Council Study Session
VIRTUAL meeting being conducted by electronic means in accordance with Minnesota Statutes, section 13D.021 Public portion available for connection via telephone Dial: 1-312-535-8110 Access Code: 281244297
May 11, 2020

AGENDA

The City Council requests that attendees turn off cell phones and pagers during the meeting. A copy of the full City Council packet is available to the public. The packet ring binder is located at the entrance of the council chambers.

1. **City Council Discussion of Agenda Items and Questions - 6 p.m.**
2. **Miscellaneous**
3. **Discussion of Work Session Agenda Item as Time Permits**
4. **Adjourn**

CITY COUNCIL MEETING
VIRTUAL meeting being conducted by electronic means in accordance with Minnesota Statutes, section 13D.021 Public portion available for connection via telephone Dial: 1-312-535-8110 Access Code: 281244297
May 11, 2020

AGENDA

1. Informal Open Forum with City Council - 6:45 p.m. Individuals wanting to participate in Open Forum, please dial: 1-312-535-8110 Access Code: 801 615 321

Provides an opportunity for the public to address the Council on items which are not on the agenda. Open Forum will be limited to 15 minutes, it is not televised, and it may not be used to make personal attacks, to air personality grievances, to make political endorsements, or for political campaign purposes. Council Members will not enter into a dialogue with presenter. Questions from the Council will be for clarification only. Open Forum will not be used as a time for problem solving or reacting to the comments made but, rather, for hearing the presenter for informational purposes only.

2. Invocation - 7 p.m. (Mayor Elliott)

3. Call to Order Regular Business Meeting

The City Council requests that attendees turn off cell phones and pagers during the meeting. A copy of the full City Council packet is available to the public. The packet ring binder is located at the entrance of the council chambers.

4. Roll Call

5. Pledge of Allegiance

6. Approval of Agenda and Consent Agenda

The following items are considered to be routine by the City Council and will be enacted by one motion. There will be no separate discussion of these items unless a Councilmember so requests, in which event the item will be removed from the consent agenda and considered at the end of Council Consideration Items.

a. Approval of Minutes

- Motion to approve the following minutes:

- *March 17, 2020 Special City Council*
- *March 23, 2020 Special City Council*
- *April 6, 2020 Executive Session Special*
- *April 10, 2020 Continued Executive Session Special*
- *April 12, 2020 Continued Executive Session Special*

b. Approval of Licenses

- Motion to approve licenses as presented

c. Ordinance Amending Chapter 3 of the City Code of Ordinances

- Motion to approve the first reading of an Ordinance Amending Chapter 3 of the City Code of Ordinances regarding state building code and calling for a public hearing and second reading to be held on June 8, 2020.

d. Resolution Expressing Support for Converting Highway 252 From an at-grade Expressway to a Grade Separated Freeway

- Motion to approve a resolution expressing support for converting Highway 252 from an at-grade expressway to a grade separated freeway

e. Resolution Identifying the Need for Livable Communities Demonstration Account (LCDA) Funding and Authorizing an Application for Grant Funds

- Motion to approve the resolution identifying the need for Livable Communities Demonstration Account (LCDA) funding and authorizing the submission of an application for grant funds.

f. Resolution In Support of the Medicare for All Act of 2019 and Resolution Supporting the MN Health Plan

- Approve a resolution supporting the Medicare for All Act of 2019

g. Resolution Authorizing Letter of Support for Legislation to Provide Funding for Small Businesses

- Motion to approve a resolution authorizing a letter of support for legislation providing funding for small businesses

7. Presentations/Proclamations/Recognitions/Donations

a. Recognition of Police Week and Peace Officer's Memorial Day

- Motion to approve a resolution recognizing Police Week and May 15, 2020 as Peace Officer's Memorial Day

b. The 2020 Biennial Body Worn Camera Audit

-Motion to approve the Brooklyn Center Police 2020 Biennial Body Worn Camera Audit

