location of the schools participating in the grants and the results of the evaluation of the program in terms of improving access to sealants for school-aged children ages six to nine.

Sec. 10. **[144.1912] GREATER MINNESOTA FAMILY MEDICINE RESIDENCY GRANT PROGRAM.**

Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have the meanings given.

(b) "Commissioner" means the commissioner of health.

(c) "Eligible family medicine residency program" means a program that meets the following criteria:

(1) is located in Minnesota outside the seven-county metropolitan area, as defined in section 473.121, subdivision 4;

(2) is accredited as a family medicine residency program or is a candidate for accreditation;

(3) is focused on the education and training of family medicine physicians to serve communities outside the metropolitan area; and

(4) demonstrates that over the most recent three years, at least 25 percent of its graduates practice in Minnesota communities outside the metropolitan area.

Subd. 2. **Program administration.** (a) The commissioner shall award family medicine residency grants to existing, eligible, not-for-profit family medicine residency programs to support current and new residency positions. Funds shall be allocated first to proposed new family medicine residency positions, and remaining funds shall be allocated proportionally based on the number of existing residents in eligible programs. The commissioner may fund a new residency position for up to three years.

(b) Grant funds awarded may only be spent to cover the costs of:

(1) establishing, maintaining, or expanding training for family medicine residents;

(2) recruitment, training, and retention of residents and faculty;

(3) travel and lodging for residents; and

(4) faculty, resident, and preceptor salaries.

(c) Grant funds shall not be used to supplant any other government or private funds available for these purposes.

Subd. 3. **Applications.** Eligible family medicine residency programs seeking a grant must apply to the commissioner. The application must include objectives, a related work plan and budget, a description of the number of new and existing residency positions that will be supported using grant funds, and additional information the commissioner

determines to be necessary. The commissioner shall determine whether applications are complete and responsive and may require revisions or additional information before awarding a grant.

Subd. 4. **Program oversight.** The commissioner shall require and collect from family medicine residency programs receiving grants, information necessary to administer and evaluate the program. The evaluation shall include the scope of expansion of new residency positions and information describing specific programs to enhance current residency positions, which may include facility improvements. The commissioner shall continue to collect data on greater Minnesota family residency shortages.

Sec. 11. Minnesota Statutes 2015 Supplement, section 144.4961, subdivision 3, is amended to read:

Subd. 3. **Rulemaking.** The commissioner of health shall adopt rules ~~for~~ establishing licensure requirements and ~~enforcement of applicable laws and rules~~ work standards relating to indoor radon in dwellings and other buildings, with the exception of newly constructed Minnesota homes according to section 326B.106, subdivision 6. The commissioner shall coordinate, oversee, and implement all state functions in matters concerning the presence, effects, measurement, and mitigation of risks of radon in dwellings and other buildings.

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

Sec. 12. Minnesota Statutes 2015 Supplement, section 144.4961, subdivision 4, is amended to read:

Subd. 4. **System tag.** All radon mitigation systems installed in Minnesota on or after ~~October 1, 2017~~ January 1, 2018, must have a radon mitigation system tag provided by the commissioner. A radon mitigation professional must attach the tag to the radon mitigation system in a visible location.

Sec. 13. Minnesota Statutes 2015 Supplement, section 144.4961, subdivision 5, is amended to read:

Subd. 5. **License required annually.** Effective January 1, 2018, 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.~~

Sec. 14. Minnesota Statutes 2015 Supplement, section 144.4961, subdivision 6, is amended to read:

Subd. 6. **Exemptions.** This section does not apply to:

(1) radon control 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.~~;

(2) employees of a firm or corporation that installs radon control systems in newly constructed Minnesota homes specified in clause (1);

(3) a person authorized as a building official under Minnesota Rules, part 1300.0110, or that person's designee; or

(4) any person, firm, corporation, or entity that distributes radon testing devices or information for general educational purposes.

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

Sec. 15. Minnesota Statutes 2015 Supplement, section 144.4961, subdivision 8, is amended to read:

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, ~~$300~~ $150 per year. "Measurement professional" means any person who performs a test to determine the presence and concentration of radon in a building ~~they do~~ the person does not own or lease~~; 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~~.

(2) Each mitigation professional license, ~~$500~~ $250 per year. "Mitigation professional" means an individual who ~~performs~~ installs or designs a radon mitigation system in a building ~~they do~~ the individual does not own or lease; ~~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~~. "On-site supervision" means a review at the property of mitigation work upon completion of the work and attachment of a system tag. Employees or subcontractors who are supervised by a licensed mitigation professional are not required to be licensed under this clause. This license also permits the licensee to perform the activities of a measurement professional described in clause (1).

(3) Each mitigation company license, ~~$500~~ $100 per year. "Mitigation company" means any business or government entity that performs or authorizes employees to perform radon mitigation. This fee is waived if the mitigation company ~~is a sole proprietorship~~ employs only one licensed mitigation professional.

(4) Each radon analysis laboratory license, $500 per year. "Radon analysis laboratory" means a business entity or government entity that analyzes passive radon detection devices to determine the presence and concentration of radon in the devices. This fee is waived if the laboratory is a government entity and is only distributing test kits for the general public to use in Minnesota.

(5) Each Minnesota Department of Health radon mitigation system tag, $75 per tag. "Minnesota Department of Health radon mitigation system tag" or "system tag" means a unique identifiable radon system label provided by the commissioner of health.

(b) Fees collected under this section shall be deposited in the state treasury and credited to the state government special revenue fund.

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

Sec. 16. Minnesota Statutes 2015 Supplement, section 144.4961, is amended by adding a subdivision to read:

Subd. 10. **Local inspections or permits.** This section does not preclude local units of government from requiring additional permits or inspections for radon control systems, and does not supersede any local inspection or permit requirements.

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

Sec. 17. Minnesota Statutes 2014, section 144A.75, subdivision 5, is amended to read:

Subd. 5. **Hospice provider.** "Hospice provider" means an individual, organization, association, corporation, unit of government, or other entity that is regularly engaged in the delivery, directly or by contractual arrangement, of hospice services for a fee to ~~terminally ill~~ hospice patients. A hospice must provide all core services.

Sec. 18. Minnesota Statutes 2014, section 144A.75, subdivision 6, is amended to read:

Subd. 6. **Hospice patient.** "Hospice patient" means an individual ~~who has been diagnosed as terminally ill, with a probable life expectancy of under one year, as~~ whose illness has been documented by the individual's attending physician and hospice medical director, who alone or, when unable, through the individual's family has voluntarily consented to and received admission to a hospice provider, and who:

(1) has been diagnosed as terminally ill, with a probable life expectancy of under one year; or

(2) is 21 years of age or younger and has been diagnosed with a life-threatening illness contributing to a shortened life expectancy.

Sec. 19. Minnesota Statutes 2014, section 144A.75, subdivision 8, is amended to read:

Subd. 8. **Hospice services; hospice care.** "Hospice services" or "hospice care" means palliative and supportive care and other services provided by an interdisciplinary team under the direction of an identifiable hospice administration to ~~terminally ill~~ hospice patients and their families to meet the physical, nutritional, emotional, social, spiritual, and special needs experienced during the final stages of illness, dying, and bereavement, or during a life-threatening illness contributing to a shortened life expectancy. These services are provided through a centrally coordinated program that ensures continuity and consistency of home and inpatient care that is provided directly or through an agreement.

Sec. 20. Minnesota Statutes 2015 Supplement, section 144A.75, subdivision 13, is amended to read:

Subd. 13. **Residential hospice facility.** (a) "Residential hospice facility" means a facility that resembles a single-family home modified to address life safety, accessibility, and care needs, located in a residential area that directly provides 24-hour residential and support services in a home-like setting for hospice patients as an integral part of the continuum of home care provided by a hospice and that houses:

(1) no more than eight hospice patients; or

(2) at least nine and no more than 12 hospice patients with the approval of the local governing authority, notwithstanding section 462.357, subdivision 8.

(b) Residential hospice facility also means a facility that directly provides 24-hour residential and support services for hospice patients and that:

(1) houses no more than 21 hospice patients;

(2) meets hospice certification regulations adopted pursuant to title XVIII of the federal Social Security Act, United States Code, title 42, section 1395, et seq.; and

(3) is located on St. Anthony Avenue in St. Paul, Minnesota, and was licensed as a 40-bed non-Medicare certified nursing home as of January 1, 2015.

Sec. 21. Minnesota Statutes 2014, section 144A.75, is amended by adding a subdivision to read:

Subd. 13a. **Respite care.** "Respite care" means short-term care in an inpatient facility such as a residential hospice facility, when necessary to relieve the hospice patient's family or other persons caring for the patient. Respite care may be provided on an occasional basis.

Sec. 22. Minnesota Statutes 2014, section 152.27, subdivision 2, is amended to read:

Subd. 2. **Commissioner duties.** (a) The commissioner shall:

(1) give notice of the program to health care practitioners in the state who are eligible to serve as health care practitioners and explain the purposes and requirements of the program;

(2) allow each health care practitioner who meets or agrees to meet the program's requirements and who requests to participate, to be included in the registry program to collect data for the patient registry;

(3) allow each health care practitioner who meets the requirements of subdivision 8, and who requests access for a permissible purpose, to have limited access to a patient's registry information;

~~(3)~~ (4) provide explanatory information and assistance to each health care practitioner in understanding the nature of therapeutic use of medical cannabis within program requirements;

~~(4)~~ (5) create and provide a certification to be used by a health care practitioner for the practitioner to certify whether a patient has been diagnosed with a qualifying medical condition and include in the certification an option for the practitioner to certify whether the patient, in the health care practitioner's medical opinion, is developmentally or physically disabled and, as a result of that disability, the patient is unable to self-administer medication or acquire medical cannabis from a distribution facility;

~~(5)~~ (6) supervise the participation of the health care practitioner in conducting patient treatment and health records reporting in a manner that ensures stringent security and record-keeping requirements and that prevents the unauthorized release of private data on individuals as defined by section 13.02;

~~(6)~~ (7) develop safety criteria for patients with a qualifying medical condition as a requirement of the patient's participation in the program, to prevent the patient from undertaking any task under the influence of medical cannabis that would constitute negligence or professional malpractice on the part of the patient; and

~~(7)~~ (8) conduct research and studies based on data from health records submitted to the registry program and submit reports on intermediate or final research results to the legislature and major scientific journals. The commissioner may contract with a third

party to complete the requirements of this clause. Any reports submitted must comply with section 152.28, subdivision 2.

(b) If the commissioner wishes to add a delivery method under section 152.22, subdivision 6, or a qualifying medical condition under section 152.22, subdivision 14, the commissioner must notify the chairs and ranking minority members of the legislative policy committees having jurisdiction over health and public safety of the addition and the reasons for its addition, including any written comments received by the commissioner from the public and any guidance received from the task force on medical cannabis research, by January 15 of the year in which the commissioner wishes to make the change. The change shall be effective on August 1 of that year, unless the legislature by law provides otherwise.

Sec. 23. Minnesota Statutes 2014, section 152.27, is amended by adding a subdivision to read:

Subd. 8. **Access to registry data.** (a) Notwithstanding section 152.31, a health care practitioner may access a patient's registry information to the extent the information relates specifically to a current patient, to whom the health care practitioner is:

(1) prescribing or considering prescribing any controlled substance;

(2) providing emergency medical treatment for which access to the data may be necessary; or

(3) providing other medical treatment for which access to the data may be necessary and the patient has consented to access to the registry account information, and with the provision that the health care practitioner remains responsible for the use or misuse of data accessed by a delegated agent or employee.

(b) A health care practitioner who is authorized to access the patient registry under this subdivision may be registered to electronically access limited data in the medical cannabis patient registry. If the data is accessed electronically, the health care practitioner shall implement and maintain a comprehensive information security program that contains administrative, technical, and physical safeguards that are appropriate to the user's size and complexity, and the sensitivity of the personal information obtained. The health care practitioner shall identify reasonably foreseeable internal and external risks to the security, confidentiality, and integrity of personal information that could result in the unauthorized disclosure, misuse, or other compromise of the information and assess the sufficiency of any safeguards in place to control the risks.

(c) When requesting access based on patient consent, a health care practitioner shall warrant that the request:

(1) contains no information known to the provider to be false;

(2) accurately states the patient's desire to have health records disclosed or that there is specific authorization in law; and

(3) does not exceed any limits imposed by the patient in the consent.

(d) Before a health care practitioner may access the data, the commissioner shall ensure that the health care practitioner agrees to comply with paragraph (b).

(e) The commissioner shall maintain a log of all persons who access the data for a period of three years.

Sec. 24. Minnesota Statutes 2014, section 152.33, is amended by adding a subdivision to read:

Subd. 7. **Improper access to registry; criminal penalty.** In addition to any other applicable penalty in law, a person who intentionally makes a false statement or misrepresentation to gain access to the patient registry under section 152.27, subdivision 8, or otherwise accesses the patient registry under false pretenses, is guilty of a misdemeanor punishable by imprisonment for not more that 90 days or by payment of a fine of not more than $1,000, or both. The penalty is in addition to any other penalties that may apply for making a false statement, misrepresentation, or unauthorized acquisition of not public data.

Sec. 25. Minnesota Statutes 2014, section 327.14, subdivision 8, is amended to read:

Subd. 8. **Recreational camping area.** "Recreational camping area" means any area, whether privately or publicly owned, used on a daily, nightly, weekly, or longer basis for the accommodation of five or more tents or recreational camping vehicles free of charge or for compensation. "Recreational camping area" excludes:

(1) children's camps;

(2) industrial camps;

(3) migrant labor camps, as defined in Minnesota Statutes and state commissioner of health rules;

(4) United States Forest Service camps;

(5) state forest service camps;

(6) state wildlife management areas or state-owned public access areas which are restricted in use to picnicking and boat landing; ~~and~~

(7) temporary holding areas for self-contained recreational camping vehicles created by and adjacent to motor sports facilities, if the chief law enforcement officer of an affected jurisdiction determines that it is in the interest of public safety to provide a temporary holding area; and

(8) a privately owned area used for camping no more than once a year and for no longer than seven consecutive days by members of a private club where the members pay annual dues to belong to the club.

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

Sec. 26. Laws 2015, chapter 71, article 8, section 24, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective July 1, 2015, except subdivisions 4 and 5, which are effective ~~October 1, 2017~~ July 1, 2016.

Sec. 27. **CONTAMINATED PRIVATE WELLS.**

Ten priority points must be assigned by the Department of Health pursuant to Minnesota Rules, part 4720.9020, if a drinking water advisory has been issued or a special well construction area has been established by the Department of Health.

EFFECTIVE DATE. This section is effective the day following final enactment and applies to Minnesota Rules, part 4720.9020, until the Department of Health modifies part 4720.9020.

Sec. 28. **HEALTH RISK LIMITS.**

Fifteen points must be assigned by the Department of Health pursuant to Minnesota Rules, part 4720.9020, if the department has confirmed an exceedance of a health risk limit under Minnesota Rules, parts 4717.7500 to 4717.7900, within the past 36 calendar months.

EFFECTIVE DATE. This section is effective the day following final enactment and applies to Minnesota Rules, part 4720.9020, until the Department of Health modifies part 4720.9020.

Sec. 29. **MEDICALLY NECESSARY CARE DEFINITION FOR HEALTH MAINTENANCE ORGANIZATIONS.**

The commissioner of health shall convene a public meeting with interested stakeholders to discuss the need for a uniform definition of medically necessary care for health maintenance organizations to utilize when determining the medical necessity, appropriateness, or efficacy of a health care service or procedure, and a uniform process for each health maintenance organization to follow when making such an initial determination or utilization review. This discussion shall exclude determinations or reviews involving

enrollees covered under a public health care program administered by the commissioner of human services under Minnesota Statutes, chapter 256B or 256L.

By January 15, 2017, the commissioner shall report results of the public input and any recommendations, including draft legislation, to the chairs and ranking minority members of the legislative committees with jurisdiction over health care on the proposed uniform definition and determination process, and a process in which the commissioner may periodically review the medically necessary care determinations to ensure that the determinations made by a health maintenance organization adheres to the uniform definition and process.

Sec. 30. **PEER REVIEW DISCLOSURE.**

The commissioner of health shall consult with interested stakeholders including members of the public and family members of facility residents and make recommendations regarding when quality of care complaint investigations under Minnesota Statutes, section 62D.115, should be subject to peer review confidentiality and identifying circumstances in which peer review final determinations may be disclosed or made available to the public, notwithstanding Minnesota Statutes, section 145.64, including, but not limited to, patient safety and the parameters surrounding such disclosure. The commissioner shall submit these recommendations, including draft legislation to the chairs and ranking minority members of the legislative committees with jurisdiction over health care and data privacy by January 15, 2017.

Sec. 31. **COST AND BENEFIT ANALYSIS; HEALTH CARE SYSTEM PROPOSALS.**

Subdivision 1. **Contract for analysis of proposals.** The commissioner of health shall contract with the University of Minnesota School of Public Health to conduct an analysis of the costs and benefits of three specific proposals that seek to create a health care system with increased access, greater affordability, lower costs, and improved quality of care in comparison to the current system.

Subd. 2. **Plans.** The commissioner of health, with input from the commissioners of human services and commerce, legislators, and other stakeholders, shall submit to the University of Minnesota the following proposals:

(1) a free-market insurance-based competition approach;

(2) a universal health care plan designed to meet the following principles:

(i) ensure all Minnesotans receive quality health care;

(ii) cover all necessary care, including all coverage currently required by law, complete mental health services, chemical dependency treatment, prescription drugs, medical equipment and supplies, dental care, long-term care, and home care services;

(iii) allow patients to choose their own providers; and

(iv) use premiums based on ability to pay; and

(3) a MinnesotaCare public option that would allow individuals with income above the maximum income eligibility limit established for the MinnesotaCare program the option of purchasing this public option instead of purchasing a qualified health plan through MNsure or an individual health plan offered outside of MNsure. For purposes of conducting the analysis, the MinnesotaCare public option shall include the following:

(i) individuals who qualify for advanced tax credits and cost-sharing credits under the Affordable Care Act may use the credits to purchase the MinnesotaCare public option;

(ii) enrollee premium rates shall be established at rates that are similar to the average rate paid by the state to managed care plan contractors for MinnesotaCare;

(iii) the covered benefit set shall be equal to the benefits covered under MinnesotaCare;

(iv) the same annual open enrollment period established for MNsure shall apply for this public option; and

(v) cost-sharing shall be established that maintains an actuarial value no lower than 87 percent.

The analysis of this option must include potential financial impacts on MNsure, the long-term financial stability of the MinnesotaCare program, impacts to premiums in the individual and small group insurance market, and impacts to health care provider reimbursement rates and to the financial stability of urban, rural, and safety net providers.