8. Public Hearings

9. Planning Commission Items

10. Council Consideration Items

a. Resolution to Approve a Grant Program to Support Local Nonprofit Organizations

- Motion to approve a resolution approving establishment of the local nonprofit emergency grant program

11. Council Report

12. Adjournment

Council Regular Meeting

DATE: 5/11/2020

TO: City Council
FROM: Curt Boganey, City Manager
THROUGH: Dr. Reggie Edwards, Deputy City Manager
BY: Barb Suciu, City Clerk

SUBJECT: Approval of Minutes

Background:

In accordance with Minnesota State Statute 15.17, the official records of all meetings must be documented and approved by the governing body.

Budget Issues:

- None

Strategic Priorities and Values:

Operational Excellence

ATTACHMENTS:

Description	Upload Date	Type
3-17 Special Meeting	5/5/2020	Backup Material
3-23 Minutes	5/5/2020	Backup Material
4-6 Executive Session	5/5/2020	Backup Material
4-10 Executive Session Continuation	5/5/2020	Backup Material
4-12 Executive Session Continuation	5/5/2020	Backup Material

MINUTES OF THE PROCEEDINGS OF THE CITY COUNCIL
OF THE CITY OF BROOKLYN CENTER IN THE COUNTY
OF HENNEPIN AND THE STATE OF MINNESOTA

SPECIAL EMERGENCY MEETING
MARCH 17, 2020
CITY HALL

CALL TO ORDER

The Brooklyn Center City Council met in Special Emergency Meeting called to order by Mayor Mike Elliott at 6:00 p.m.

ROLL CALL

In light of the alarming increase in COVID-19 cases in Minnesota and Governor Walz' emergency declaration, the Mayor, Councilmembers, and City Attorney attended this meeting telephonically.

Mayor Mike Elliott (via telephone) and Councilmembers Marquita Butler (via telephone), April Graves (via telephone), Kris Lawrence-Anderson (via telephone), and Dan Ryan (via telephone); and City Attorney Troy Gilchrist (via telephone). Present were: City Manager Curt Boganey, Deputy City Manager Reggie Edwards, and City Clerk Barb Suciu.

1. CONSIDER RESOLUTION NO. 2020-XX ACCEPTING A DECLARATION OF LOCAL EMERGENCY, PURSUANT TO MINNESOTA STATE STATUTE SECTION 1229, DUE TO COVID-19 HEALTH PANDEMIC

City Manager Curt Boganey stated this special meeting has been called to provide the City Council with an update on actions taken by the City in response to the COVID-19 pandemic, and what is expected to unfold in the coming weeks and months. He added the Governor of Minnesota, as well as the President, have declared a state of emergency, as well as several local cities. He noted a local emergency is being declared for the City of Brooklyn Center, which will trigger other provisions for emergency planning. The City Council has received a copy of the Declaration for their consideration and approval.

Mayor Elliott stated the Declaration allows the City Manager and the Fire Chief, who will serve as Emergency Manager, to take actions and implement an appropriate emergency plan to contain and mitigate the virus in an expeditious manner. The Declaration suspends compliance with City and State laws, and other laws, related to compliance with policies and procedures in an effort to

protect the public health, safety and welfare. The emergency Declaration suspends all City meetings including City Council, EDA and all Boards, Commissions and Committees, until the end of April 2020. Special meetings may be called that require action but must be conducted via phone or other electronic means. All City buildings will be closed as of March 18, 2020 with the exception of the Police Department until the beginning of April 2020 and can be extended.

Mayor Elliott stated the emergency Declaration allocates resources to local food emergency agencies that serve Brooklyn Center residents. This includes financial support for food assistance of $10,000 to CEAP, CAPI and West African Family & Children's Services. These organizations have experienced a significant increase in demand for food, and they along with other food shelves are working to deliver food to senior citizens and other vulnerable community members adversely affected by the pandemic. These organizations have requested assistance from the City of Brooklyn Center.