Subd. 3. **Proposal analysis.** (a) The analysis of each proposal must measure the impact on total public and private health care spending in Minnesota that would result from each proposal, including spending by individuals. "Total public and private health care spending" means spending on all medical care, including dental care, prescription drugs, medical equipment and supplies, complete mental health services, chemical dependency treatment, long-term care, and home care services as well as all of the costs for administering, delivering, and paying for the care. The analysis of total health care spending shall include whether there are savings or additional costs compared to the existing system due to:

(1) increased or reduced insurance, billing, underwriting, marketing, and other administrative functions;

(2) changes in access to and timely and appropriate use of medical care;

(3) availability and take-up of health insurance coverage;

(4) market-driven or negotiated prices on medical services and products, including pharmaceuticals;

(5) shortages or excess capacity of medical facilities and equipment;

(6) increased or decreased utilization, better health outcomes, increased wellness due to prevention, early intervention, and health-promoting activities;

(7) payment reforms;

(8) coordination of care; and

(9) to the extent possible given available data and resources, non-health care impacts on state and local expenditures such as reduced out-of-home placement or crime costs due to mental health or chemical dependency coverage.

(b) To the extent possible given available data and resources, the analysis must also estimate for each proposal job losses or gains in health care and elsewhere in the economy due to implementation of the reforms.

(c) The analysis shall assume that the provisions in each proposal are not preempted by federal law or that the federal government gives a waiver to the preemption.

Subd. 4. **Report.** The commissioner shall provide a preliminary report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by March 15, 2017, and a final report by October 1, 2017. The analyses described in paragraph (a), clause (9), and paragraph (b), a final report is due by March 15, 2018.

ARTICLE 7

HEALTH-RELATED OCCUPATIONAL LICENSING

SPOKEN LANGUAGE HEALTH CARE INTERPRETERS

Section 1. **[146C.01] DEFINITIONS.**

Subdivision 1. **Applicability.** The definitions in this section apply to this chapter.

Subd. 2. **Advisory council.** "Advisory council" means the Spoken Language Health Care Interpreter Advisory Council established in section 146C.11.

Subd. 3. **Code of ethics.** "Code of ethics" means the National Code of Ethics for Interpreters in Health Care, as published by the National Council on Interpreting in Health Care or its successor, or the International Medical Interpreters Association or its successor.

Subd. 4. **Commissioner.** "Commissioner" means the commissioner of health.

Subd. 5. **Common languages.** "Common languages" mean the ten most frequent languages without regard to dialect in Minnesota for which interpreters are listed on the registry.

Subd. 6. **Interpreting standards of practice.** "Interpreting standards of practice" means the interpreting standards of practice in health care as published by the National Council on Interpreting in Health Care or its successor, or the International Medical Interpreters Association or its successor.

Subd. 7. **Registry.** "Registry" means a database of spoken language health care interpreters in Minnesota who have met the qualifications described under section 146C.03, subdivision 2, 3, 4, or 5, which shall be maintained by the commissioner of health.

Subd. 8. **Remote interpretation.** "Remote interpretation" means providing spoken language interpreting services via a telephone or by video conferencing.

Subd. 9. **Spoken language health care interpreter or interpreter.** "Spoken language health care interpreter" or "interpreter" means an individual who receives compensation or other remuneration for providing spoken language interpreter services for patients with limited English proficiency within a medical setting either by face-to-face interpretation or remote interpretation.

Subd. 10. **Spoken language interpreting services.** "Spoken language interpreting services" means the conversion of one spoken language into another by an interpreter for the purpose of facilitating communication between a patient and a health care provider who do not share a common spoken language.

Sec. 2. **[146C.03] REGISTRY.**

Subdivision 1. **Establishment.** (a) By July 1, 2017, the commissioner of health shall establish and maintain a registry for spoken language health care interpreters. The registry shall contain four separate tiers based on different qualification standards for education and training.

(b) An individual who wants to be listed on the registry must submit an application to the commissioner on a form provided by the commissioner along with all applicable fees required under section 146C.13. The form must include the applicant's name; Social Security number; business address and telephone number, or home address and telephone number if the applicant has a home office; the applicant's employer or the agencies with which the applicant is affiliated; the employer's or agencies' addresses and telephone numbers; and the languages the applicant is qualified to interpret.

(c) Upon receipt of the application, the commissioner shall determine if the applicant meets the requirements for the applicable registry tier. The commissioner may request

further information from the applicant if the information provided is not complete or accurate. The commissioner shall notify the applicant of action taken on the application, and if the application is denied, the grounds for denying the application.

(d) If the commissioner denies an application, the applicant may apply for a lower tier or may reapply for the same tier at a later date. If an applicant applies for a different tier or reapplies for the same tier, the applicant must submit with the new application the applicable fees under section 146C.13.

(e) Applicants who qualify for different tiers for different languages shall only be required to complete one application and submit with the application the fee associated with the highest tier for which the applicant is applying.

(f) The commissioner may request, as deemed necessary, additional information from an applicant to determine or verify qualifications or collect information to manage the registry or monitor the field of health care interpreting.

Subd. 2. **Tier 1 requirements.** The commissioner shall include on the tier 1 registry an applicant who meets the following requirements:

(1) is at least 18 years of age;

(2) passes an examination approved by the commissioner on basic medical terminology in English;

(3) passes an examination approved by the commissioner on interpreter ethics and standards of practice; and

(4) affirms by signature, including electronic signature, that the applicant has read the code of ethics and interpreting standards of practice identified on the registry Web site and agrees to abide by them.

Subd. 3. **Tier 2 requirements.** The commissioner shall include on the tier 2 registry an applicant who meets the requirements for tier 1 described under subdivision 2 and who:

(1) effective July 1, 2017, to June 30, 2018, provides proof of successfully completing a training program for medical interpreters approved by the commissioner that is, at a minimum, 40 hours in length; or

(2) effective July 1, 2018, provides proof of successfully completing a training program for medical interpreters approved by the commissioner that is equal in length to the number of hours required by the Certification Commission for Healthcare Interpreters (CCHI) or National Board of Certification for Medical Interpreters (NBCMI) or their successors. If the number of hours required by CCHI or its successor and the number of hours required by NBCMI or its successor differ, the number of hours required to qualify for the registry shall be the greater of the two. A training program of 40 hours or more

approved by the commissioner and completed prior to July 1, 2017, may count toward the number of hours required.

Subd. 4. **Tier 3 requirements.** The commissioner shall include on the tier 3 registry an applicant who meets the requirements for tier 1 described under subdivision 2 and who:

(1) has a national certification in health care interpreting that does not include a performance examination from a certifying organization approved by the commissioner; or

(2) provides proof of successfully completing an interpreting certification program from an accredited United States academic institution approved by the commissioner that is, at a minimum, 18 semester credits.

Subd. 5. **Tier 4 requirements.** (a) The commissioner shall include on the tier 4 registry an applicant who meets the requirements for tier 1 described under subdivision 2 and who:

(1) has a national certification from a certifying organization approved by the commissioner in health care interpreting that includes a performance examination in the non-English language in which the interpreter is registering to interpret; or

(2)(i) has an associate's degree or higher in interpreting from an accredited United States academic institution. The degree and institution must be approved by the commissioner and the degree must include a minimum of three semester credits in medical terminology or medical interpreting; and

(ii) has achieved a score of "advanced mid" or higher on the American Council on the Teaching of Foreign Languages Oral Proficiency Interview in a non-English language in which the interpreter is registering to interpret.

(b) The commissioner, in consultation with the advisory council, may approve alternative means of meeting oral proficiency requirements for tier 4 for languages in which the American Council of Teaching of Foreign Languages Oral Proficiency Interview is not available.

(c) The commissioner, in consultation with the advisory council, may approve a degree from an educational institution from a foreign country as meeting the associate's degree requirement in paragraph (a), clause (2). The commissioner may assess the applicant a fee to cover the cost of foreign credential evaluation services approved by the commissioner, in consultation with the advisory council, and any additional steps necessary to process the application. Any assessed fee must be paid by the interpreter before the interpreter will be registered.

Subd. 6. **Change of name and address.** Registered spoken language health care interpreters who change their name, address, or e-mail address must inform the commissioner in writing of the change within 30 days. All notices or other correspondence

mailed to the interpreter's address or e-mail address on file with the commissioner shall be considered as having been received by the interpreter.

Subd. 7. **Data.** Section 13.41 applies to government data of the commissioner on applicants and registered interpreters.

Sec. 3. **[146C.05] RENEWAL.**

Subdivision 1. **Registry period.** Listing on the registry is valid for a one-year period. To renew inclusion on the registry, an interpreter must submit:

(1) a renewal application on a form provided by the commissioner;

(2) a continuing education report on a form provided by the commissioner as specified under section 146C.09; and

(3) the required fees under section 146C.13.

Subd. 2. **Notice.** (a) Sixty days before the registry expiration date, the commissioner shall send out a renewal notice to the spoken language health care interpreter's last known address or e-mail address on file with the commissioner. The notice must include an application for renewal and the amount of the fee required for renewal. If the interpreter does not receive the renewal notice, the interpreter is still required to meet the deadline for renewal to qualify for continuous inclusion on the registry.

(b) An application for renewal must be received by the commissioner or postmarked at least 30 calendar days before the registry expiration date.

Subd. 3. **Late fee.** A renewal application submitted after the renewal deadline date must include the late fee specified in section 146C.13. Fees for late renewal shall not be prorated.

Subd. 4. **Lapse in renewal.** An interpreter whose registry listing has been expired for a period of one year or longer must submit a new application to be listed on the registry instead of a renewal application.

Sec. 4. **[146C.07] DISCIPLINARY ACTIONS; OVERSIGHT OF COMPLAINTS.**

Subdivision 1. **Prohibited conduct.** (a) The following conduct is prohibited and is grounds for disciplinary or corrective action:

(1) failure to provide spoken language interpreting services consistent with the code of ethics and interpreting standards of practice, or performance of the interpretation in an incompetent or negligent manner;

(2) conviction of a crime, including a finding or verdict of guilt, an admission of guilt, or a no-contest plea, in any court in Minnesota or any other jurisdiction in the United States, demonstrably related to engaging in spoken language health care interpreter

services. Conviction includes a conviction for an offense which, if committed in this state, would be deemed a felony;

(3) conviction of violating any state or federal law, rule, or regulation that directly relates to the practice of spoken language health care interpreters;

(4) adjudication as mentally incompetent or as a person who is dangerous to self or adjudication pursuant to chapter 253B as chemically dependent, developmentally disabled, mentally ill and dangerous to the public, or as a sexual psychopathic personality or sexually dangerous person;

(5) violation or failure to comply with an order issued by the commissioner;

(6) obtaining money, property, services, or business from a client through the use of undue influence, excessive pressure, harassment, duress, deception, or fraud;

(7) revocation of the interpreter's national certification as a result of disciplinary action brought by the national certifying body;

(8) failure to perform services with reasonable judgment, skill, or safety due to the use of alcohol or drugs or other physical or mental impairment;

(9) engaging in conduct likely to deceive, defraud, or harm the public;

(10) demonstrating a willful or careless disregard for the health, welfare, or safety of a client;

(11) failure to cooperate with the commissioner or advisory council in an investigation or to provide information in response to a request from the commissioner or advisory council;

(12) aiding or abetting another person in violating any provision of this chapter; and

(13) release or disclosure of a health record in violation of sections 144.291 to 144.298.

(b) In disciplinary actions alleging a violation of paragraph (a), clause (2), (3), or (4), a copy of the judgment or proceeding under seal of the court administrator, or of the administrative agency that entered the same, is admissible into evidence without further authentication and constitutes prima facie evidence of its contents.

Subd. 2. **Complaints.** The commissioner may initiate an investigation upon receiving a complaint or other oral or written communication that alleges or implies a violation of subdivision 1. In the receipt, investigation, and hearing of a complaint that alleges or implies a violation of subdivision 1, the commissioner shall follow the procedures in section 214.10.

Subd. 3. **Disciplinary actions.** If the commissioner finds that an interpreter who is listed on the registry has violated any provision of this chapter, the commissioner may take any one or more of the following actions:

(1) remove the interpreter from the registry;

(2) impose limitations or conditions on the interpreter's practice, impose rehabilitation requirements, or require practice under supervision; or

(3) censure or reprimand the interpreter.

Subd. 4. **Reinstatement requirements after disciplinary action.** Interpreters who have been removed from the registry may request and provide justification for reinstatement. The requirements of this chapter for registry renewal and any other conditions imposed by the commissioner must be met before the interpreter may be reinstated on the registry.

Sec. 5. **[146C.09] CONTINUING EDUCATION.**

Subdivision 1. **Course approval.** The advisory council shall approve continuing education courses and training. A course that has not been approved by the advisory council may be submitted, but may be disapproved by the commissioner. If the course is disapproved, it shall not count toward the continuing education requirement. The interpreter must complete the following hours of continuing education during each one-year registry period:

(1) for tier 2 interpreters, a minimum of four contact hours of continuing education;

(2) for tier 3 interpreters, a minimum of six contact hours of continuing education; and

(3) for tier 4 interpreters, a minimum of eight contact hours of continuing education.

Contact hours shall be prorated for interpreters who are assigned a registry cycle of less than one year.

Subd. 2. **Continuing education verification.** Each spoken language health care interpreter shall submit with a renewal application a continuing education report on a form provided by the commissioner that indicates that the interpreter has met the continuing education requirements of this section. The form shall include the following information:

(1) the title of the continuing education activity;

(2) a brief description of the activity;

(3) the sponsor, presenter, or author;

(4) the location and attendance dates;

(5) the number of contact hours; and

(6) the interpreter's notarized affirmation that the information is true and correct.

Subd. 3. **Audit.** The commissioner or advisory council may audit a percentage of the continuing education reports based on a random selection.

Sec. 6. **[146C.11] SPOKEN LANGUAGE HEALTH CARE INTERPRETER ADVISORY COUNCIL.**

Subdivision 1. **Establishment.** The commissioner shall appoint 12 members to a Spoken Language Health Care Interpreter Advisory Council consisting of the following members:

(1) three members who are interpreters listed on the roster prior to July 1, 2017, or on the registry after July 1, 2017, and who are Minnesota residents. Of these members, each must be an interpreter for a different language; at least one must have a national certification credential; and at least one must have been listed on the roster prior to July 1, 2017, or on the registry after July 1, 2017, as an interpreter in a language other than the common languages and must have completed a training program for medical interpreters approved by the commissioner that is, at a minimum, 40 hours in length;

(2) three members representing limited English proficient (LEP) individuals, of these members, two must represent LEP individuals who are proficient in a common language and one must represent LEP individuals who are proficient in a language that is not one of the common languages;

(3) one member representing a health plan company;

(4) one member representing a Minnesota health system who is not an interpreter;

(5) one member representing an interpreter agency;

(6) one member representing an interpreter training program or postsecondary educational institution program providing interpreter courses or skills assessment;

(7) one member who is affiliated with a Minnesota-based or Minnesota chapter of a national or international organization representing interpreters; and

(8) one member who is a licensed direct care health provider.

Subd. 2. **Organization.** The advisory council shall be organized and administered under section 15.059.

Subd. 3. **Duties.** The advisory council shall:

(1) advise the commissioner on issues relating to interpreting skills, ethics, and standards of practice, including reviewing and recommending changes to the examinations identified in section 146C.03, subdivision 2, on basic medical terminology in English and interpreter ethics and interpreter standards of practice;

(2) advise the commissioner on recommended changes to accepted spoken language health care interpreter qualifications, including degree and training programs and performance examinations;

(3) address barriers for interpreters to gain access to the registry, including barriers to interpreters of uncommon languages and interpreters in rural areas;

(4) advise the commissioner on methods for identifying gaps in interpreter services in rural areas and make recommendations to address interpreter training and funding needs;

(5) inform the commissioner on emerging issues in the spoken language health care interpreter field;

(6) advise the commissioner on training and continuing education programs;

(7) provide for distribution of information regarding interpreter standards and resources to help interpreters qualify for higher registry tier levels;

(8) make recommendations for necessary statutory changes to Minnesota interpreter law;

(9) compare the annual cost of administering the registry and the annual total collection of registration fees and advise the commissioner, if necessary, to recommend an adjustment to the registration fees;

(10) identify barriers to meeting tier requirements and make recommendations to the commissioner for addressing these barriers;

(11) identify and make recommendations to the commissioner for Web distribution of patient and provider education materials on working with an interpreter and on reporting interpreter behavior as identified in section 146C.07; and

(12) review and update as necessary the process for determining common languages.

Sec. 7. **[146C.13] FEES.**

Subdivision 1. **Fees.** (a) The initial and renewal application fees for interpreters listed on the registry shall be established by the commissioner not to exceed $90.

(b) The renewal late fee for the registry shall be established by the commissioner not to exceed $30.

(c) If the commissioner must translate a document to verify whether a foreign degree qualifies for registration for tier 4, the commissioner may assess a fee equal to the actual cost of translation and additional effort necessary to process the application.

Subd. 2. **Nonrefundable fees.** The fees in this section are nonrefundable.

Subd. 3. **Deposit.** Fees received under this chapter shall be deposited in the state government special revenue fund.

GENETIC COUNSELORS

Sec. 8. **[147F.01] DEFINITIONS.**

Subdivision 1. **Applicability.** For purposes of this chapter, the terms defined in this section have the meanings given them.

Subd. 2. **ABGC.** "ABGC" means the American Board of Genetic Counseling, a national agency for certification and recertification of genetic counselors, or its successor organization or equivalent.

Subd. 3. **ABMG.** "ABMG" means the American Board of Medical Genetics, a national agency for certification and recertification of genetic counselors, medical geneticists, and Ph.D. geneticists, or its successor organization.

Subd. 4. **ACGC.** "ACGC" means the Accreditation Council for Genetic Counseling, a specialized program accreditation board for educational training programs granting master's degrees or higher in genetic counseling, or its successor organization.

Subd. 5. **Board.** "Board" means the Board of Medical Practice.

Subd. 6. **Eligible status.** "Eligible status" means an applicant who has met the requirements and received approval from the ABGC to sit for the certification examination.

Subd. 7. **Genetic counseling.** "Genetic counseling" means the provision of services described in section 147F.03 to help clients and their families understand the medical, psychological, and familial implications of genetic contributions to a disease or medical condition.

Subd. 8. **Genetic counselor.** "Genetic counselor" means an individual licensed under this chapter to engage in the practice of genetic counseling.

Subd. 9. **Licensed physician.** "Licensed physician" means an individual who is licensed to practice medicine under chapter 147.

Subd. 10. **NSGC.** "NSGC" means the National Society of Genetic Counselors, a professional membership association for genetic counselors that approves continuing education programs.

Subd. 11. **Qualified supervisor.** "Qualified supervisor" means any person who is licensed under this chapter as a genetic counselor or a physician licensed under chapter 147 to practice medicine in Minnesota.

Subd. 12. **Supervisee.** "Supervisee" means a genetic counselor with a provisional license.

Subd. 13. **Supervision.** "Supervision" means an assessment of the work of the supervisee, including regular meetings and file review, by a qualified supervisor according to the supervision contract. Supervision does not require the qualified supervisor to be present while the supervisee provides services.

Sec. 9. **[147F.03] SCOPE OF PRACTICE.**

The practice of genetic counseling by a licensed genetic counselor includes the following services:

(1) obtaining and interpreting individual and family medical and developmental histories;

(2) determining the mode of inheritance and the risk of transmitting genetic conditions and birth defects;

(3) discussing the inheritance, features, natural history, means of diagnosis, and management of conditions with clients;

(4) identifying, coordinating, ordering, and explaining the clinical implications of genetic laboratory tests and other laboratory studies;

(5) assessing psychosocial factors, including social, educational, and cultural issues;

(6) providing client-centered counseling and anticipatory guidance to the client or family based on their responses to the condition, risk of occurrence, or risk of recurrence;

(7) facilitating informed decision-making about testing and management;

(8) identifying and using community resources that provide medical, educational, financial, and psychosocial support and advocacy; and

(9) providing accurate written medical, genetic, and counseling information for families and health care professionals.

Sec. 10. **[147F.05] UNLICENSED PRACTICE PROHIBITED; PROTECTED TITLES AND RESTRICTIONS ON USE.**

Subdivision 1. **Protected titles.** No individual may use the title "genetic counselor," "licensed genetic counselor," "gene counselor," "genetic consultant,""genetic assistant," "genetic associate," or any words, letters, abbreviations, or insignia indicating or implying that the individual is eligible for licensure by the state as a genetic counselor unless the individual has been licensed as a genetic counselor according to this chapter.

Subd. 2. **Unlicensed practice prohibited.** Effective January 1, 2018, no individual may practice genetic counseling unless the individual is licensed as a genetic counselor under this chapter except as otherwise provided under this chapter.

Subd. 3. **Other practitioners.** (a) Nothing in this chapter shall be construed to prohibit or restrict the practice of any profession or occupation licensed or registered by the state by an individual duly licensed or registered to practice the profession or occupation or to perform any act that falls within the scope of practice of the profession or occupation.

(b) Nothing in this chapter shall be construed to require a license under this chapter for:

(1) an individual employed as a genetic counselor by the federal government or a federal agency if the individual is providing services under the direction and control of the employer;

(2) a student or intern, having graduated within the past six months, or currently enrolled in an ACGC-accredited genetic counseling educational program providing genetic counseling services that are an integral part of the student's or intern's course of study, are performed under the direct supervision of a licensed genetic counselor or physician who is on duty in the assigned patient care area, and the student is identified by the title "genetic counseling intern";

(3) a visiting ABGC- or ABMG-certified genetic counselor working as a consultant in this state who permanently resides outside of the state, or the occasional use of services from organizations from outside of the state that employ ABGC- or ABMG-certified genetic counselors. This is limited to practicing for 30 days total within one calendar year. Certified genetic counselors from outside of the state working as a consultant in this state must be licensed in their state of residence if that credential is available; or

(4) an individual who is licensed to practice medicine under chapter 147.

Subd. 4. **Sanctions.** An individual who violates this section is guilty of a misdemeanor and shall be subject to sanctions or actions according to section 214.11.

Sec. 11. **[147F.07] LICENSURE REQUIREMENTS.**

Subdivision 1. **General requirements for licensure.** To be eligible for licensure, an applicant, with the exception of those seeking licensure by reciprocity under subdivision 2, must submit to the board:

(1) a completed application on forms provided by the board along with all fees required under section 147F.17. The applicant must include:

(i) the applicant's name, Social Security number, home address and telephone number, and business address and telephone number if currently employed;

(ii) the name and location of the genetic counseling or medical program the applicant completed;

(iii) a list of degrees received from other educational institutions;

(iv) a description of the applicant's professional training;

(v) a list of registrations, certifications, and licenses held in other jurisdictions;

(vi) a description of any other jurisdiction's refusal to credential the applicant;

(vii) a description of all professional disciplinary actions initiated against the applicant in any jurisdiction; and

(viii) any history of drug or alcohol abuse, and any misdemeanor, gross misdemeanor, or felony conviction;

(2) evidence of graduation from an education program accredited by the ACGC or its predecessor or successor organization;

(3) a verified copy of a valid and current certification issued by the ABGC or ABMG as a certified genetic counselor, or by the ABMG as a certified medical geneticist;

(4) additional information as requested by the board, including any additional information necessary to ensure that the applicant is able to practice with reasonable skill and safety to the public;

(5) a signed statement verifying that the information in the application is true and correct to the best of the applicant's knowledge and belief; and

(6) a signed waiver authorizing the board to obtain access to the applicant's records in this or any other state in which the applicant completed an educational program or engaged in the practice of genetic counseling.

Subd. 2. **Licensure by reciprocity.** To be eligible for licensure by reciprocity, the applicant must hold a current genetic counselor or medical geneticist registration or license in another state, the District of Columbia, or a territory of the United States, whose standards for registration or licensure are at least equivalent to those of Minnesota, and must:

(1) submit the application materials and fees as required by subdivision 1, clauses (1), (2), and (4) to (6);

(2) provide a verified copy from the appropriate government body of a current registration or license for the practice of genetic counseling in another jurisdiction that has initial registration or licensing requirements equivalent to or higher than the requirements in subdivision 1; and

(3) provide letters of verification from the appropriate government body in each jurisdiction in which the applicant holds a registration or license. Each letter must state the applicant's name, date of birth, registration or license number, date of issuance, a statement regarding disciplinary actions, if any, taken against the applicant, and the terms under which the registration or license was issued.

Subd. 3. **Licensure by equivalency.** (a) The board may grant a license to an individual who does not meet the certification requirements in subdivision 1 but who has been employed as a genetic counselor for a minimum of ten years and provides the following documentation to the board no later than January 1, 2018:

(1) proof of a master's or higher degree in genetics or related field of study from an accredited educational institution;

(2) proof that the individual has never failed the ABGC or ABMG certification examination;

(3) three letters of recommendation, with at least one from an individual eligible for licensure under this chapter, and at least one from an individual certified as a genetic

counselor by the ABGC or ABMG or an individual certified as a medical geneticist by the ABMG. An individual who submits a letter of recommendation must have worked with the applicant in an employment setting during the past ten years and must attest to the applicant's competency; and

(4) documentation of the completion of 100 hours of NSGC-approved continuing education credits within the past five years.

(b) This subdivision expires January 1, 2018.

Subd. 4. **License expiration.** A genetic counselor license shall be valid for one year from the date of issuance.

Subd. 5. **License renewal.** To be eligible for license renewal, a licensed genetic counselor must submit to the board:

(1) a renewal application on a form provided by the board;

(2) the renewal fee required under section 147F.17;

(3) evidence of compliance with the continuing education requirements in section 147F.11; and

(4) any additional information requested by the board.

Sec. 12. **[147F.09] BOARD ACTION ON APPLICATIONS FOR LICENSURE.**

(a) The board shall act on each application for licensure according to paragraphs (b) to (d).

(b) The board shall determine if the applicant meets the requirements for licensure under section 147F.07. The board may investigate information provided by an applicant to determine whether the information is accurate and complete.

(c) The board shall notify each applicant in writing of action taken on the application, the grounds for denying licensure if a license is denied, and the applicant's right to review the board's decision under paragraph (d).

(d) Applicants denied licensure may make a written request to the board, within 30 days of the board's notice, to appear before the advisory council and for the advisory council to review the board's decision to deny the applicant's license. After reviewing the denial, the advisory council shall make a recommendation to the board as to whether the denial shall be affirmed. Each applicant is allowed only one request for review per licensure period.

Sec. 13. **[147F.11] CONTINUING EDUCATION REQUIREMENTS.**

(a) A licensed genetic counselor must complete a minimum of 25 hours of NSGC- or ABMG-approved continuing education units every two years. If a licensee's renewal

term is prorated to be more or less than one year, the required number of continuing education units is prorated proportionately.

(b) The board may grant a variance to the continuing education requirements specified in this section if a licensee demonstrates to the satisfaction of the board that the licensee is unable to complete the required number of educational units during the renewal term. The board may allow the licensee to complete the required number of continuing education units within a time frame specified by the board. In no case shall the board allow the licensee to complete less than the required number of continuing education units.

Sec. 14. **[147F.13] DISCIPLINE; REPORTING.**

For purposes of this chapter, licensed genetic counselors and applicants are subject to sections 147.091 to 147.162.

Sec. 15. **[147F.15] LICENSED GENETIC COUNSELOR ADVISORY COUNCIL.**

Subdivision 1. **Membership.** The board shall appoint a five-member Licensed Genetic Counselor Advisory Council. One member must be a licensed physician with experience in genetics, three members must be licensed genetic counselors, and one member must be a public member.

Subd. 2. **Organization.** The advisory council shall be organized and administered under section 15.059, except that section 15.059, subdivision 2, does not apply to this section. Members shall serve two-year terms, and shall serve until their successors have been appointed. The council shall select a chair from its membership.

Subd. 3. **Duties.** The advisory council shall:

(1) advise the board regarding standards for licensed genetic counselors;

(2) provide for distribution of information regarding licensed genetic counselor practice standards;

(3) advise the board on enforcement of this chapter;

(4) review applications and recommend granting or denying licensure or license renewal;

(5) advise the board on issues related to receiving and investigating complaints, conducting hearings, and imposing disciplinary action in relation to complaints against licensed genetic counselors; and

(6) perform other duties authorized for advisory councils under chapter 214, as directed by the board.

Subd. 4. **Expiration.** Notwithstanding section 15.059, the advisory council does not expire.

Sec. 16. **[147F.17] FEES.**

Subdivision 1. **Fees.** Fees are as follows:

(1) license application fee, $200;

(2) initial licensure and annual renewal, $150; and

(3) late fee, $75.

Subd. 2. **Proration of fees.** The board may prorate the initial license fee. All licensees are required to pay the full fee upon license renewal.

Subd. 3. **Penalty for late renewals.** An application for registration renewal submitted after the deadline must be accompanied by a late fee in addition to the required fees.

Subd. 4. **Nonrefundable fees.** All fees are nonrefundable.

Subd. 5. **Deposit.** Fees collected by the board under this section shall be deposited in the state government special revenue fund.

LACTATION CARE PROVIDERS

Sec. 17. **[148.9801] SCOPE AND APPLICATION.**

Subdivision 1. **Scope.** Sections 148.9801 to 148.9812 apply to persons who are applicants for licensure, who are licensed, who use protected titles, or who represent that they are licensed under sections 148.9801 to 148.9812.

Subd. 2. **Application.** Nothing in sections 148.9801 to 148.9812 shall prohibit any person from providing breastfeeding education and support services, whether or not that person is licensed under sections 148.9801 to 148.9812.

Sec. 18. **[148.9802] DEFINITIONS.**

Subdivision 1. **Application.** For purposes of sections 148.9801 to 148.9812, the following terms have the meanings given.

Subd. 2. **Biennial licensure period.** "Biennial licensure period" means the two-year period for which licensure is effective.

Subd. 3. **Breastfeeding education and support services.** "Breastfeeding education and support services" refers to services such as educating women, families, health professionals, and the community about the impact of breastfeeding and human lactation on health and what to expect in the normal course of breastfeeding; facilitating the development of policies that protect, promote, and support breastfeeding; acting as an advocate for breastfeeding as the child-feeding norm; providing holistic breastfeeding support, encouragement, and care from preconception to weaning in order to help women and their families meet their breastfeeding goals; using principles of adult education when

teaching clients, health care providers, and others in the community; and identifying and referring high-risk mothers and babies and those requiring clinical treatment to licensed providers. Any individual, with or without a license, may provide breastfeeding education and support services.

Subd. 4. **Certified lactation counselor, advanced lactation consultant, or advanced nurse lactation consultant.** "Certified lactation counselor, advanced lactation consultant, or advanced nurse lactation consultant" means an individual who possesses certification from the Academy of Lactation Policy and Practice of the Healthy Children Project, Inc.

Subd. 5. **Clinical lactation services.** "Clinical lactation services" refers to the clinical application of evidence-based practices for evaluation, problem identification, treatment, education, and consultation in providing lactation care and services to childbearing families. Clinical lactation services involves one or more of the following activities: lactation assessment through the systematic collection of data; analysis of data; creation of lactation care plans; implementation of lactation care plans, including but not limited to providing demonstration and instruction to parents and communicating with the primary health care provider; evaluation of outcomes; and recommending the use of assistive devices when appropriate. Individuals who provide one or more of the services listed in this subdivision are providing clinical lactation services.

Subd. 6. **Commissioner.** "Commissioner" means the commissioner of health or a designee.

Subd. 7. **Credential.** "Credential" means a license, permit, certification, registration, or other evidence of qualification or authorization to engage in the practice of clinical lactation care services issued by any authority.

Subd. 8. **International Board-Certified Lactation Consultant.** "International Board-Certified Lactation Consultant" means an individual who possesses certification from the International Board of Lactation Consultant Examiners as accredited by the National Commission for Certifying Agencies.

Subd. 9. **License or licensed.** "License" or "licensed" means the act or status of a natural person who meets the requirements of sections 148.9801 to 148.9812.

Subd. 10. **Licensed lactation care provider.** "Licensed lactation care provider" means an individual who meets the requirements of sections 148.9801 to 148.9812, is licensed by the commissioner, and is permitted to provide clinical lactation services and use the titles authorized in this section and section 148.9803.

Subd. 11. **Licensee.** "Licensee" means a person who meets the requirements of sections 148.9801 to 148.9812.

Subd. 12. **Licensure by equivalency.** "Licensure by equivalency" means a method of licensure described in section 148.9806, subdivision 2, by which an individual who possesses a credential from the International Board of Lactation Consultant Examiners as accredited by the National Commission for Certifying Agencies, from the Academy of Lactation Policy and Practice of the Healthy Children Project, Inc., or from another nationally recognized credentialing agency may qualify for licensure.

Subd. 13. **Licensure by reciprocity.** "Licensure by reciprocity" means a method of licensure described in section 148.9806, subdivision 3, by which an individual who possesses a credential from another jurisdiction may qualify for Minnesota licensure.

Subd. 14. **Protected title.** "Protected title" means the title of licensed lactation consultant, licensed certified lactation counselor, licensed advanced lactation consultant, licensed advanced nurse lactation consultant, or licensed International Board-Certified Lactation Consultant.

Sec. 19. **[148.9803] LICENSURE; PROTECTED TITLES AND RESTRICTIONS ON USE; EXEMPT PERSONS; SANCTIONS.**

Subdivision 1. **Unlicensed practice prohibited.** Effective July 1, 2017, no person shall engage in the practice of clinical lactation services unless the person is licensed as a lactation care provider in accordance with sections 148.9801 to 148.9812.

Subd. 2. **Protected titles and restrictions on use.** (a) The terms or phrases "licensed International Board-Certified Lactation Consultant" or "licensed lactation consultant" alone or in combination can only be used by an individual licensed under sections 148.9801 to 148.9812 and who possesses a credential from the International Board of Lactation Consultant Examiners as accredited by the National Commission for Certifying Agencies.

(b) The terms or phrases "licensed certified lactation counselor," "certified lactation counselor," "licensed advanced lactation consultant," "advanced lactation consultant," "licensed advanced nurse lactation consultant," "advanced nurse lactation consultant," "licensed lactation counselor," or "licensed lactation consultant" alone or in combination can only be used by an individual licensed under sections 148.9801 to 148.9812 and who possesses a credential from the Academy of Lactation Policy and Practice of the Healthy Children Project, Inc.

Subd. 3. **Exempt persons.** This section does not apply to:

(1) a person employed as a lactation consultant or lactation counselor by the government of the United States or any agency of it. However, use of the protected titles under those circumstances is allowed only in connection with performance of official duties for the federal government;

(2) a student participating in supervised fieldwork or supervised coursework that is necessary to meet the requirements of sections 148.9801 to 148.9812 if the student is designated by a title which clearly indicates the student's status as a student trainee. Any use of the protected titles under these circumstances is allowed only while the person is performing the duties of the supervised fieldwork or supervised coursework;

(3) a person visiting and then leaving the state and performing clinical lactation services while in the state if the services are performed no more than 30 days in a calendar year as part of a professional activity that is limited in scope and duration and is in association with a licensed lactation care provider licensed under sections 148.9801 to 148.9812, and:

(i) the person is credentialed under the law of another state which has credentialing requirements at least as stringent as the requirements of sections 148.9801 to 148.9812;

(ii) the person meets the requirements for certification as an International Board-Certified Lactation Consultant established by the International Board of Lactation Consultant Examiners as accredited by the National Commission for Certifying Agencies; or

(iii) the person is certified as a certified lactation counselor, advanced lactation consultant, or advanced nurse lactation consultant by the Academy of Lactation Policy and Practice of the Healthy Children Project, Inc.;

(4) a person licensed to practice as a dentist under chapter 150A, physician or osteopath under chapter 147, nurse under sections 148.171 to 148.285, physician assistant under chapter 147A, dietitian under sections 148.621 to 148.634, or midwife under chapter 147D, when providing clinical lactation services incidental to the practice of the person's profession, except the person shall not use the protected titles;

(5) an employee of a department, agency, or division of state, county, or local government, when providing clinical lactation services within the discharge of the employee's official duties including, but not limited to, peer counselors in the Special Supplemental Nutrition Program for Women, Infants, and Children; or

(6) a volunteer providing clinical lactation services, if:

(i) the volunteer does not use the protected titles or represent that the volunteer is licensed or has the clinical skills and abilities associated with licensure;

(ii) the volunteer service is performed for free, with no fee charged to or payment, monetary or otherwise, provided by the individual or group served; and

(iii) the volunteer receives no compensation, monetary or otherwise, except for administrative expenses including, but not limited to, mileage.

Subd. 4. **Sanctions.** A person who practices clinical lactation services or represents that they are a licensed lactation care provider by or through the use of any title described in subdivision 2 without prior licensure according to sections 148.9801 to 148.9812 is subject to sanctions or action against continuing the activity according to section 148.9804, chapter 214, or other statutory authority.

Subd. 5. **Exemption.** Nothing in sections 148.9801 to 148.9812 shall prohibit the practice of any profession or occupation, licensed or registered by the state, by any person duly licensed or registered to practice the profession or occupation or to perform any act that falls within the scope of practice of the profession or occupation.

Sec. 20. **[148.9804] PENALTY.**

If the commissioner finds that a licensed lactation care provider has violated the provisions of sections 148.9801 to 148.9812 or rules adopted under those sections, the commissioner may impose a civil penalty not exceeding $10,000 for each separate violation. The amount of the civil penalty shall be fixed so as to deprive the licensed lactation care provider of any economic advantage gained by reason of the violation charged, to discourage similar violations, and to reimburse the commissioner for the cost of the investigation and proceeding, including, but not limited to: fees paid for services provided by the Office of Administrative Hearings; legal and investigative services provided by the Office of the Attorney General; services of court reporters; witnesses; and reproduction of records.