Mayor Elliott stated the emergency Declaration directs the City Manager to work with City Staff to establish a program that allows City employees to volunteer to use City vehicles to assist in delivering food. Those who assist in this effort will follow the most current recommendations of health and safety officials, establishing protocols including curbside delivery.

Mayor Elliott stated the emergency Declaration encourages City departments to evaluate and make recommendations to the City Manager regarding deployment of resources for the purpose of helping residents during this period of emergency. The local situation is evolving quickly, from one day to the next, and the City will take additional steps as needed to address issues as they arise. The emergency Declaration will remain in place as long as the Governor of Minnesota maintains his executive order declaring a peacetime emergency.

Mayor Elliott stated this Declaration is effective for three days pending City Council action authorizing its extension. A Resolution accompanies the Declaration which includes a recommendation that groups of no larger than 10 people will gather. He added medical professionals recommend no more than 5 people.

Mayor Elliott stated this unprecedented situation is evolving rapidly, and the City of Brooklyn Center will need to be able to respond and make decisions based on fast-moving recommendations and guidelines. He stressed the importance of taking measures to prevent as many people as possible from getting the virus. Medical professionals have indicated it may be impossible to prevent the virus, but people can take measures to slow its pace and reduce demands on the health care system.

Mr. Boganey stated a message to City employees was distributed on Monday March 16, 2020. He added a copy of this message has been provided to the City Council. He noted directors and employees are encouraged to work at home, to reinforce the message of social distancing and do whatever possible to prevent the virus from spreading.

Mr. Boganey stated with the closing of all City buildings, it should be noted that this includes closure of the liquor store and Earle Brown Heritage Center, effective March 18, 2020. A program has been established wherein City employees will continue to be paid in the immediate future, and options are being reviewed to provide funding for employee salaries. There was concern that employees would want to come to work out of concern that they will not be paid. He noted all additional costs directly related to the emergency Declaration are being tracked and recorded in the event that there will be reimbursements available.

Mr. Boganey stated the City's essential services will continue but may be modified or discontinued. He added phone, email and online services will be available. Non-essential services will be deferred for the time being.

Mayor Elliott called for comments and discussion.

Councilmember Ryan asked whether the Governor's state of emergency is timed at 90 days.

City Attorney Troy Gilchrist stated the Governor's Order indicated the State of Emergency will be ongoing until there is Declaration of Repeal.

Councilmember Ryan asked whether the City's Declaration must be consistent with State statutes that specify conditions and the authority of the State's emergency Declaration.

Mr. Gilchrist stated the Resolution that is being considered at tonight's meeting, which requires City Council approval, will tie the City's Declaration of local emergency to the Governor's Declaration.

Councilmember Graves asked how many City employees are actually not able to work from home and are coming into work. She stressed the importance of ensuring that the necessary precautions are taken at City Hall.

Mr. Boganey stated City Staff are currently working on getting that information, including the number of laptops that will be available for employees who need them to work from home. He added the question is whether it will be practical for all employees to work from home. He agreed to provide more information.

Councilmember Graves requested the City Council be notified if there's anything that needs to be done to ensure that City employees' needs are met. Mr. Boganey agreed. He added the Declaration provides the City with the authority to make certain decisions without prior approval from the City Council.

Councilmember Graves stated, regarding evictions, whether the City will be able to prevent people from being displaced from their homes during this period. She asked whether it will be necessary to work with City or State policy makers to push that to a higher level.

Mayor Elliott stated the City has taken steps to communicate with Hennepin County and other government units to prevent displacement. He added the emergency Declaration calls upon the Sheriff to not participate in the eviction of City residents. He noted, in addition, fees, penalties and administrative costs will be suspended, that would normally have been charged, and water will not be shut off, which is something the City does not do anyway.

Mayor Elliott stated City Staff plans to connect with Comcast and other utilities providers to ensure that there is a plan in place to continue to provide utilities.

Councilmember Graves asked about support for small businesses. She stated there are some links with information about supporting small businesses on the City website.

Mayor Elliott stated those discussions are still pending, but he has been contacted by local small businesses asking for financial assistance from the City. He added small business owners are being asked to stay home, and they are isolated and have no income. He noted he has some ideas about how to address that need.

Councilmember Ryan stated the Governor has indicated that there are plans at the State level to increase unemployment insurance and other financial assistance programs. He added there has also been discussion at the federal level regarding transfer payments to workers, and City Staff can monitor those developments. He noted the City can prevent evictions, waive administrative fees and late payments, and other measures that are appropriate at the City level. He noted financial support for workers is beyond the City's means and should be handled at the State and Federal levels.

Mayor Elliott stated there have been indications that there will be reimbursements for COVID-19 related expenses that the City undertakes. He stressed the importance of helping residents in the community who are in dire need, and to think broadly about community support.

Councilmember Butler stated there is information about resources for families like food shelves, and restaurants that are providing free meals for children, that have been popping up on social media. She added this type of information can be added to the City website.

Mr. Boganey stated City Staff will do everything they can to get that type of information. He requested that the City Council send him an email if anyone hears of something in the community that should be on the website.

Councilmember Lawrence-Anderson asked about Item 5 in the declaration, regarding encouraging stores to put limits on the amount of goods they can purchase. She asked whether City Staff have reached out to Cub Foods and Walmart yet. Mr. Boganey stated City Staff will be doing that tomorrow, after the emergency Declaration goes into effect.

Councilmember Lawrence-Anderson stated Mayor Elliott had mentioned financial assistance for local organizations. She asked where this funding will come from within the City budget.

Mr. Boganey stated a General Fund allocation of $150,000 has been set aside for contingencies, and these organizations qualify for funding under that definition.

Mayor Elliott stated it is hoped that the City of Brooklyn Park will contribute funding to these organizations as well, as this is an ongoing situation. He added a phone meeting is planned with local area Mayors to talk about actions that other cities are taking. He noted a similar phone meeting with Hennepin County will also be planned. A conference call is planned for Thursday March 19, 2020 with leaders of local organizations to discuss mitigation strategies, how to work together as a community.

Mayor Elliott stated residents who live in multi-family housing are of great concern, and discussions should be planned to consider ways of ensuring that those residents are safe, and their needs are met.

Councilmember Lawrence-Anderson stated providing $10,000 in assistance to local organizations is a good initial outlay, and the City Council can act if more assistance is needed. She added the immediate future is very uncertain, and the City should attempt to retain as much of its contingency funding as possible, since it is impossible to know how much will be expended.

Mayor Elliott agreed, adding the City should be mindful of the amount of contingency funding. He added there may be some cost savings associated with the closure of City buildings and facilities. He added the intention is to continue to pay City Staff, including hourly staff.

Mr. Boganey stated the City is confident that all employees will have 2 weeks of direct pay assuming they will not be working. He added the majority of employees will continue to work remotely. He noted part-time hourly employees, at the liquor store and Earle Brown Heritage Center can be paid for two weeks although they are not working.

Mr. Boganey stated it is important to note that there will come a time when it will be difficult and costly to pay employees who are not working. He added it will become necessary to make some hard choices with respect to employees who are not working. He noted, however, it is anticipated that the State of Minnesota will make changes to unemployment laws that will provide some relief. The situation can be reviewed again in two weeks.

Councilmember Ryan moved and Councilmember Graves seconded to adopt RESOLUTION NO. 2020-XX Accepting a Declaration of Local Emergency, pursuant to Minnesota State Statute Section 1229, due to COVID-19 health pandemic.

Upon vote via phone, Mayor Elliott and Councilmembers Butler, Graves, Lawrence-Anderson and Ryan voted aye. Motion passed unanimously.

MOTION TO SUSPEND RULES

Mayor Elliott requested a motion to extend the meeting past one hour.

Councilmember Butler moved, and Mayor Elliott seconded, to extend the meeting past 7:00 p.m.

Councilmember Ryan asked what the purpose of extending the meeting is. Mayor Elliott stated the City Council should conclude the discussion regarding next steps.