Sec. 21. **[148.9806] APPLICATION REQUIREMENTS; PROCEDURE.**

Subdivision 1. **Application for licensure.** An applicant for licensure must:

(1) have a current certification from the International Board of Lactation Consultant Examiners as accredited by the National Commission for Certifying Agencies, the Academy of Lactation Policy and Practice of the Healthy Children Project, Inc., or another jurisdiction whose standards for credentialing are determined by the commissioner to be equivalent to or exceed the requirements for licensure under subdivision 2;

(2) submit a completed application for licensure on forms provided by the commissioner and supply the information requested on the application, including:

(i) the applicant's name, business address, business telephone number, business setting, and daytime telephone number;

(ii) a description of the applicant's education and training, including a list of degrees received from educational institutions;

(iii) the applicant's work history for the six years preceding the application, including the number of hours worked;

(iv) a list of all lactation consulting credentials currently and previously held in Minnesota and other jurisdictions;

(v) a description of any jurisdiction's refusal to credential the applicant;

(vi) a description of all professional disciplinary actions initiated against the applicant in any jurisdiction;

(vii) information on any physical or mental condition or chemical dependency that impairs the applicant's ability to provide clinical lactation services with reasonable judgment or safety;

(viii) a description of any misdemeanor, gross misdemeanor, or felony conviction that is reasonably related to the practice of clinical lactation services; and

(ix) a description of any state or federal court order, including a conciliation court order or a disciplinary order, related to the individual's clinical lactation services practice;

(3) submit with the application all fees required by section 148.9811;

(4) sign a statement that the information in the application is true and correct to the best of the applicant's knowledge and belief;

(5) sign a waiver authorizing the commissioner to obtain access to the applicant's records in this or any other state in which the applicant holds or previously held a credential for the practice of an occupation, completed a clinical lactation services education program, or engaged in the practice of clinical lactation services;

(6) within 30 days of a request, submit additional information as requested by the commissioner to clarify information in the application, including information to determine whether the individual has engaged in conduct warranting disciplinary action under section 148.9812; and

(7) submit the additional information required for licensure by equivalency or licensure by reciprocity.

Subd. 2. **Credentialed applicants.** An applicant who is credentialed by the International Board of Lactation Consultant Examiners as accredited by the National Commission for Certifying Agencies as an International Board-Certified Lactation Consultant or an applicant who is credentialed by the Academy of Lactation Policy and Practice of the Healthy Children Project, Inc. may be eligible for licensure by equivalency as a licensed lactation care provider. Nothing in this section limits the commissioner's authority to deny licensure based upon the grounds for discipline in section 148.9812. Applicants under this subdivision must provide the materials required in subdivision 1 and must also provide:

(1) verified documentation from the International Board of Lactation Consultant Examiners stating that the applicant is credentialed as an International Board-Certified Lactation Consultant, or verified documentation from the Academy of Lactation Policy and Practice of the Healthy Children Project, Inc., that the applicant is credentialed as a certified lactation counselor, advanced lactation consultant, or advanced nurse lactation consultant. The applicant is responsible for obtaining this documentation; and

(2) a waiver authorizing the commissioner to obtain access to the applicant's records maintained by the International Board of Lactation Consultant Examiners or the Academy of Lactation Policy and Practice of the Healthy Children Project, Inc.

Subd. 3. **Applicants credentialed in another jurisdiction.** (a) An applicant who holds a current credential as a licensed lactation consultant, licensed lactation care provider, or licensed lactation counselor in the District of Columbia or a state or territory of the United States whose standards for credentialing are determined by the commissioner to be equivalent to or exceed the requirements for licensure under subdivision 2, may be eligible for licensure by reciprocity as a licensed lactation care provider. Nothing in this section limits the commissioner's authority to deny licensure based upon the grounds for discipline in section 148.9812.

(b) Applicants under this subdivision must provide the materials required in subdivision 1 and must also request that the appropriate government body in each jurisdiction in which the applicant holds or held credentials as a licensed lactation care provider or substantially similar title send a letter to the commissioner verifying the applicant's credentials. A license shall not be issued until the commissioner receives a letter verifying each of the applicant's credentials. Each letter must include the applicant's name and date of birth, credential number and date of issuance, a statement regarding investigations pending and disciplinary actions taken or pending against the applicant, current status of the credential, and the terms under which the credential was issued.

Subd. 4. **Action on applications for licensure.** (a) The commissioner shall approve, approve with conditions, or deny licensure. The commissioner shall act on an application for licensure according to paragraphs (b) to (d).

(b) The commissioner shall determine if the applicant meets the requirements for licensure. The commissioner may investigate information provided by an applicant to determine whether the information is accurate and complete.

(c) The commissioner shall notify an applicant of action taken on the application and, if licensure is denied or approved with conditions, the grounds for the commissioner's determination.

(d) An applicant denied licensure or granted licensure with conditions may make a written request to the commissioner, within 30 days of the date of the commissioner's determination, for reconsideration of the commissioner's determination. Individuals requesting reconsideration may submit information which the applicant wants considered in the reconsideration. After reconsideration of the commissioner's determination to deny licensure or grant licensure with conditions, the commissioner shall determine whether the original determination should be affirmed or modified. An applicant is allowed no more than one request in any one biennial licensure period for reconsideration of the commissioner's determination to deny licensure or approve licensure with conditions.

Sec. 22. **[148.9807] LICENSURE RENEWAL.**

Subdivision 1. **Renewal requirements.** To be eligible for licensure renewal, a licensee must:

(1) submit a completed and signed application for licensure renewal on forms provided by the commissioner;

(2) submit the renewal fee required under section 148.9811;

(3) submit proof that the licensee is currently credentialed by the International Board of Lactation Consultant Examiners as accredited by the National Commission for Certifying Agencies, the Academy of Lactation Policy and Practice of the Healthy Children Project, Inc., or another jurisdiction as described in section 148.9806; and

(4) submit additional information as requested by the commissioner to clarify information presented in the renewal application. The information must be submitted within 30 days after the commissioner's request.

Subd. 2. **Renewal deadline.** (a) Except as provided in paragraph (c), licenses must be renewed every two years. Licensees must comply with the procedures in paragraphs (b) to (e).

(b) Each license must state an expiration date. An application for licensure renewal must be received by the Department of Health at least 30 calendar days before the expiration date.

(c) If the commissioner changes the renewal schedule and the new expiration date is less than two years in the future, the fee to be reported at the next renewal must be prorated.

(d) An application for licensure renewal not received within the time required under paragraph (b), but received on or before the expiration date, must be accompanied by a late fee in addition to the renewal fee specified in section 148.9811.

(e) Licensure renewals received after the expiration date shall not be accepted and persons seeking licensed status must comply with the requirements of section 148.9808.

Subd. 3. **Licensure renewal notice.** At least 60 calendar days before the expiration date in subdivision 2, the commissioner shall notify the licensee. The notice must include an application for licensure renewal and notice of fees required for renewal. The licensee's failure to receive notice does not relieve the licensee of the obligation to meet the renewal deadline and other requirements for licensure renewal.

Sec. 23. **[148.9808] LICENSURE RENEWAL; AFTER EXPIRATION DATE.**

An individual whose application for licensure renewal is received after the licensure expiration date must submit the following:

(1) a completed and signed application for licensure following lapse in licensed status on forms provided by the commissioner;

(2) the renewal fee and the late fee required under section 148.9811;

(3) proof that the licensee is currently credentialed by the International Board of Lactation Consultant Examiners, the Academy of Lactation Policy and Practice of the Healthy Children Project, Inc., or another jurisdiction as described in section 148.9806; and

(4) additional information as requested by the commissioner to clarify information in the application, including information to determine whether the individual has engaged in conduct warranting disciplinary action as set forth in section 148.9812. This information must be submitted within 30 days after the commissioner's request.

Sec. 24. **[148.9809] CHANGE OF NAME, ADDRESS, OR EMPLOYMENT.**

A licensee who changes a name, address, or employment must inform the commissioner, in writing, of the change of name, address, employment, business address, or business telephone number within 30 days. A change in name must be accompanied by a copy of a marriage certificate or court order. All notices or other correspondence mailed to or served on a licensee by the commissioner at the licensee's address on file with the commissioner shall be considered as having been received by the licensee.

Sec. 25. **[148.9810] RECIPIENT NOTIFICATION.**

Subdivision 1. **Required notification.** In the absence of a physician referral or prior authorization, and before providing clinical lactation services for remuneration or expectation of payment from the client, a licensed lactation care provider must provide the following written notification in all capital letters of 12-point or larger boldface type to the client, parent, or guardian: "Your health care provider, insurer, or plan may require a physician referral or prior authorization and you may be obligated for partial or full payment for clinical lactation services rendered." Information other than this notification may be

included as long as the notification remains conspicuous on the face of the document. A nonwritten disclosure format may be used to satisfy the recipient notification requirement when necessary to accommodate the physical condition of a client or client's guardian.

Subd. 2. **Evidence of recipient notification.** The licensed lactation care provider is responsible for providing evidence of compliance with the recipient notification requirement of this section.

Sec. 26. **[148.9811] FEES.**

Subdivision 1. **Initial licensure fee.** The initial licensure fee for licensed lactation care providers is $80. The commissioner shall prorate fees based on the number of quarters remaining in the biennial licensure period.

Subd. 2. **Licensure renewal fee.** The biennial licensure renewal fee for licensed lactation care providers is $80.

Subd. 3. **Duplicate license fee.** The fee for a duplicate license is $25.

Subd. 4. **Late fee.** The fee for late submission of a renewal application is $25.

Subd. 5. **Verification to other states.** The fee for verification of licensure to other states is $25.

Subd. 6. **Use of fees.** All fees are nonrefundable. Fees collected under this section shall be deposited in the state treasury and credited to the state government special revenue fund for the purposes of administering sections 148.9801 to 148.9812.

Subd. 7. **Penalty fee.** (a) The penalty for using one of the protected titles without a current license after the credential has expired and before it is renewed is the amount of the license renewal fee for any part of the first month, plus the license renewal fee for any part of any subsequent month up to 36 months.

(b) The penalty for applicants who use the protected title of licensed lactation care provider before being issued a license is the amount of the license application fee for any part of the first month, plus the license application fee for any part of any subsequent month up to 36 months.

(c) For conduct described in paragraph (a) or (b) exceeding six months, payment of a penalty does not preclude any disciplinary action reasonably justified by the individual case.

Sec. 27. **[148.9812] GROUNDS FOR DISCIPLINE OR DENIAL OF LICENSURE; INVESTIGATION PROCEDURES; DISCIPLINARY ACTIONS.**

Subdivision 1. **Grounds for discipline or denial of licensure.** The commissioner may deny an application for licensure, may approve licensure with conditions, or may

discipline a licensee using any disciplinary action listed in subdivision 3 on proof that the individual has:

(1) intentionally submitted false or misleading information to the commissioner;

(2) failed, within 30 days, to provide information in response to a written request by the commissioner;

(3) performed services of a licensed lactation care provider in an incompetent manner, in a manner that is outside of the provider's scope of practice, or in a manner that falls below the community standard of care;

(4) violated a provision of sections 148.9801 to 148.9812;

(5) aided or abetted another person in violating a provision of sections 148.9801 to 148.9812;

(6) failed to perform services with reasonable judgment, skill, or safety due to the use of alcohol or drugs, or other physical or mental impairment;

(7) been convicted of violating any state or federal law, rule, or regulation which directly relates to the practice of clinical lactation services;

(8) been disciplined for conduct in the practice of an occupation by the state of Minnesota, another jurisdiction, or a national professional association, if any of the grounds for discipline are the same or substantially equivalent to those in sections 148.9801 to 148.9812;

(9) not cooperated with the commissioner in an investigation conducted according to subdivision 2;

(10) advertised in a manner that is false or misleading;

(11) engaged in dishonest, unethical, or unprofessional conduct in connection with the practice of clinical lactation services that is likely to deceive, defraud, or harm the public;

(12) demonstrated a willful or careless disregard for the health, welfare, or safety of a client;

(13) performed medical diagnosis or provided treatment without being licensed to do so under the laws of this state;

(14) paid or promised to pay a commission or part of a fee to any person who contacts the licensed lactation care provider for consultation or sends patients to the licensed lactation care provider for treatment;

(15) engaged in abusive or fraudulent billing practices, including violations of federal Medicare and Medicaid laws, Food and Drug Administration regulations, or state medical assistance laws;

(16) obtained money, property, or services from a consumer through the use of undue influence, high-pressure sales tactics, harassment, duress, deception, or fraud;

(17) performed services for a client who had no possibility of benefiting from the services;

(18) failed to refer a client for medical evaluation when appropriate or when a client indicated symptoms associated with diseases that could be medically or surgically treated;

(19) engaged in conduct with a client that is sexual, or may reasonably be interpreted by the client as sexual, or in any verbal behavior that is seductive or sexually demeaning to a client;

(20) violated a federal or state court order, including a conciliation court judgment, or a disciplinary order issued by the commissioner, related to the person's clinical lactation services practice; or

(21) any other just cause related to the practice of clinical lactation services.

Subd. 2. **Investigation of complaints.** The commissioner may initiate an investigation upon receiving a complaint or other oral or written communication that alleges or implies that a person has violated sections 148.9801 to 148.9812. In the receipt, investigation, and hearing of a complaint that alleges or implies that a person has violated sections 148.9801 to 148.9812, the commissioner shall follow the procedures in section 214.10.

Subd. 3. **Disciplinary action.** If the commissioner finds that a licensed lactation care provider should be disciplined according to subdivision 1, the commissioner may take any one or more of the following actions:

(1) refuse to grant or renew licensure;

(2) approve licensure with conditions;

(3) revoke licensure;

(4) suspend licensure;

(5) any reasonable lesser action including, but not limited to, reprimand or restriction on licensure; or

(6) any action authorized by statute.

Subd. 4. **Effect of specific disciplinary action on use of title.** Upon notice from the commissioner denying licensure renewal or upon notice that disciplinary actions have been imposed and the person is no longer entitled to provide clinical lactation services and use one of the protected titles, the person shall cease to provide clinical lactation services, to use the title protected by sections 148.9801 to 148.9812, and to represent to the public that the person is licensed by the commissioner.

Subd. 5. **Reinstatement requirements after disciplinary action.** A person who has had licensure suspended may request and provide justification for reinstatement following the period of suspension specified by the commissioner. The requirements

of section 148.9808 for renewing licensure and any other conditions imposed with the suspension must be met before licensure may be reinstated.

Subd. 6. **Authority to contract.** The commissioner shall contract with the health professionals services program as authorized by sections 214.31 to 214.37 to provide these services to practitioners under sections 148.9801 to 148.9812. The health professionals services program does not affect the commissioner's authority to discipline violations of sections 148.9801 to 148.9812.

MASSAGE AND BODYWORK THERAPY

Sec. 28. **[148.982] DEFINITIONS.**

Subdivision 1. **Applicability.** The definitions in this section apply to sections 148.982 to 148.9885.

Subd. 2. **Advertise.** "Advertise" means to publish, display, broadcast, or disseminate information by any means that can be reasonably construed as an advertisement.

Subd. 3. **Advisory council.** "Advisory council" means the Registered Massage and Bodywork Therapist Advisory Council established under section 148.9861.

Subd. 4. **Applicant.** "Applicant" means an individual applying for registration or renewal according to sections 148.982 to 148.9885.

Subd. 5. **Board.** "Board" means the Minnesota Board of Nursing.

Subd. 6. **Client.** "Client" means a recipient of massage and bodywork therapy services.

Subd. 7. **Competency exam.** "Competency exam" means a massage and bodywork therapy competency assessment that is approved by the board and is psychometrically valid, based on a job task analysis, and administered by a national testing organization.

Subd. 8. **Contact hour.** "Contact hour" means an instructional session of at least 50 consecutive minutes, excluding coffee breaks, registration, meals without a speaker, and social activities.

Subd. 9. **Credential.** "Credential" means a license, registration, or certification.

Subd. 10. **Health care provider.** "Health care provider" means a person who has a state credential to provide one or more of the following services: medical as defined in section 147.081, chiropractic as defined in section 148.01, podiatry as defined in section 153.01, dentistry as defined in section 150A.01, physical therapy as defined in section 148.65, or other state-credentialed providers.

Subd. 11. **Massage and bodywork therapy.** "Massage and bodywork therapy" means a health care service involving systematic and structured touch and palpation, and pressure and movement of the muscles, tendons, ligaments, and fascia, in order to reduce

muscle tension, relieve soft tissue pain, improve circulation, increase flexibility, increase activity of the parasympathetic branch of the autonomic nervous system, or to promote general wellness, by use of the techniques and applications described in section 148.983.

Subd. 12. **Municipality.** "Municipality" means a county, town, or home rule charter or statutory city.

Subd. 13. **Physical agent modality.** "Physical agent modality" means modalities that use the properties of light, water, temperature, sound, and electricity to produce a response in soft tissue.

Subd. 14. **Practice of massage and bodywork therapy.** "Practice of massage and bodywork therapy" means to engage professionally for compensation or as a volunteer in massage and bodywork therapy or the instruction of professional technique coursework.

Subd. 15. **Professional organization.** "Professional organization" means an organization that represents massage and bodywork therapists, was established before the year 2005, offers professional liability insurance as a benefit of membership, has an established code of professional ethics, and is board approved.

Subd. 16. **Registered massage and bodywork therapist or registrant.** "Registered massage and bodywork therapist" or "registrant" means a health care provider registered according to sections 148.982 to 148.9885, for the practice of massage and bodywork therapy.

Subd. 17. **State.** "State" means any state in the United States, the District of Columbia, Puerto Rico, the United States Virgin Islands, or Guam; or any Canadian province or similar political subdivision of a foreign country; except "this state" means the state of Minnesota.

Sec. 29. **[148.983] MASSAGE AND BODYWORK THERAPY.**

(a) The practice of massage and bodywork therapy by a registered massage and bodywork therapist includes the following:

(1) use of any or all of the following techniques using the hands, forearms, elbows, knees, or feet, or handheld, nonpuncturing, mechanical, or electrical devices that mimic or enhance the actions of the human hands: effleurage or gliding; petrissage or kneading; vibration and jostling; friction; tapotement or percussion; compression; fascial manipulation; passive stretching within the normal anatomical range of motion; and

(2) application and use of any of the following: oils, lotions, gels, rubbing alcohol, or powders for the purpose of lubricating the skin to be massaged; creams, with the exception of prescription medicinal creams; hot or cold stones; essential oils as used in aromatherapy for inhalation or diluted for topical application; salt glows and wraps; or heat or ice.