Upon vote via phone, Mayor Elliott and Councilmembers Butler, Graves, Lawrence-Anderson and Ryan voted aye. Motion passed unanimously.

2. DISCUSSION REGARDING NEXT STEPS

Mayor Elliott stated the City will work with other government agencies and local municipalities to coordinate efforts related to long- and short-term plans to address the pandemic at the local level. He added City Staff will continue to meet as needed to ensure that City residents are kept informed about the latest updates, via the City's website as well as social media. He noted it will be important to provide more information rather than not enough.

Mayor Elliott stated City Staff are working with County and State representatives, as well as the City Attorney, to figure out how to postpone the upcoming Board of Appeals and Equalization meetings in April 2020, which are governed by State statute.

Mayor Elliott stated the City Council will hold a Regular Session meeting on Monday, March 23, 2020 to address items that are time-sensitive and for which action is required.

Mr. Boganey stated, as the City Council is aware, the City of Brooklyn Center has a contractual relationship with a health services provider that can be a resource for the general public. He added City Staff is working with the provider to determine whether they can provide support related to mental health issues, in addition to other services offered by the City, with regard to COVID-19.

Mr. Boganey stated he has a meeting scheduled with the School Superintendent which will be rescheduled to May 2020. He added the next City Council meeting will be scheduled in June 2020. He noted he fully agrees with the Mayor's comments regarding the sharing of as much information as possible with City Staff, the City Council and the City's residents.

Councilmember Graves stated she appreciates Mr. Boganey's comments about mental health concerns during this crisis. She added she hopes the health services agency can be secured as a

resource, and other national or state-wide information related to mental health wellness can be included on the City's website. She noted some School Districts are providing lunches for students who need them, and that information should be on the City's website. She stressed the importance of spreading the news.

Councilmember Graves stated there has been a local and national initiative to release non-violent offenders from jail. She asked whether Brooklyn Center's Police Officers are making changes, and what equipment they are using to do their jobs safely and effectively.

Mr. Boganey stated all City employees who deal with the general public are required to wear personal protective equipment.

Mayor Elliott stated there has not been a discussion yet at the City level regarding release of non-violent offenders. He added there will be an effort to work with the Sheriff's Department to address these concerns. He noted all members of the community are at risk, but especially those who live in close proximity to each other.

Mr. Boganey stated the City will reconsider how Police Officers are engaged in arrests. He added the arrest of non-violent offenders, and sending them to jail, would be a bad idea, and a low priority. He noted, in addition, resources are limited, and there may be fewer police officers to do critical work.

Councilmember Graves requested that the City Council receive updates as often as they come, and also be involved in electronic meetings if possible. She stated she is involved in leading an emergency response team at the City of Minneapolis, to determine how the City and the Health Department can work together in collaboration with some other groups. She added she can provide details on these efforts to the City Council as they develop.

Mayor Elliott agreed to include the City Council in communications related to small businesses and health support.

Councilmember Lawrence-Anderson requested clarification regarding Item 11 in the Declaration, which indicates that all City meetings will be cancelled through the end of April 2020 except Special Meetings that can be conducted via telephone or other electronic means. She asked whether City Council meetings will still be held, but via phone or video.

Mayor Elliott stated there will be no meetings through the end of April 2020, but the City Council may have several Special Meetings to address time sensitive issues.

Mr. Boganey agreed, adding City Staff have been instructed to provide any items that will need to be addressed by the City Council before April.

Councilmember Lawrence-Anderson asked whether there will be a City Council meeting on Monday, May 23, 2020, as previously discussed.

Mayor Elliott confirmed there will be a City Council meeting on May 23 that will be conducted electronically.

Councilmember Lawrence-Anderson asked whether City Staff still wanted to update the City Council's electronic tablets, as previously indicated.

Mr. Edwards stated City Staff would like to collect the Councilmembers' tablets to test them for video capability.

Mr. Boganey stated Councilmembers can drop off their tablets, or someone from City Staff can pick it up.