(b) The practice of massage and bodywork therapy does not include any of the following:

(1) diagnosing any illness or disease;

(2) altering a course of recommended massage and bodywork therapy when recommended by a state-credentialed health care provider without first consulting that health care provider;

(3) prescription of drugs or medicines;

(4) intentional adjustment, manipulation, or mobilization of abnormal articulations, neurological disturbances, structural alterations, biomechanical alterations as described in section 148.01, including by means of a high-velocity, low-amplitude thrusting force or by means of manual therapy or mechanical therapy for the manipulation or adjustment of joint articulation as defined in section 146.23; or

(5) application of physical agent modalities, needles that puncture the skin, or injection therapy.

Sec. 30. **[148.984] LIMITATIONS ON PRACTICE.**

If a massage and bodywork therapist has reason to believe a client's medical condition is beyond the scope of practice established by sections 148.982 to 148.9885, or by rules of the board for a registered massage and bodywork therapist, the massage and bodywork therapist must refer the client to a health care provider as defined in sections 148.982 to 148.9885, but is not prohibited from comanaging the client.

Sec. 31. **[148.985] PROTECTED TITLES AND RESTRICTIONS ON USE.**

Subdivision 1. **Designation.** An individual regulated by sections 148.982 to 148.9885, is designated as a "registered massage and bodywork therapist" or "RMBT."

Subd. 2. **Title protection.** Effective July 1, 2017, no individual may use the title "registered massage and bodywork therapist," or use, in connection with the individual's name, the letters "RMBT," or any other titles, words, letters, abbreviations, or insignia indicating or implying that the individual is registered or eligible for registration by this state as a registered massage therapist unless the individual has been registered under sections 148.982 to 148.9885.

Subd. 3. **Identification of registrants.** (a) A massage and bodywork therapist registered according to sections 148.982 to 148.9885 shall be identified as a "registered massage and bodywork therapist." If not written in full, this must be designated as "RMBT."

(b) The board may adopt rules for the implementation of this section, including the identification of terms or references that may be used only by registered massage and bodywork therapists as necessary to protect the public.

(c) A massage and bodywork therapist who is credentialed by another state, or who holds a certification from organizations, agencies, or educational providers may advertise using those terms or letters to indicate that credential, provided that the credentialing body is clearly identified.

Subd. 4. **Other health care providers.** Nothing in sections 148.982 to 148.9885 may be construed to prohibit, restrict the practice of, or require massage and bodywork therapy registration of any of the following:

(1) a health care provider credentialed by this state, using massage and bodywork therapy techniques within the scope of the provider's credential, provided the provider does not advertise or imply that they are registered according to sections 148.982 to 148.9885; or

(2) the natural health procedures, practices, and treatments in section 146A.01, subdivision 4, provided that the provider does not advertise or imply that they are registered according to sections 148.982 to 148.9885.

Sec. 32. **[148.986] POWERS OF BOARD.**

The board, acting with the advice of the advisory council, shall issue registrations to duly qualified applicants and shall exercise the following powers and duties:

(1) adopt rules, including standards of practice and a professional code of ethics, consistent with the law, as may be necessary to enable the board to implement the provisions of sections 148.982 to 148.9885;

(2) assign duties to the advisory council that are necessary to implement the provisions of sections 148.982 to 148.9885;

(3) approve or conduct a competency exam;

(4) appoint members to the advisory council according to section 148.9861 and chapter 214;

(5) enforce sections 148.982 to 148.9885; investigate violations of section 148.9882 by a registrant or applicant; impose discipline as described in section 148.9882, and incur any necessary expense;

(6) maintain a record of names and addresses of registrants;

(7) keep a permanent record of all its proceedings;

(8) distribute information regarding massage and bodywork therapy standards, including applications and forms necessary to carry into effect the provisions of sections 148.982 to 148.9885;

(9) take action on applications according to section 148.9881; and

(10) employ and establish the duties of necessary personnel.

Sec. 33. **[148.9861] REGISTERED MASSAGE AND BODYWORK THERAPIST ADVISORY COUNCIL.**

Subdivision 1. **Creation; membership.** (a) The Registered Massage and Bodywork Therapist Advisory Council is created and is composed of five members appointed by the board. All members must have resided in this state for at least three years prior to appointment. The advisory council consists of:

(1) two public members, as defined in section 214.02;

(2) three members who, except for initial appointees, are registered massage and bodywork therapists. Initial appointees must practice massage and bodywork therapy. An initial appointee shall be removed from the council if the appointee does not obtain registration under section 148.987 within a reasonable time after registration procedures are established.

(b) A person may not be appointed to serve more than two consecutive full terms.

(c) No more than one member of the advisory council may be an owner or administrator of a massage and bodywork therapy education provider.

Subd. 2. **Vacancies.** When a vacancy occurs for a member who is a registered massage and bodywork therapist, the board may appoint a member from among qualified candidates or from a list of nominees submitted by professional organizations that contains twice the number of nominees as vacancies. The board may fill vacancies occurring on the advisory council for unexpired terms according to this section. Members shall retain membership until a qualified successor is appointed.

Subd. 3. **Terms; compensation; removal.** Membership terms shall be as provided in section 15.059, subdivision 2. The members appointed under subdivision 1, clause (2), of this section shall serve terms that are coterminous with the governor. Members shall be compensated as provided in section 15.059, subdivision 3. Members may be removed and vacancies filled as provided in section 15.059, subdivision 4, except as provided in subdivision 2 of this section.

Subd. 4. **Chair.** The council must elect a chair from among its members.

Subd. 5. **Staffing.** The Minnesota Board of Nursing shall provide meeting space and administrative support for the advisory council.

Subd. 6. **Duties.** The advisory council shall advise the board regarding:

(1) establishment of standards of practice and a code of ethics for registered massage and bodywork therapists;

(2) distribution of information regarding massage and bodywork standards;

(3) enforcement of sections 148.982 to 148.9885;

(4) applications and recommendations of applicants for registration or registration renewal;

(5) complaints and recommendations regarding disciplinary matters and proceedings according to sections 214.10; 214.103; and 214.13, subdivisions 6 and 7;

(6) approval or creation of a competency exam granting status as an approved education provider; and

(7) performance of other duties of advisory councils under chapter 214, or as directed by the board.

Subd. 7. **Sunset.** The advisory council shall not expire.

Sec. 34. **[148.987] REGISTRATION REQUIREMENTS.**

Subdivision 1. **Registration.** To be eligible for registration according to sections 148.982 to 148.9885, an applicant must:

(1) pay applicable fees;

(2) submit to a criminal background check and pay the fees associated with obtaining the criminal background check. The background check shall be conducted in accordance with section 214.075; and

(3) file a written application on a form provided by the board that includes:

(i) the applicant's name, Social Security number, home address and telephone number, business address and telephone number, and business setting;

(ii) provide proof, as required by the board, of:

(A) having obtained a high school diploma or its equivalent;

(B) being 18 years of age or older;

(C) current cardiopulmonary resuscitation and first aid certification;

(D) current professional liability insurance coverage, with a minimum of $1,000,000 of coverage per occurrence; and

(E) proof, as required by the board, that the applicant has completed a postsecondary course of study that includes:

(aa) science, including anatomy and physiology, kinesiology, pathology, hygiene, and standard precautions; and

(bb) clinical practice in massage and bodywork therapy techniques; supervised practice; professional ethics and standards of practice; business and legal practices related to massage and bodywork therapy; and history, theory, and research related to massage and bodywork therapy;

(iii) unless registered under subdivision 3 or 4, successful completion of a competency exam;

(iv) a list of credentials or memberships held in this state or other states or from private credentialing or professional organizations;

(v) a description of any other state or municipality's refusal to credential the applicant;

(vi) a description of all professional disciplinary actions initiated against the applicant in any jurisdiction;

(vii) any history of drug or alcohol abuse;

(viii) any misdemeanor, gross misdemeanor, or felony conviction;

(ix) additional information as requested by the board;

(x) the applicant's signature on a statement that the information in the application is true and correct to the best of the applicant's knowledge; and

(xi) the applicant's signature on a waiver authorizing the board to obtain access to the applicant's records in this state or any other state in which the applicant has engaged in the practice of massage and bodywork therapy.

Subd. 2. **Registration prohibited.** The board may deny an application for registration if an applicant:

(1) has been convicted in this state of any of the following crimes, or of equivalent crimes in another state:

(i) prostitution as defined under section 609.321, 609.324, or 609.3242;

(ii) criminal sexual conduct under sections 609.342 to 609.3451, or 609.3453; or

(iii) a violent crime as defined under section 611A.08, subdivision 6;

(2) is a registered sex offender under section 243.166;

(3) has been subjected to disciplinary action under section 146A.09, if the board determines such denial is necessary to protect the public; or

(4) if an applicant is charged with or under investigation for complaints in this state or any state that would constitute a violation of the statutes or rules established for the practice of massage and bodywork therapy in this state, the applicant shall not be registered until the complaints have been resolved in the applicant's favor. Should a complaint be resolved in favor of the complainant, the application for registration in this state may be denied.

Subd. 3. **Registration by endorsement.** (a) To be eligible for registration by endorsement, an applicant shall:

(1) meet the requirements for registration in subdivision 1, clauses (1), (2), and (3), items (v) to (xii); and

(2) provide proof of a current and unrestricted equivalent credential in another state that has qualifications at least equivalent to the requirements of sections 148.981 to 148.9885. The proof shall include records as required by rules of the board.

(b) Registrations issued by endorsement shall expire on the same schedule and be renewed by the same procedures as registrations issued under subdivision 1.

Subd. 4. **Registration by grandfathering.** (a) To be eligible for registration by grandfathering, an applicant shall:

(1) meet the requirements for registration in subdivision 1, clauses (1), (2), and (3), items (v) to (xii); and

(2) provide documentation as specified by the board demonstrating the applicant has met at least one of the following qualifications:

(i) successful completion of at least 500 hours of supervised classroom and hands-on instruction relating to massage and bodywork therapy;

(ii) successful completion of a competency exam;

(iii) evidence of experience in the practice of massage and bodywork therapy for at least two of the previous five years immediately preceding application; or

(iv) active membership in a professional organization for at least two of the previous five years immediately preceding application.

(b) Registrations issued by grandfathering shall expire and be renewed on the same schedule and by the same procedures as registrations issued under subdivision 1.

(c) This subdivision is effective for two years after the first date the board has made applications available.

Subd. 5. **Temporary permit.** A temporary permit to practice as a registered massage and bodywork therapist may be issued to an applicant eligible for registration under subdivision 1, 3, or 4, if the application for registration is complete, all applicable requirements in this section have been met, and applicable fees have been paid. The temporary permit remains valid until the board takes action on the applicant's application.

Sec. 35. **[148.9871] EXPIRATION AND RENEWAL.**

Subdivision 1. **Registration expiration.** Registrations issued according to this chapter expire annually.

Subd. 2. **Renewal.** To be eligible for registration renewal, a registrant must annually, or as determined by the board:

(1) complete a renewal application on a form provided by the board;

(2) submit applicable fees; and

(3) submit any additional information requested by the board to clarify information presented in the renewal application. The information must be submitted within 30 days after the board's request, or the renewal request is cancelled.

Subd. 3. **Change of address.** A registrant who changes addresses must inform the board within 30 days, in writing, of the change of address. Notices or other correspondence mailed to or served on a registrant at the registrant's current address on file shall be considered as having been received by the registrant.

Subd. 4. **Registration renewal notice.** At least 60 days before the registration renewal date, the board shall send out a renewal notice to the last known address of the registrant on file. The notice must include a renewal application and a notice of fees required for renewal. It must also inform the registrant that registration will expire without further action by the board if an application for registration renewal is not received before the deadline for renewal. The registrant's failure to receive this notice shall not relieve the registrant of the obligation to meet the deadline and other requirements for registration renewal. Failure to receive this notice is not grounds for challenging expiration of registered status.

Subd. 5. **Renewal deadline.** The renewal application and fee must be postmarked on or before October 1 of the year of renewal or as determined by the board. If the postmark is illegible, the application shall be considered timely if received by the third working day after the deadline.

Subd. 6. **Inactive status and return to active status.** (a) A registration may be placed in inactive status upon application to the board by the registrant and upon payment of an inactive status fee.

(b) A registrant seeking restoration to active status from inactive status must pay the current renewal fees and all unpaid back inactive fees. The registrant must meet the criteria for renewal under subdivision 7 prior to submitting an application to regain registered status. If the registrant has been in inactive status for more than five years, a qualifying score on a competency exam is required.

Subd. 7. **Registration following lapse of registration status for two years or less.** In order for an individual whose registration status has lapsed for two years or less, to regain registration status, the individual must:

(1) apply for registration renewal according to subdivision 2; and

(2) submit applicable fees for the period not registered, including the fee for late renewal.

Subd. 8. **Cancellation due to nonrenewal.** The board shall not renew, reissue, reinstate, or restore a registration that has lapsed and has not been renewed within two

years. A registrant whose registration is canceled for nonrenewal must obtain a new registration by applying for initial registration and fulfilling all requirements then in existence for initial registration as a massage and bodywork therapist.

Subd. 9. **Cancellation of registration in good standing.** (a) A registrant holding active registration as a massage and bodywork therapist in this state may, upon approval of the board, be granted registration cancellation if the board is not investigating the person as a result of a complaint or information received or if the board has not begun disciplinary proceedings against the registrant. Such action by the board shall be reported as a cancellation of registration in good standing.

(b) A registrant who receives board approval for registration cancellation is not entitled to a refund of any registration fees paid for the registration period in which cancellation of the registration occurred.

(c) To obtain registration after cancellation, an applicant must obtain a new registration by applying for initial registration and fulfilling the requirements then in existence for obtaining initial registration according to sections 148.981 to 148.9885.

Sec. 36. **[148.9881] BOARD ACTION ON APPLICATIONS; DATA PRACTICES.**

(a) The board shall act on each application for registration or renewal according to paragraphs (b) and (d).

(b) The board or advisory council shall determine if the applicant meets the requirements for registration or renewal under section 148.987 or 148.9871. The board or advisory council may investigate information provided by an applicant to determine whether the information is accurate and complete, and may request additional information or documentation.

(c) The board shall notify each applicant, in writing, of action taken on the application, the grounds for denying registration if registration is denied, and the applicant's right to review under paragraph (d).

(d) An applicant denied registration may make a written request to the board, within 30 days of the board's notice, to appear before the advisory council and for the advisory council to review the board's decision to deny the applicant's registration. After reviewing the denial, the advisory council shall make a recommendation to the board as to whether the denial shall be affirmed. Each applicant is allowed only one request for review per registration period.

(e) Section 13.41 applies to government data of the board on applicants and registrants.

Sec. 37. **[148.9882] GROUNDS FOR DISCIPLINARY ACTION.**

Subdivision 1. **Grounds listed.** (a) The board may deny, revoke, suspend, limit, or condition the registration of a registrant or registered massage and bodywork therapist, or may otherwise discipline a registrant. The fact that massage and bodywork therapy may be considered a less customary approach to health care shall not constitute the basis for disciplinary action per se.

(b) The following are grounds for disciplinary action, regardless of whether injury to a client is established:

(1) failing to demonstrate the qualifications or to satisfy the requirements for registration contained in sections 148.982 to 148.9885, or rules of the board. In the case of an applicant, the burden of proof is on the applicant to demonstrate the qualifications or satisfy the requirements;

(2) advertising in a false, fraudulent, deceptive, or misleading manner, including, but not limited to:

(i) advertising or holding oneself out as a "registered massage and bodywork therapist" or any abbreviation or derivative thereof to indicate such a title, when such registration is not valid or current for any reason;

(ii) advertising or holding oneself out as a "licensed massage and bodywork therapist" or any abbreviation or derivative thereof to indicate such a title, unless the registrant currently holds a valid state license in another state and provided that the state is clearly identified;

(iii) advertising a service, the provision of which would constitute a violation of this chapter or rules established by the board; and

(iv) using fraud, deceit, or misrepresentation when communicating with the general public, health care providers, or other business professionals;

(3) falsifying information in a massage and bodywork therapy registration or renewal application or attempting to obtain registration, registration renewal, or reinstatement by fraud, deception, or misrepresentation, or aiding and abetting any of these acts;

(4) engaging in conduct with a client that is sexual or may reasonably be interpreted by the client as sexual, or in any verbal behavior that is seductive or sexually demeaning to a client, or engaging in sexual exploitation of a client, without regard to who initiates such behaviors;

(5) committing an act of gross malpractice, negligence, or incompetency, or failing to practice massage and bodywork therapy with the level of care, skill, and treatment that is recognized by a reasonably prudent massage and bodywork therapist as being acceptable under similar conditions and circumstances;

(6) having an actual or potential inability to practice massage and bodywork therapy with reasonable skill and safety to clients by reason of illness, as a result of any mental or physical condition, or use of alcohol, drugs, chemicals, or any other material. Being adjudicated as mentally incompetent, mentally ill, a chemically dependent person, or a person dangerous to the public by a court of competent jurisdiction, inside or outside of this state, may be considered as evidence of an inability to practice massage and bodywork therapy;

(7) being the subject of disciplinary action as a massage and bodywork therapist by another state or jurisdiction where the board or advisory council determines that the cause of the disciplinary action would be a violation under this state's statutes or rules of the board if the violation had occurred in this state;

(8) failing to notify the board of revocation or suspension of a credential, or any other disciplinary action taken by this or any other state, territory, or country, including any restrictions on the right to practice; or the surrender or voluntary termination of a credential during a board investigation of a complaint, as part of a disciplinary order, or while under a disciplinary order;

(9) conviction of a crime, including a finding or verdict of guilt, an admission of guilt, or a no-contest plea, in this state or elsewhere, reasonably related to engaging in massage and bodywork therapy practices. Conviction, as used in this clause, includes a conviction of an offense which, if committed in this state, would be deemed a felony, gross misdemeanor, or misdemeanor, without regard to its designation elsewhere, or a criminal proceeding where a finding or verdict of guilty is made or returned but the adjudication of guilt is either withheld or not entered;

(10) if a registrant is on probation, failing to abide by terms of that probation;

(11) practicing or offering to practice beyond the scope of the practice of massage and bodywork therapy;

(12) managing client records and information improperly, including, but not limited to failing to maintain adequate client records, comply with a client's request made according to sections 144.291 to 144.298, or furnish a client record or report required by law;

(13) revealing a privileged communication from or relating to a client except when otherwise required or permitted by law;

(14) providing massage and bodywork therapy services that are linked to the financial gain of a referral source;

(15) obtaining money, property, or services from a client, other than reasonable fees for services provided to the client, through the use of undue influence, harassment, duress, deception, or fraud;

(16) engaging in abusive or fraudulent billing practices, including violations of federal Medicare and Medicaid laws or state medical assistance laws;

(17) failing to consult with a client's health care provider who prescribed a course of massage and bodywork therapy treatment if the treatment needs to be altered from the original written order to conform with standards in the massage and bodywork therapy field or the registrant's level of training or experience;

(18) failing to cooperate with an investigation of the board or its representatives, including failing to respond fully and promptly to any question raised by or on behalf of the board relating to the subject of the investigation, failing to execute all releases requested by the board, failing to provide copies of client records, as reasonably requested by the board to assist in its investigation, and failing to appear at conferences or hearings scheduled by the board or its staff;

(19) interfering with an investigation or disciplinary proceeding, including by willful misrepresentation of facts or by the use of threats or harassment to prevent a person from providing evidence in a disciplinary proceeding or any legal action;

(20) violating a statute, rule, order, or agreement for corrective action that the board issued or is otherwise authorized or empowered to enforce;

(21) aiding or abetting a person in violating sections 148.982 to 148.9885;

(22) failing to report to the board other massage and bodywork therapists who commit violations of sections 148.982 to 148.9885; and

(23) failing to notify the board, in writing, of the entry of a final judgment by a court of competent jurisdiction against the registrant for malpractice of massage and bodywork therapy, or any settlement by the registrant in response to charges or allegations of malpractice of massage and bodywork therapy. The notice must be provided to the board within 60 days after the entry of a judgment, and must contain the name of the court, case number, and the names of all parties to the action.