Councilmember Lawrence-Anderson agreed to drop off her tablet on Thursday. Mr. Boganey requested that she send an email or call City Staff so someone will be there to receive it.

3. ADJOURNMENT

Councilmember Lawrence-Anderson moved and Councilmember Butler seconded adjournment of the City Council meeting at 7:08 p.m.

Upon vote via phone, Mayor Elliott and Councilmembers Butler, Lawrence-Anderson and Ryan voted aye. Councilmember Graves abstain. Motion passed unanimously.

MINUTES OF THE PROCEEDINGS OF THE CITY COUNCIL
OF THE CITY OF BROOKLYN CENTER IN THE COUNTY
OF HENNEPIN AND THE STATE OF MINNESOTA

CITY COUNCIL MEETING
MARCH 23, 2020
WEBEX

City Manager Curt Boganey stated the Local Board of Appeal and Equalization meeting will be scheduled for April 6, 2020 at 7:00 p.m. He added the City is required by State statute to reschedule the Board meeting after it has been cancelled.

1. INVOCATION

Councilmember Butler offered the following quotes as an Invocation:

In commemoration of Women's History Month:

> " Each time a woman stands up for herself, without knowing it or claiming it, she stands up for all women." -Maya Angelou

For reflection during this time of crisis:

> "It is our attitude at the beginning of a difficult task which more than anything else will affect a successful outcome." -Roland James

2. CALL TO ORDER REGULAR BUSINESS MEETING

The Brooklyn Center City Council meeting was called to order by Mayor Mike Elliott at 6:00 p.m. The meeting was conducted by Webex.

3. ROLL CALL

By Webex: Mayor Mike Elliott and Councilmembers Marquita Butler, April Graves, and Dan Ryan. Councilmember Kris Lawrence-Anderson was not reachable. Also by Webex: City Manager Curt Boganey, Deputy City Manager Reggie Edwards, and City Clerk Barb Suciu and City Attorney Troy Gilchrist.

A member of the public called in by Webex to listen to the meeting.

4. PLEDGE OF ALLEGIANCE

The Pledge of Allegiance was recited.

5. APPROVAL OF AGENDA AND CONSENT AGENDA

Councilmember Graves moved and Councilmember Ryan seconded to approve the Agenda and Consent Agenda, and the following consent items were approved:

5a. APPROVAL OF MINUTES

1. March 9, 2020 Study Session
2. March 9, 2020 Regular Session

5b. LICENSES

MECHANICAL LICENSE

K & H Heating, Air Conditioning & Plumbing Inc	4205 Hwy 14 W Rochester 55901
KB Service Co.	430 County Rd D East Little Canada 55117

RENTAL LICENSE

INITIAL (TYPE III – one-year license)

3501 62nd Ave N	Doreen Kalema / Butterfly Bound Care
1344 68th Ln N	Syewon Weah
7101 Girard Ave N	Sesan Ogunnuran / EE&J Investment LLC

INITIAL (TYPE II – two-year license)

6813 Noble Ave N	Janee Garrison & Jerome English
3212 Quarles RD	HPA US1 LLC / Pathlight

RENEWAL (TYPE IV – one-year license)

6725 Bryant Ave N	Vong Duong - missing CPTED
5834 Camden Ave N	FYR SFR Borrower LLC
6342 Dupont Ave N	Ceberus SFR Holdings - missing CPTED
6736 Perry Ave N	Mark Coville - missing CPTED

RENEWAL (TYPE III – one-year license)

4506 65th Ave N	Virginia Lazo - missing CPTED
7212 Lee Ave N	Qiang Fang
7243 Riverdale Rd	IH3 Property Illinois LP - missing CPTED

RENEWAL (TYPE II – two-year license)

5329-33 Brooklyn Blvd	Tech P Ung
5228 Ewing Ave N	IH3 Property Illinois LP - met action plan
4207 Lakeside Ave #138	Patrick Hall
5322 Logan Ave N	Mary Jo Schwartz - met action plan