Subd. 2. **Evidence.** In disciplinary actions alleging a violation of subdivision 1, a copy of the judgment or proceeding under the seal of the court administrator or of the administrative agency that entered the same shall be admissible into evidence without further authentication and shall constitute prima facie evidence of the violation.

Subd. 3. **Examination; access to medical data.** The board may take the actions described in section 148.261, subdivision 5, if it has probable cause to believe that grounds for disciplinary action exist under subdivision 1. The requirements and limitations described in section 148.261, subdivision 5, shall apply.

Sec. 38. **[148.9883] DISCIPLINE; REPORTING.**

For purposes of sections 148.982 to 148.9885, registered massage and bodywork therapists and applicants are subject to sections 148.262 to 148.266.

Sec. 39. **[148.9884] EFFECT ON MUNICIPAL ORDINANCES.**

Subdivision 1. **License authority.** The provisions of sections 148.982 to 148.9885 preempt the licensure and regulation of registered massage and bodywork therapists by a municipality, including, without limitation, conducting a criminal background investigation and examination of a massage and bodywork therapist or applicant for a municipality's credential to practice massage and bodywork therapy.

Subd. 2. **Municipal regulation.** Nothing in sections 148.982 to 148.9885 shall be construed to limit a municipality from:

(1) requiring a massage business establishment to obtain a business license or permit in order to transact business in the jurisdiction regardless of whether the massage business establishment is operated by a registered or unregistered massage and bodywork therapist;

(2) enforcing the provisions of health codes related to communicable diseases;

(3) requiring a criminal background check of any unregistered massage and bodywork therapist applying for a license to conduct massage and bodywork therapy in the municipality; and

(4) otherwise regulating massage business establishments by ordinance regardless of whether the massage business establishment is operated by a registered or unregistered massage and bodywork therapist.

Subd. 3. **Prosecuting authority.** A municipality may prosecute violations of sections 148.982 to 148.9885, a local ordinance, or any other law by a registered or unregistered massage and bodywork therapist in its jurisdiction.

Sec. 40. **[148.9885] FEES.**

Subdivision 1. **Fees.** Fees are as follows:

(1) initial registration with application fee must not exceed $285;

(2) annual registration renewal fee must not exceed $185;

(3) duplicate registration certificate, $15;

(4) late fee, $50;

(5) inactive status and inactive to active status reactivation, $50;

(6) temporary permit, $50; and

(7) returned check, $35.

Subd. 2. **Penalty fee for late renewals.** An application for registration renewal submitted after the deadline must be accompanied by a late fee in addition to the required fees.

Subd. 3. **Nonrefundable fees.** All of the fees in subdivision 1 are nonrefundable.

Subd. 4. **Deposit.** Fees collected by the board under this section shall be deposited into the state government special revenue fund.

Subd. 5. **Special assessment fee.** A special assessment fee not to exceed $85 shall be assessed annually upon registration renewal until the fee revenue equals the board's expenditures for registration activities under sections 148.982 to 148.9885.

ORTHODICS, PEDORTHICS, AND PROSTHETICS

Sec. 41. **[153B.10] SHORT TITLE.**

Chapter 153B may be cited as the "Minnesota Orthotist, Prosthetist, and Pedorthist Practice Act."

Sec. 42. **[153B.15] DEFINITIONS.**

Subdivision 1. **Application.** For purposes of this act, the following words have the meanings given.

Subd. 2. **Advisory council.** "Advisory council" means the Orthotics, Prosthetics, and Pedorthics Advisory Council established under section 153B.25.

Subd. 3. **Board.** "Board" means the Board of Podiatric Medicine.

Subd. 4. **Custom-fabricated device.** "Custom-fabricated device" means an orthosis, prosthesis, or pedorthic device for use by a patient that is fabricated to comprehensive measurements or a mold or patient model in accordance with a prescription and which requires on-site or in-person clinical and technical judgment in its design, fabrication, and fitting.

Subd. 5. **Licensed orthotic-prosthetic assistant.** "Licensed orthotic-prosthetic assistant" or "assistant" means a person, licensed by the board, who is educated and trained to participate in comprehensive orthotic and prosthetic care while under the supervision of a licensed orthotist or licensed prosthetist. Assistants may perform orthotic and prosthetic procedures and related tasks in the management of patient care. The assistant may fabricate, repair, and maintain orthoses and prostheses. The use of the title "orthotic-prosthetic assistant" or representations to the public is limited to a person who is licensed under this chapter as an orthotic-prosthetic assistant.

Subd. 6. **Licensed orthotic fitter.** "Licensed orthotic fitter" or "fitter" means a person licensed by the board who is educated and trained in providing certain orthoses,

and is trained to conduct patient assessments, formulate treatment plans, implement treatment plans, perform follow-up, and practice management pursuant to a prescription. An orthotic fitter must be competent to fit certain custom-fitted, prefabricated, and off-the-shelf orthoses as follows:

(1) cervical orthoses, except those used to treat an unstable cervical condition;

(2) prefabricated orthoses for the upper and lower extremities, except those used in:

(i) the initial or acute treatment of long bone fractures and dislocations;

(ii) therapeutic shoes and inserts needed as a result of diabetes; and

(iii) functional electrical stimulation orthoses;

(3) prefabricated spinal orthoses, except those used in the treatment of scoliosis or unstable spinal conditions, including halo cervical orthoses; and

(4) trusses.

The use of the title "orthotic fitter" or representations to the public is limited to a person who is licensed under this chapter as an orthotic fitter.

Subd. 7. **Licensed orthotist.** "Licensed orthotist" means a person licensed by the board who is educated and trained to practice orthotics, which includes managing comprehensive orthotic patient care pursuant to a prescription. The use of the title "orthotist" or representations to the public is limited to a person who is licensed under this chapter as an orthotist.

Subd. 8. **Licensed pedorthist.** "Licensed pedorthist" means a person licensed by the board who is educated and trained to manage comprehensive pedorthic patient care and who performs patient assessments, formulates and implements treatment plans, and performs follow-up and practice management pursuant to a prescription. A pedorthist may fit, fabricate, adjust, or modify devices within the scope of the pedorthist's education and training. Use of the title "pedorthist" or representations to the public is limited to a person who is licensed under this chapter as a pedorthist.

Subd. 9. **Licensed prosthetist.** "Licensed prosthetist" means a person licensed by the board who is educated and trained to manage comprehensive prosthetic patient care, and who performs patient assessments, formulates and implements treatment plans, and performs follow-up and practice management pursuant to a prescription. Use of the title "prosthetist" or representations to the public is limited to a person who is licensed under this chapter as a prosthetist.

Subd. 10. **Licensed prosthetist orthotist.** "Licensed prosthetist orthotist" means a person licensed by the board who is educated and trained to manage comprehensive prosthetic and orthotic patient care, and who performs patient assessments, formulates and implements treatment plans, and performs follow-up and practice management pursuant to

a prescription. Use of the title "prosthetist orthotist" or representations to the public is limited to a person who is licensed under this chapter as a prosthetist orthotist.

Subd. 11. **NCOPE.** "NCOPE" means National Commission on Orthotic and Prosthetic Education, an accreditation program that ensures educational institutions and residency programs meet the minimum standards of quality to prepare individuals to enter the orthotic, prosthetic, and pedorthic professions.

Subd. 12. **Orthosis.** "Orthosis" means an external device that is custom-fabricated or custom-fitted to a specific patient based on the patient's unique physical condition and is applied to a part of the body to help correct a deformity, provide support and protection, restrict motion, improve function, or relieve symptoms of a disease, syndrome, injury, or postoperative condition.

Subd. 13. **Orthotics.** "Orthotics" means the science and practice of evaluating, measuring, designing, fabricating, assembling, fitting, adjusting, or servicing an orthosis pursuant to a prescription. The practice of orthotics includes providing the initial training necessary for fitting an orthotic device for the support, correction, or alleviation of neuromuscular or musculoskeletal dysfunction, disease, injury, or deformity.

Subd. 14. **Over-the-counter.** "Over-the-counter" means a prefabricated, mass-produced item that is prepackaged, requires no professional advice or judgment in size selection or use, and is currently available at retail stores without a prescription. Over-the-counter items are not regulated by this act.

Subd. 15. **Off-the-shelf.** "Off-the-shelf" means a prefabricated device sized or modified for the patient's use pursuant to a prescription and which requires changes to be made by a qualified practitioner to achieve an individual fit, such as requiring the item to be trimmed, bent, or molded with or without heat, or requiring any other alterations beyond self adjustment.

Subd. 16. **Pedorthic device.** "Pedorthic device" means below-the-ankle partial foot prostheses for transmetatarsal and more distal amputations, foot orthoses, and subtalar-control foot orthoses to control the range of motion of the subtalar joint. A prescription is required for any pedorthic device, modification, or prefabricated below-the-knee orthosis addressing a medical condition that originates at the ankle or below. Pedorthic devices do not include nontherapeutic inlays or footwear regardless of method of manufacture; unmodified, nontherapeutic over-the-counter shoes; or prefabricated foot care products.

Subd. 17. **Pedorthics.** "Pedorthics" means the science and practice of evaluating, measuring, designing, fabricating, assembling, fitting, adjusting, or servicing a pedorthic device pursuant to a prescription for the correction or alleviation of neuromuscular or

musculoskeletal dysfunction, disease, injury, or deformity. The practice of pedorthics includes providing patient care and services pursuant to a prescription to prevent or ameliorate painful or disabling conditions of the foot and ankle.

Subd. 18. **Prescription.** "Prescription" means an order deemed medically necessary by a physician, podiatric physician, osteopathic physician, or a licensed health care provider who has authority in this state to prescribe orthotic and prosthetic devices, supplies, and services.

Subd. 19. **Prosthesis.** "Prosthesis" means a custom-designed, fabricated, fitted, or modified device to treat partial or total limb loss for purposes of restoring physiological function or cosmesis. Prosthesis does not include artificial eyes, ears, fingers, or toes; dental appliances; external breast prosthesis; or cosmetic devices that do not have a significant impact on the musculoskeletal functions of the body.

Subd. 20. **Prosthetics.** "Prosthetics" means the science and practice of evaluating, measuring, designing, fabricating, assembling, fitting, adjusting, or servicing a prosthesis pursuant to a prescription. It includes providing the initial training necessary to fit a prosthesis in order to replace external parts of a human body lost due to amputation, congenital deformities, or absence.

Subd. 21. **Resident.** "Resident" means a person who has completed a NCOPE-approved education program in orthotics or prosthetics and is receiving clinical training in a residency accredited by NCOPE.

Subd. 22. **Residency.** "Residency" means a minimum of an NCOPE-approved program to acquire practical clinical training in orthotics and prosthetics in a patient care setting.

Subd. 23. **Supervisor.** "Supervisor" means the licensed orthotist, prosthetist, or pedorthist who oversees and is responsible for the delivery of appropriate, effective, ethical, and safe orthotic, prosthetic, or pedorthic patient care.

Sec. 43. **[153B.20] EXCEPTIONS.**

Nothing in this chapter shall prohibit:

(1) a physician or podiatric physician licensed by the state of Minnesota from providing services within the physician's scope of practice;

(2) a health care professional licensed by the state of Minnesota, including, but not limited to, chiropractors, physical therapists, and occupational therapy practitioners from providing services within the professional's scope of practice, or an individual working under the supervision of a licensed physician or podiatric physician;

(3) the practice of orthotics, prosthetics, or pedorthics by a person who is employed by the federal government or any bureau, division, or agency of the federal government while in the discharge of the employee's official duties;

(4) the practice of orthotics, prosthetics, or pedorthics by:

(i) a student enrolled in an accredited or approved orthotics, prosthetics, or pedorthics education program who is performing activities required by the program;

(ii) a resident enrolled in an NCOPE-accredited residency program; or

(iii) a person working in a qualified, supervised work experience or internship who is obtaining the clinical experience necessary for licensure under this chapter; or

(5) an orthotist, prosthetist, prosthetist orthotist, pedorthist, assistant, or fitter who is licensed in another state or territory of the United States or in another country that has equivalent licensure requirements as approved by the board from providing services within the professional's scope of practice subject to this paragraph, if the individual is qualified and has applied for licensure under this chapter. The individual shall be allowed to practice for no longer than six months following the filing of the application for licensure, unless the individual withdraws the application for licensure or the board denies the license.

Sec. 44. **[153B.25] ORTHOTICS, PROSTHETICS, AND PEDORTHICS ADVISORY COUNCIL.**

Subdivision 1. **Creation; membership.** (a) There is established an Orthotics, Prosthetics, and Pedorthics Advisory Council which shall consist of seven voting members appointed by the board. Five members shall be licensed and practicing orthotists, prosthetists, or pedorthists. Each profession shall be represented on the advisory council. One member shall be a Minnesota-licensed doctor of podiatric medicine who is also a member of the Board of Podiatric Medicine, and one member shall be a public member.

(b) The council shall be organized and administered under section 15.059.

Subd. 2. **Duties.** The advisory council shall:

(1) advise the board on enforcement of the provisions contained in this chapter;

(2) review reports of investigations or complaints relating to individuals and make recommendations to the board as to whether a license should be denied or disciplinary action taken against an individual;

(3) advise the board regarding standards for licensure of professionals under this chapter; and

(4) perform other duties authorized for advisory councils by chapter 214, as directed by the board.

Subd. 3. **Chair.** The council must elect a chair from among its members.

Subd. 4. **Administrative provisions.** The Board of Podiatric Medicine must provide meeting space and administrative services for the council.

Sec. 45. **[153B.30] LICENSURE.**

Subdivision 1. **Application.** An application for a license shall be submitted to the board in the format required by the board and shall be accompanied by the required fee, which is nonrefundable.

Subd. 2. **Qualifications.** (a) To be eligible for licensure as an orthotist, prosthetist, or prosthetist orthotist, an applicant shall meet orthotist, prosthetist, or prosthetist orthotist certification requirements of either the American Board for Certification in Orthotics, Prosthetics, and Pedorthics or the Board of Certification/Accreditation requirements in effect at the time of the individual's application for licensure and be in good standing with the certifying board.

(b) To be eligible for licensure as a pedorthist, an applicant shall meet the pedorthist certification requirements of either the American Board for Certification in Orthotics, Prosthetics, and Pedorthics or the Board of Certification/Accreditation that are in effect at the time of the individual's application for licensure and be in good standing with the certifying board.

(c) To be eligible for licensure as an orthotic or prosthetic assistant, an applicant shall meet the orthotic or prosthetic assistant certification requirements of the American Board for Certification in Orthotics, Prosthetics, and Pedorthics that are in effect at the time of the individual's application for licensure and be in good standing with the certifying board.

(d) To be eligible for licensure as an orthotic fitter, an applicant shall meet the orthotic fitter certification requirements of either the American Board for Certification in Orthotics, Prosthetics, and Pedorthics or the Board of Certification/Accreditation that are in effect at the time of the individual's application for licensure and be in good standing with the certifying board.

Subd. 3. **License term.** A license to practice is valid for a term of up to 24 months beginning on January 1 or commencing after initially fulfilling the license requirements and ending on December 31 of the following year.

Sec. 46. **[153B.35] EMPLOYMENT BY AN ACCREDITED FACILITY; SCOPE OF PRACTICE.**

A licensed orthotist, prosthetist, pedorthist, assistant, or orthotic fitter may provide limited, supervised orthotic or prosthetic patient care services beyond their licensed scope of practice if all of the following conditions are met:

(1) the licensee is employed by a patient care facility that is accredited by a national accrediting organization in orthotics, prosthetics, and pedorthics;

(2) written objective criteria are documented by the accredited facility to describe the knowledge and skills required by the licensee to demonstrate competency to provide additional specific and limited orthotic or prosthetic patient care services that are outside the licensee's scope of practice;

(3) the licensee provides orthotic or prosthetic patient care only at the direction of a supervisor who is licensed as an orthotist, pedorthist, or prosthetist who is employed by the facility to provide the specific orthotic or prosthetic patient care or services that are outside the licensee's scope of practice; and

(4) the supervised orthotic or prosthetic patient care occurs in compliance with facility accreditation standards.

Sec. 47. **[153B.40] CONTINUING EDUCATION.**

Subdivision 1. **Requirement.** Each licensee shall obtain the number of continuing education hours required by the certifying board to maintain certification status pursuant to the specific license category.

Subd. 2. **Proof of attendance.** A licensee must submit to the board proof of attendance at approved continuing education programs during the license renewal period in which it was attended in the form of a certificate, statement of continuing education credits from the American Board for Certification in Orthotics, Prosthetics, and Pedorthics or the Board of Certification/Accreditation, descriptive receipt, or affidavit. The board may conduct random audits.

Subd. 3. **Extension of continuing education requirements.** For good cause, a licensee may apply to the board for a six-month extension of the deadline for obtaining the required number of continuing education credits. No more than two consecutive extensions may be granted. For purposes of this subdivision, "good cause" includes unforeseen hardships such as illness, family emergency, or military call-up.

Sec. 48. **[153B.45] LICENSE RENEWAL.**

Subdivision 1. **Submission of license renewal application.** A licensee must submit to the board a license renewal application on a form provided by the board together with the license renewal fee. The completed form must be postmarked no later than January 1 in the year of renewal. The form must be signed by the licensee in the place provided for the renewal applicant's signature, include evidence of participation in approved continuing education programs, and any other information as the board may reasonably require.

Subd. 2. **Renewal application postmarked after January 1.** A renewal application postmarked after January 1 in the renewal year shall be returned to the licensee for addition of the late renewal fee. A license renewal application postmarked after January 1 in the renewal year is not complete until the late renewal fee has been received by the board.

Subd. 3. **Failure to submit renewal application.** (a) At any time after January 1 of the applicable renewal year, the board shall send notice to a licensee who has failed to apply for license renewal. The notice shall be mailed to the licensee at the last address on file with the board and shall include the following information:

(1) that the licensee has failed to submit application for license renewal;

(2) the amount of renewal and late fees;

(3) information about continuing education that must be submitted in order for the license to be renewed;

(4) that the licensee must respond within 30 calendar days after the notice was sent by the board; and

(5) that the licensee may voluntarily terminate the license by notifying the board or may apply for license renewal by sending the board a completed renewal application, license renewal and late fees, and evidence of compliance with continuing education requirements.

(b) Failure by the licensee to notify the board of the licensee's intent to voluntarily terminate the license or to submit a license renewal application shall result in expiration of the license and termination of the right to practice. The expiration of the license and termination of the right to practice shall not be considered disciplinary action against the licensee.

(c) A license that has been expired under this subdivision may be reinstated.

Sec. 49. **[153B.50] NAME AND ADDRESS CHANGE.**

(a) A licensee who has changed names must notify the board in writing within 90 days and request a revised license. The board may require official documentation of the legal name change.

(b) A licensee must maintain with the board a correct mailing address to receive board communications and notices. A licensee who has changed addresses must notify the board in writing within 90 days. Mailing a notice by United States mail to a licensee's last known mailing address constitutes valid mailing.

Sec. 50. **[153B.55] INACTIVE STATUS.**

(a) A licensee who notifies the board in the format required by the board may elect to place the licensee's credential on inactive status and shall be excused from payment of renewal fees until the licensee notifies the board in the format required by the board of the licensee's plan to return to practice.

(b) A person requesting restoration from inactive status shall be required to pay the current renewal fee and comply with section 153B.45.

(c) A person whose license has been placed on inactive status shall not practice in this state.

Sec. 51. **[153B.60] LICENSE LAPSE DUE TO MILITARY SERVICE.**

A licensee whose license has expired while on active duty in the armed forces of the United States, with the National Guard while called into service or training, or while in training or education preliminary to induction into military service may have the licensee's license renewed or restored without paying a late fee or license restoration fee if the licensee provides verification to the board within two years of the termination of service obligation.

Sec. 52. **[153B.65] ENDORSEMENT.**

The board may license, without examination and on payment of the required fee, an applicant who is an orthotist, prosthetist, prosthetist orthotist, pedorthist, assistant, or fitter who is certified by the American Board for Certification in Orthotics, Prosthetics, and Pedorthics or a national certification organization with educational, experiential, and testing standards equal to or higher than the licensing requirements in Minnesota.

Sec. 53. **[153B.70] GROUNDS FOR DISCIPLINARY ACTION.**

(a) The board may refuse to issue or renew a license, revoke or suspend a license, or place on probation or reprimand a licensee for one or any combination of the following:

(1) making a material misstatement in furnishing information to the board;

(2) violating or intentionally disregarding the requirements of this chapter;

(3) conviction of a crime, including a finding or verdict of guilt, an admission of guilt, or a no-contest plea, in this state or elsewhere, reasonably related to the practice of the profession. Conviction, as used in this clause, includes a conviction of an offense which, if committed in this state, would be deemed a felony, gross misdemeanor, or misdemeanor, without regard to its designation elsewhere, or a criminal proceeding where a finding or verdict of guilty is made or returned but the adjudication of guilt is either withheld or not entered;

(4) making a misrepresentation in order to obtain or renew a license;

(5) displaying a pattern of practice or other behavior that demonstrates incapacity or incompetence to practice;

(6) aiding or assisting another person in violating the provisions of this chapter;

(7) failing to provide information within 60 days in response to a written request from the board, including documentation of completion of continuing education requirements;

(8) engaging in dishonorable, unethical, or unprofessional conduct;

(9) engaging in conduct of a character likely to deceive, defraud, or harm the public;

(10) inability to practice due to habitual intoxication, addiction to drugs, or mental or physical illness;

(11) being disciplined by another state or territory of the United States, the federal government, a national certification organization, or foreign nation, if at least one of the grounds for the discipline is the same or substantially equivalent to one of the grounds in this section;

(12) directly or indirectly giving to or receiving from a person, firm, corporation, partnership, or association a fee, commission, rebate, or other form of compensation for professional services not actually or personally rendered;

(13) incurring a finding by the board that the licensee, after the licensee has been placed on probationary status, has violated the conditions of the probation;

(14) abandoning a patient or client;

(15) willfully making or filing false records or reports in the course of the licensee's practice including, but not limited to, false records or reports filed with state or federal agencies;

(16) willfully failing to report child maltreatment as required under the Maltreatment of Minors Act, section 626.556; or

(17) soliciting professional services using false or misleading advertising.

(b) A license to practice is automatically suspended if (1) a guardian of a licensee is appointed by order of a court pursuant to sections 524.5-101 to 524.5-502, for reasons other than the minority of the licensee, or (2) the licensee is committed by order of a court pursuant to chapter 253B. The license remains suspended until the licensee is restored to capacity by a court and, upon petition by the licensee, the suspension is terminated by the board after a hearing. The licensee may be reinstated to practice, either with or without restrictions, by demonstrating clear and convincing evidence of rehabilitation. The regulated person is not required to prove rehabilitation if the subsequent court decision overturns previous court findings of public risk.

(c) If the board has probable cause to believe that a licensee or applicant has violated paragraph (a), clause (10), it may direct the person to submit to a mental or physical

examination. For the purpose of this section, every person is deemed to have consented to submit to a mental or physical examination when directed in writing by the board and to have waived all objections to the admissibility of the examining physician's testimony or examination report on the grounds that the testimony or report constitutes a privileged communication. Failure of a regulated person to submit to an examination when directed constitutes an admission of the allegations against the person, unless the failure was due to circumstances beyond the person's control, in which case a default and final order may be entered without the taking of testimony or presentation of evidence. A regulated person affected under this paragraph shall at reasonable intervals be given an opportunity to demonstrate that the person can resume the competent practice of the regulated profession with reasonable skill and safety to the public. In any proceeding under this paragraph, neither the record of proceedings nor the orders entered by the board shall be used against a regulated person in any other proceeding.

(d) In addition to ordering a physical or mental examination, the board may, notwithstanding section 13.384 or 144.293, or any other law limiting access to medical or other health data, obtain medical data and health records relating to a licensee or applicant without the person's or applicant's consent if the board has probable cause to believe that a licensee is subject to paragraph (a), clause (10). The medical data may be requested from a provider as defined in section 144.291, subdivision 2, paragraph (i), an insurance company, or a government agency, including the Department of Human Services. A provider, insurance company, or government agency shall comply with any written request of the board under this subdivision and is not liable in any action for damages for releasing the data requested by the board if the data are released pursuant to a written request under this subdivision, unless the information is false and the provider giving the information knew, or had reason to know, the information was false. Information obtained under this subdivision is private data on individuals as defined in section 13.02.

(e) If the board issues an order of immediate suspension of a license, a hearing must be held within 30 days of the suspension and completed without delay.

Sec. 54. **[153B.75] INVESTIGATION; NOTICE AND HEARINGS.**

The board has the authority to investigate alleged violations of this chapter, conduct hearings, and impose corrective or disciplinary action as provided in section 214.103.

Sec. 55. **[153B.80] UNLICENSED PRACTICE.**

Subdivision 1. **License required.** Effective January 1, 2018, no individual shall practice as an orthotist, prosthetist, prosthetist orthotist, pedorthist, orthotic or prosthetic

assistant, or orthotic fitter, unless the individual holds a valid license issued by the board under this chapter, except as permitted under section 153B.20 or 153B.35.

Subd. 2. **Designation.** No individual shall represent themselves to the public as a licensed orthotist, prosthetist, prosthetist orthotist, pedorthist, orthotic or prosthetic assistant, or an orthotic fitter, unless the individual is licensed under this chapter.

Subd. 3. **Penalties.** Any individual who violates this section is guilty of a misdemeanor. The board shall have the authority to seek a cease and desist order against any individual who is engaged in the unlicensed practice of a profession regulated by the board under this chapter.

Sec. 56. **[153B.85] FEES.**

Subdivision 1. **Fees.** (a) The application fee for initial licensure shall not exceed $600.

(b) The biennial renewal fee for a license to practice as an orthotist, prosthetist, prosthetist orthotist, or pedorthist shall not exceed $600.

(c) The biennial renewal fee for a license to practice as an assistant or a fitter shall not exceed $300.

(d) The fee for license restoration shall not exceed $600.

(e) The fee for license verification shall not exceed $30.

(f) The fee to obtain a list of licensees shall not exceed $25.

Subd. 2. **Proration of fees.** For the first renewal period following initial licensure, the renewal fee is the fee specified in subdivision 1, paragraph (b) or (c), prorated to the nearest dollar that is represented by the ratio of the number of days the license is held in the initial licensure period to 730 days.

Subd. 3. **Late fee.** The fee for late license renewal is the license renewal fee in effect at the time of renewal plus $100.

Subd. 4. **Nonrefundable fees.** All fees are nonrefundable.

Subd. 5. **Deposit.** Fees collected by the board under this section shall be deposited in the state government special revenue fund.

Sec. 57. Minnesota Statutes 2014, section 214.075, subdivision 3, is amended to read:

Subd. 3. **Consent form; fees; fingerprints.** (a) In order to effectuate the federal and state level, fingerprint-based criminal background check, the applicant or licensee must submit a completed criminal history records check consent form and a full set of fingerprints to the respective health-related licensing board or a designee in the manner and form specified by the board.

(b) The applicant or licensee is responsible for all fees associated with preparation of the fingerprints, the criminal records check consent form, and the criminal background check. The fees for the criminal records background check shall be set by the BCA and the FBI and are not refundable. The fees shall be submitted to the respective health-related licensing board by the applicant or licensee as prescribed by the respective board.

(c) All fees received by the health-related licensing boards under this subdivision shall be deposited in ~~a~~ dedicated ~~account~~ accounts in the special revenue fund and are appropriated to ~~the Board of Nursing Home Administrators for the administrative services unit~~ health-related licensing boards to pay for the criminal background checks conducted by the Bureau of Criminal Apprehension and Federal Bureau of Investigation.

Sec. 58. Minnesota Statutes 2015 Supplement, section 256B.0625, subdivision 18a, is amended to read:

Subd. 18a. **Access to medical services.** (a) Medical assistance reimbursement for meals for persons traveling to receive medical care may not exceed $5.50 for breakfast, $6.50 for lunch, or $8 for dinner.

(b) Medical assistance reimbursement for lodging for persons traveling to receive medical care may not exceed $50 per day unless prior authorized by the local agency.

(c) Regardless of the number of employees that an enrolled health care provider may have, medical assistance covers sign and ~~oral~~ spoken language health care interpreter services when provided by an enrolled health care provider during the course of providing a direct, person-to-person covered health care service to an enrolled recipient with limited English proficiency or who has a hearing loss and uses interpreting services. Coverage for ~~face-to-face oral language~~ spoken language health care interpreter services shall be provided only if the ~~oral language~~ spoken language health care interpreter used by the enrolled health care provider is listed ~~in~~ on the ~~registry or~~ roster established under section 144.058 or the registry established under chapter 146C. Beginning July 1, 2018, coverage for spoken language health care interpreter services shall be provided only if the spoken language health care interpreter used by the enrolled health care provider is listed on the registry established under chapter 146C.

Sec. 59. **[325F.816] MUNICIPAL OR CITY BUSINESS LICENSE; MASSAGE.**

An individual who is issued a municipal or city business license to practice massage is prohibited from advertising as a licensed massage and bodywork therapist unless the individual has received a professional credential from another state, is current in licensure, and remains in good standing under the credentialing state's requirements.

Sec. 60. **FIRST APPOINTMENTS, FIRST MEETING, AND FIRST CHAIR OF THE ORTHOTICS, PROSTHETICS, AND PEDORTHICS ADVISORY COUNCIL.**

The Board of Podiatric Medicine shall make its first appointments authorized under Minnesota Statutes, section 153B.25, to the Orthotics, Prosthetics, and Pedorthics Advisory Council, by September 1, 2016. The board shall designate four of its first appointees to serve terms that are coterminous with the governor. The chair of the Board of Podiatric Medicine or the chair's designee shall convene the first meeting of the council by November 1, 2016. The council must elect a chair from among its members at the first meeting of the council.

Sec. 61. **INITIAL APPOINTMENTS, TERMS, AND MEETING.**

The Minnesota Board of Nursing shall make initial appointments to the Registered Massage and Bodywork Therapist Advisory Council under Minnesota Statutes, section 148.9861, by October 1, 2016, and shall designate one member to call the first meeting of the advisory council by November 15, 2016. The terms of the initial members appointed under Minnesota Statutes, section 148.9861, subdivision 1, clause (1), shall end the first Monday in January 2019. The terms of the initial members appointed under Minnesota Statutes, section 148.9861, subdivision 1, clause (2), shall end the first Monday in January 2020.

Sec. 62. **STAKEHOLDER ENGAGEMENT.**

The commissioner of health shall work with community stakeholders in Minnesota including, but not limited to, the Minnesota Breastfeeding Coalition; the women, infants, and children program; hospitals and clinics; local public health professionals and organizations; community-based organizations; and representatives of populations with low breastfeeding rates to carry out a study identifying barriers, challenges, and successes affecting initiation, duration, and exclusivity of breastfeeding. The study shall address policy, systemic, and environmental factors that both support and create barriers to breastfeeding. These factors include, but are not limited to, issues such as levels of practice and barriers such as education, clinical experience, and cost to those seeking certification as an International Board-Certified Lactation Consultant. The study shall identify and make recommendations regarding culturally appropriate practices that have been shown to increase breastfeeding rates in populations that have the greatest breastfeeding disparity rates. A report on the study must be completed and submitted to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance on or before September 15, 2017.

Sec. 63. **INITIAL SPOKEN LANGUAGE HEALTH CARE ADVISORY COUNCIL MEETING.**

The commissioner of health shall convene the first meeting of the Spoken Language Health Care Advisory Council by October 1, 2016.

Sec. 64. **SPOKEN LANGUAGE HEALTH CARE INTERPRETER REGISTRY FEES.**

Notwithstanding Minnesota Statutes, section 148.9987, paragraph (a), the initial and renewal fees for interpreters listed on the spoken language health care registry shall be $50 between the period of July 1, 2017, through June 30, 2018, and shall be $70 between the period of July 1, 2018, through June 30, 2019. Beginning July 1, 2019, the fees shall be in accordance with Minnesota Statutes, section 148.9987.

Sec. 65. **STRATIFIED MEDICAL ASSISTANCE REIMBURSEMENT SYSTEM FOR SPOKEN LANGUAGE HEALTH CARE INTERPRETERS.**

(a) The commissioner of human services, in consultation with the commissioner of health, the Spoken Language Health Care Interpreter Advisory Council established under Minnesota Statutes, section 148.9986, and representatives from the interpreting stakeholder community at large, shall study and make recommendations for creating a tiered reimbursement system for the Minnesota public health care programs for spoken language health care interpreters based on the different tiers of the spoken language health care interpreters registry established by the commissioner of health under Minnesota Statutes, sections 148.9981 to 148.9987.

(b) The commissioner of human services shall submit the proposed reimbursement system, including the fiscal costs for the proposed system to the chairs and ranking minority members of the house of representatives and senate committees with jurisdiction over health and human services policy and finance by January 15, 2017.

(c) The commissioner of health, in consultation with the Spoken Language Health Care Interpreter Advisory Council, shall review the fees established under Minnesota Statutes, section 148.9987, and make recommendations based on the results of the study and recommendations under paragraph (a) whether the fees are established at an appropriate level, including whether specific fees should be established for each tier of the registry instead of one uniform fee for all tiers. The total fees collected must be sufficient to recover the costs of the spoken language health care registry. If the commissioner recommends different fees for the tiers, the commissioner shall submit the proposed fees

to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by January 15, 2018.

Sec. 66. **REPEALER.**

Minnesota Statutes 2014, section 144.058, is repealed effective July 1, 2018.

ARTICLE 8

HUMAN SERVICES FORECAST ADJUSTMENTS

Section 1. **HUMAN SERVICES APPROPRIATION.**

The sums shown in the columns marked "Appropriations" are added to or, if shown in parentheses, are subtracted from the appropriations in Laws 2015, chapter 71, article 13, from the general fund or any fund named to the Department of Human Services for the purposes specified in this article, to be available for the fiscal year 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 years 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**	**$ (615,912,000)**	**$ (518,891,000)**
Appropriations by Fund		
General Fund	(307,806,000)	(246,029,000)
Health Care Access Fund	(289,770,000)	(277,101,000)
Federal TANF	(18,336,000)	4,239,000
Subd. 2. **Forecasted Programs**		
(a) **MFIP/DWP**		
Appropriations by Fund		
General Fund	9,833,000	(8,799,000)
Federal TANF	(20,225,000)	4,212,000
(b) **MFIP Child Care Assistance**	(23,094,000)	(7,760,000)

(c) **General Assistance**	(2,120,000)	(1,078,000)
(d) **Minnesota Supplemental Aid**	(1,613,000)	(1,650,000)
(e) **Group Residential Housing**	(8,101,000)	(7,954,000)
(f) **Northstar Care for Children**	2,231,000	4,496,000
(g) **MinnesotaCare**	(227,821,000)	(230,027,000)

These appropriations are from the health care access fund.

(h) **Medical Assistance**

	Appropriations by Fund	
General Fund	(294,773,000)	(243,700,000)
Health Care Access Fund	(61,949,000)	(47,074,000)

(i) **Alternative Care Program**	-0-	-0-
(j) **CCDTF Entitlements**	9,831,000	20,416,000
Subd. 3. **Technical Activities**	1,889,000	27,000

These appropriations are from the federal TANF fund.

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

ARTICLE 9

HEALTH AND HUMAN SERVICES APPROPRIATIONS

Section 1. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are added to or, if shown in parentheses, subtracted from the appropriations in Laws 2015, chapter 71, article 14, to the agencies and for the purposes specified in this act. The appropriations are from the general fund or other named fund and are available for the fiscal years indicated for each purpose. The figures "2016" and "2017" used in this act mean that the addition to or subtraction from the appropriation listed under them is available for the fiscal year ending June 30, 2016, or June 30, 2017, respectively. Supplemental appropriations and reductions to appropriations for the fiscal year ending June 30, 2016, are effective the day following final enactment unless a different effective date is explicit.

		APPROPRIATIONS Available for the Year Ending June 30	
		2016	2017
Sec. 2. **COMMISSIONER OF HUMAN SERVICES**			
Subdivision 1. **Total Appropriation**		**$ -0-**	**$ 121,798,000**
Appropriations by Fund			
	2016		2017
General		-0-	122,115,000
State Government Special Revenue		-0-	(3,684,000)
Health Care Access		-0-	3,367,000
Subd. 2. **Central Office Operations**			
(a) **Operations**			
Appropriations by Fund			
General		-0-	34,000
State Government Special Revenue		-0-	(3,709,000)
Health Care Access		-0-	432,000

Payments for Timely Administration of Criminal Proceedings. $200,000 in fiscal year 2017 is for the timely administration of criminal proceedings involving clients and patients in the Minnesota sex offender program and the state-operated forensic services. In fiscal year 2017 and each fiscal year thereafter, up to $50,000 shall be paid to Carlton County, up to $50,000 shall be paid to Nicollet County, up to $50,000 shall be paid to the Sixth Judicial District Public Defender's Office, and up to $50,000 shall be paid to the Fifth District Public Defender's Office. The commissioner shall monitor the payments at least quarterly. If the commissioner determines that an entity will not spend all of its allocation before

the end of the fiscal year, the commissioner shall reallocate any unspent dollars to an entity or entities that had an insufficient allocation. By January 15 of each year, the commissioner shall report to the chairs and ranking minority members of the house of representatives and senate health and human services finance committees the amount of unspent funds during the previous fiscal year. The commissioner shall not use funds appropriated for administrative costs.

Request for Information. $165,000 is for transfer to the commissioner of management and budget to develop a request for information on a privatized state-based marketplace model.

Base Adjustment. The general fund base is decreased by $767,000 in fiscal year 2018 and $848,000 in fiscal year 2019. The health care access fund base is increased by $905,000 in fiscal year 2018 and $468,000 in fiscal year 2019.

(b) **Children and Families** -0- 132,000

Base Adjustment. The general fund base is decreased by $132,000 in fiscal years 2018 and 2019.

(c) **Health Care**

Appropriations by Fund		
General	-0-	1,186,000
State Government Special Revenue	-0-	25,000
Health Care Access	-0-	550,000

Spoken Language Health Care Interpreters Reimbursement System Study. $25,000 is from the state government

special revenue fund to study and submit a proposed stratified medical assistance reimbursement system for spoken language health care interpreters. This is a onetime appropriation.

Base Adjustment. The general fund base is decreased by $187,000 in fiscal year 2018 and $187,000 in fiscal year 2019. The state government special revenue fund base is decreased by $25,000 in fiscal year 2018 and $25,000 in fiscal year 2019. The health care access fund base is increased by $2,948,000 in fiscal year 2018 and $2,991,000 in fiscal year 2019.

(d) **Continuing Care**	-0-	534,000

Study of Home and Community-Based Services Workforce. $414,000 in fiscal year 2017 is to complete a study of home and community-based services workforce and its impact on service access. In addition to the data collected under Minnesota Statutes, section 256B.4912, subdivision 11, the commissioner may also use surveys or other methods to complete this study. On January 1, 2018, the commissioner shall report the findings of the study, including recommendations on how to address access to services, and recommendations on a higher reimbursement rate for staff providing services to individuals with higher home care ratings, case mixes, or levels of care, to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance and labor and industry. The general fund

base for this appropriation is $621,000 in fiscal year 2018 and zero in fiscal year 2019.

Base Adjustment. The general fund base is increased by $447,000 in fiscal year 2018 and decreased by $174,000 in fiscal year 2019.

(e) **Community Supports** -0- 134,000

Base Adjustment. The general fund base is increased by $469,000 in fiscal year 2018 and $429,000 in fiscal year 2019.

Subd. 3. **Forecasted Programs**

(a) **MFIP Child Care Assistance** -0- 4,973,000

(b) **Northstar Care for Children** -0- 8,802,000

(c) **MinnesotaCare** -0- 2,108,000

This appropriation is from the health care access fund.

(d) **Medical Assistance**

Appropriations by Fund		
General	-0-	34,004,000
Health Care Access	-0-	277,000

(e) **Consolidated Chemical Dependency Treatment Fund** -0- 5,897,000

CCDTF Transfer. In fiscal year 2017, the commissioner shall transfer $2,000,000 from the consolidated chemical dependency treatment fund administrative account in the special revenue fund to the general fund. This is a onetime transfer.

Subd. 4. **Grant Programs**

(a) **BSF Child Care Assistance Grants** -0- 3,137,000

Base Adjustment. The general fund base is increased by $4,258,000 in fiscal year 2018 and $4,258,000 in fiscal year 2019.

(b) **Child Care Development Grants** -0- 1,500,000

Increased Access to Affordable Child Care in Greater Minnesota. $1,500,000 in fiscal year 2017 is from the general fund for grants of $250,000 to each of the six Minnesota Initiative Foundations to increase access to affordable child care in greater Minnesota. Grant funds may be used to increase child care provider training and professional development; support legal nonlicensed family, friend, and neighbor child care providers; provide potential and current child care providers with licensing, financial, and technical assistance; help child care providers become rated under the Parent Aware quality rating system; and strengthen local capacity and increase the availability of affordable high-quality child care in each region. This is a onetime appropriation.

Base Adjustment. The general fund base is decreased by $1,500,000 in fiscal year 2018 and $1,500,000 in fiscal year 2019.

(c) **Children's Services Grants** -0- 1,860,000

American Indian Child Welfare Initiative. $800,000 in fiscal year 2017 is for planning efforts to expand the American Indian Child Welfare Initiative authorized under Minnesota Statutes, section 256.01, subdivision 14b. Of this appropriation, $400,000 is for grants to the Mille Lacs Band of Ojibwe and $400,000 is for grants to the Red Lake Nation. This is a onetime appropriation.

Base Adjustment. The general fund base is decreased by $860,000 in fiscal year 2018 and $860,000 in fiscal year 2019.

(d) **Child and Community Service Grants** -0- 1,900,000

White Earth Band of Ojibwe Human Services Initiative Project. $1,400,000 in fiscal year 2017 is for a grant to the White Earth Band of Ojibwe for the direct implementation and administrative costs of the White Earth Human Service Initiative Project authorized under Laws 2011, First Special Session chapter 9, article 9, section 18.

Red Lake Nation Human Services Initiative Project. $500,000 in fiscal year 2017 is for a grant to the Red Lake Nation for the direct implementation and administrative costs of the Red Lake Human Service Initiative Project authorized under Minnesota Statutes, section 256.01, subdivision 2, paragraph (a), clause (7).

(e) **Child and Economic Support Grants** -0- 1,500,000

Safe Harbor for Sexually Exploited Youth. $500,000 in fiscal year 2017 is for emergency shelter and transitional and long-term housing beds for sexually exploited youth and youth at risk of sexual exploitation. The base for this appropriation is $625,000 in fiscal year 2018 and $625,000 in fiscal year 2019. The commissioner shall not use any portion of this appropriation nor of the base amounts in fiscal year 2018 and fiscal year 2019 for administrative costs.

Crisis Nursery Services. $60,000 in fiscal year 2017 is for a grant to an organization

in Minneapolis that provides free, voluntary crisis nursery services for families in crisis 24 hours per day, 365 days per year; crisis counseling; overnight residential child care; a 24-hour crisis hotline; and parent education to provide a trauma-informed continuum of care for families living in poverty, to continue efforts to prevent child abuse and neglect, and to develop practices that can be shared with organizations around the state to reduce child abuse and neglect. This is a onetime appropriation and is available until June 30, 2019.

Base Level Adjustment. The general fund base is increased by $375,000 in fiscal year 2018 and $375,000 in fiscal year 2019.

(f) **Adult Mental Health Grants** -0- 200,000

Adult Mental Illness Crisis Housing Assistance Program. The general fund appropriation for the adult mental illness crisis housing assistance program is decreased by $300,000 in fiscal year 2017. The general fund appropriation is increased by $300,000 in fiscal year 2017 for expanding eligibility to include persons with serious mental illness under Minnesota Statutes, section 245.99, subdivision 2.

Integrated Behavioral Health Care Coordination Demonstration Project. $200,000 in fiscal year 2017 is for a grant to the Zumbro Valley Health Center. The grant shall be used to continue a pilot project to test an integrated behavioral health care coordination model. The grant recipient must report measurable outcomes

to the commissioner of human services by December 1, 2018. This is a onetime appropriation and is available until June 30, 2018.

Base Adjustment. The general fund base is decreased by $200,000 in fiscal year 2018 and is decreased by $200,000 in fiscal year 2019.

(g) **Child Mental Health Grants** -0- 2,500,000

Child and Adolescent Behavioral Health Services Grant. The child mental health grants base includes $1,500,000 in fiscal year 2018 and $1,500,000 in fiscal year 2019 for children's mental health grants to sustain extended-stay inpatient psychiatric hospital services for children and adolescents under Minnesota Statutes, section 245.4889, subdivision 1, paragraph (a), clause (17).

School-Linked Mental Health Grants. $1,500,000 in fiscal year 2017 is for children's mental health grants under Minnesota Statutes, section 245.4889, subdivision 1, paragraph (b), clause (8), for current grantees to expand services to school buildings, school districts, or counties that do not have school-linked mental health available, and to provide training to grantees on the use of evidence-based practices. The general fund base for this appropriation is $2,250,000 in fiscal year 2018 and $2,250,000 in fiscal year 2019. The amount in fiscal year 2019 shall be awarded through a competitive process open to all eligible grantees as part of a new grant cycle. This appropriation does not include additional administrative money.

Children's Mental Health Collaboratives; Youth and Young Adult Mental Health Demonstration Project. $1,000,000 in fiscal year 2017 is for a grant to a children's mental health collaborative under Minnesota Statutes, section 245.493, that serves Kandiyohi, Meeker, Renville, and Yellow Medicine Counties for a rural demonstration project to assist transition-aged youth and young adults with emotional behavioral disturbance (EBD) or mental illnesses in making a successful transition into adulthood. This is a onetime appropriation and is available until June 30, 2019.

Base Adjustment. The general fund base is increased by $1,250,000 in fiscal years 2018 and 2019.

Subd. 5. **DCT State-Operated Services**

(a) **DCT State-Operated Services Mental Health**	-0-	30,942,000

Restore Funds Transferred to Minnesota State-Operated Community Services. $14,000,000 in fiscal year 2017 is to restore funds transferred to the enterprise fund for state-operated community services in fiscal year 2016. This is a onetime appropriation.

Community Behavioral Health Hospitals Full Capacity Staffing. $13,723,000 in fiscal year 2017 is to increase staffing to a level sufficient to operate the community behavioral health hospitals at full licensed capacity. The base for this appropriation is $16,450,000 in fiscal year 2018 and $16,450,000 in fiscal year 2019.

Anoka Metro Regional Treatment Center Nursing Float Pool. $788,000 in fiscal year 2017 is for a nursing float pool for weekend coverage at the Anoka Metro Regional Treatment Center. The base for this appropriation is $1,526,000 in fiscal year 2018 and $1,526,000 in fiscal year 2019.

Anoka Metro Regional Treatment Center Increased Clinical Oversight. $336,000 in fiscal year 2017 is for increased clinical oversight at the Anoka Metro Regional Treatment Center. The base for this appropriation is $632,000 in fiscal year 2018 and $632,000 in fiscal year 2019.

Child and Adolescent Behavioral Health Services Closure. The child and adolescent behavioral health services program in Willmar shall discontinue operations no later than June 30, 2017.

Base Adjustment. The general fund base is decreased by $12,852,000 in fiscal year 2018 and $13,715,000 in fiscal year 2019.

(b) **DCT State-Operated Services Minnesota Security Hospital**		-0-	17,754,000

Competency Restoration Program. $6,296,000 in fiscal year 2017 is for the development of a new residential competency restoration program to be operated by state-operated forensic services. The commissioner shall use this appropriation to make available 20 hospital beds at Anoka Metro Regional Treatment Center and 12 secure beds at the Minnesota Security Hospital.

Base Adjustment. The general fund base is increased by $3,169,000 in fiscal year 2018 and $3,169,000 in fiscal year 2019.

Subd. 6. **DCT Minnesota Sex Offender Program** -0- 5,126,000

Base Adjustment. The general fund base is decreased by $2,625,000 in fiscal year 2018 and $2,625,000 in fiscal year 2019.

Sec. 3. **COMMISSIONER OF HEALTH**

Subdivision 1. **Total Appropriation** **$** **-0-** **$** **4,709,000**

Appropriations by Fund

	2016	2017
General	-0-	1,291,000
State Government Special Revenue	-0-	873,000
Health Care Access	-0-	2,545,000

The appropriations for each purpose are shown in the following subdivisions.

Subd. 2. **Health Improvement**

Appropriations by Fund

General	-0-	1,067,000
Health Care Access	-0-	2,545,000

Medical Cannabis Patient Registry. $50,000 in fiscal year 2017 is from the general fund for updates to the medical cannabis patient registry. This is a onetime appropriation.

Health Care System Study. $500,000 in fiscal year 2017 is from the health care access fund for a health care system study. This is a onetime appropriation and is available until June 30, 2018.

Safe Harbor for Sexually Exploited Youth. $500,000 in fiscal year 2017 is from the general fund for trauma-informed, culturally

specific services for exploited youth. The base for this appropriation is $625,000 in fiscal year 2018 and $625,000 in fiscal year 2019. Neither the appropriation in fiscal year 2017 nor the base amounts in fiscal years 2018 and 2019 may be used for administration.

Greater Minnesota Family Medicine Residency. $1,035,000 in fiscal year 2017 is from the health care access fund for the greater Minnesota family medicine residency grant program under Minnesota Statutes, section 144.1912. The commissioner may use up to $35,000 for administration.

Health Care Grants for Uninsured Individuals. (a) $50,000 in fiscal year 2017 is from the health care access fund for dental provider grants in Minnesota Statutes, section 145.929, subdivision 1.

(b) $175,000 in fiscal year 2017 is from the health care access fund for community mental health program grants in Minnesota Statutes, section 145.929, subdivision 2.

(c) $600,000 in fiscal year 2017 is from the health care access fund for the emergency medical assistance outlier grant program in Minnesota Statutes, section 145.929, subdivision 3.

(d) $175,000 in fiscal year 2017 is from the health care access fund for community health center grants under Minnesota Statutes, section 145.9269. A community health center that receives a grant from this appropriation is not eligible for a grant under paragraph (b).

Statewide School-Based Sealant Grant Program. $517,000 in fiscal year 2017 is from the general fund to implement the statewide school-based sealant program under Minnesota Statutes, section 144.0615. The base for this appropriation is $615,000 in fiscal year 2018 and $717,000 in fiscal year 2019.

Base Adjustment for Early Dental Prevention Initiative. The general fund base for the early dental prevention initiative is increased by $64,000 in fiscal year 2018 and $64,000 in fiscal year 2019. The commissioner shall not use any portion of this base increase for administration. This paragraph does not expire.

Base-Level Adjustments. The general fund base is increased by $237,000 in fiscal year 2018 and $339,000 in fiscal year 2019. The health care access fund base is decreased by $510,000 in fiscal year 2018 and $510,000 in fiscal year 2019.

Subd. 3. **Health Protection**

Appropriations by Fund		
General	-0-	224,000
State Government Special Revenue	-0-	873,000

Drinking Water Revolving Fund. $230,000 in fiscal year 2017 is from the general fund for administration of the drinking water revolving fund.

Quality of Care Complaints. $180,000 in fiscal year 2017 is from the state government special revenue fund for managed care organization quality of care

complaint investigations. This is a onetime appropriation.

Spoken Language Health Care Interpreter Registry. $358,000 is from the state government special revenue fund for the spoken language health care interpreter registry and registration activities under Minnesota Statutes, chapter 146C. Of this amount, $280,000 is for onetime start-up costs for the registry and is available until June 30, 2019. The base for this appropriation is $241,000 in fiscal year 2018 and $156,000 in fiscal year 2019.

Clinical Lactation Services Licensing. $174,000 in fiscal year 2017 is from the state government special revenue fund for clinical lactation services licensure activities under Minnesota Statutes, sections 148.9801 to 148.9812. The base for this appropriation is $54,000 in fiscal year 2018 and $54,000 in fiscal year 2019.

Base Level Adjustment. The state government special revenue fund base is decreased by $636,000 in fiscal year 2018 and $658,000 in fiscal year 2019.

Sec. 4. **HEALTH-RELATED BOARDS**

Subdivision 1. **Total Appropriation**	**$ 195,000**	**$ 609,000**
This appropriation is from the state government special revenue fund.		
Subd. 2. **Board of Dentistry**	(850,000)	(864,000)
Subd. 3. **Board of Marriage and Family Therapy**	40,000	50,000
Subd. 4. **Board of Medical Practice**	-0-	22,000

Genetic Counselor Licensing. $22,000 in fiscal year 2017 is from the state government special revenue fund for genetic counselor licensure activities under Minnesota Statutes, chapter 147F.

Subd. 5. **Board of Nursing**	-0-	257,000

Massage and Bodywork Therapist Registration. $257,000 in fiscal year 2017 is from the state government special revenue fund for massage and bodywork therapist registration activities under Minnesota Statutes, sections 148.982 to 148.9885. The base appropriation in fiscal year 2018 is $275,000 and $276,000 in fiscal year 2019.

Base Level Adjustment. The state government special revenue fund base is increased by $18,000 in fiscal year 2018 and $19,000 in fiscal year 2019.

Subd. 6. **Board of Pharmacy**	115,000	145,000
Subd. 7. **Board of Physical Therapy**	890,000	924,000

Health Professional Services Program. Of this appropriation, $850,000 in fiscal year 2016 and $864,000 in fiscal year 2017 are from the state government special revenue fund for the health professional services program.

Subd. 8. **Board of Podiatric Medicine**	-0-	75,000

Orthotist, Prosthetist, and Pedorthist Licensing. $75,000 in fiscal year 2017 is from the state government special revenue fund for licensure activities under the Minnesota Orthotists, Prosthetist, and Pedorthist Practice Act, Minnesota Statutes, chapter 153B. The base appropriation is

$112,000 in fiscal year 2018 and $112,000 in fiscal year 2019.

Base Level Adjustment. The state government special revenue fund base is increased by $37,000 in fiscal year 2018 and $37,000 in fiscal year 2019.

Sec. 5. **OMBUDSMAN FOR MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES** **$ 100,000 $ 209,000**

Base Level Adjustment. The general fund base is increased by $41,000 in fiscal year 2018 and $41,000 in fiscal year 2019.

Sec. 6. **DEPARTMENT OF COMMERCE** **$ (210,000) $ (190,000)**

Sec. 7. Laws 2015, chapter 71, article 14, section 4, subdivision 3, is amended to read:

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.~~

Sec. 8. Laws 2015, chapter 71, article 14, section 9, is amended to read:

Sec. 9. **COMMISSIONER OF COMMERCE** **$ 210,000 $ 213,000**

~~The commissioner of commerce shall develop a proposal to allow individuals to purchase qualified health plans outside of MNsure directly from health plan companies and to allow eligible individuals to receive advanced premium tax credits and cost-sharing reductions when purchasing qualified health plans outside of MNsure.~~

Sec. 9. **EXPIRATION OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires on June 30, 2017, unless a different expiration date is explicit.

Sec. 10. **EFFECTIVE DATE.**

This article is effective the day following final enactment.