RENEWAL (TYPE I – three-year license)

6835 Noble Ave N	Robert Berglund
1900 Brookview Dr	IH3 Property Illinois LP
5959 Camden Ave N	Todd Havisto & Dave Baumann
7007 James Ave N	Infinite Property
4207 Lakeside Ave #224	Marina Feldman
7141 Newton Ave N	IH3 Property Illinois LP
5814 Pearson Dr	IH3 Property Illinois LP

5c. SUPPORT FOR THE CITY CLERK TO APPLY FOR THE MCFOA REGION IV DIRECTOR POSITION

Vote on the motion by Webex: Mayor Elliott and Councilmembers Ryan, Graves, and Butler voted aye.

Motion passed unanimously.

6. PRESENTATIONS/PROCLAMATIONS/RECOGNITIONS/DONATIONS

-None.

7. PUBLIC HEARINGS

-None.

8. PLANNING COMMISSION ITEMS

8a. PLANNING COMMISSION APPLICATION 2020-001 - SPECIAL USE PERMIT AND PARKING VARIANCE LOCATED AT 4900 FRANCE AVENUE N.

Community Development Director Meg Beekman reviewed a request for a Special Use Permit and parking variance for a mosque and community center at 4900 France Avenue. The Planning Commission, at its February 13, 2020 meeting, was unable to recommend approval or denial of this application, as there was a split vote. At its March 9, 2020 meeting, the City Council unanimously approved to direct City Staff to prepare a Resolution for approval of these requests.

Ms. Beekman stated concerns were expressed regarding the viability of the subject property for the proposed use, in terms of the amount of investment that will be needed, and the fact that both buildings on the property are currently unfit for occupancy. The City building official is working with the applicant to determine the changes that are necessary for a Certificate of Occupancy to be issued.

Ms. Beekman stated the primary concern for the long-term use of this property by the mosque community is the lack of adequate on-site parking. The Planning Commission noted the

importance of a barrier between the parking lot and the railway line, and the applicant has stated their intention to do this anyway. The Planning Commission raised concerns about the proposed shuttle service to bring community members to the property from an offsite parking lot.

Ms. Beekman stated the City Council directed City Staff to prepare findings that support approval of this request. She added the Resolution that has been provided for the City Council's review includes Findings of Fact and a number of conditions that would mitigate concerns discussed at the staff level and at the Planning Commission meeting, as well as the City Council's comments.

Ms. Beekman stated noted the applicant is required to have a parking plan on file with the City to accommodate parking needs. The religious services must be scheduled 30 minutes apart to allow for the parking lot to clear out. The applicant is required to have an on-site parking attendant, which they have already discussed as part of their traffic study.

Ms. Beekman stated there is a condition related to submission of architectural plans as there is currently not a clear plan for the interior of the building, and the building shall not be occupied until a Certificate of Occupancy is issued. She added there is an existing apartment unit located in the circular building, which is a pre-existing, non-conforming use, and will no longer be allowed.

Ms. Beekman stated conditions related to the site plan include landscaping requirements, accessibility, relocation of an existing trash enclosure and restriping of the parking lot. A fence is required to be installed along the property's south perimeter. A parking agreement for shuttle service to the site from an off-site lot must be on file with the City.

Ms. Beekman stated City Staff recommends that the City Council adopt the Resolution approving Special Use Permit and parking variance to allow the applicant to operate the mosque and community center, subject to the findings of approval outlined in the staff report.

Councilmember Butler requested clarification regarding the requirement for approval from the City for "major changes", as referenced in the Findings of Fact.

Ms. Beekman that is standard language that the City uses in all its approvals to restrict amendments to conditions of the approval. She added this relates to major modifications to items included in the Special Use Permit, including site plan amendments or adjustments, changes to the interior of the building, or modifications to the exterior.

Councilmember Butler asked whether the requirement of the onsite parking attended was added by the applicant. Ms. Beekman stated the applicant provided that in their traffic plan as a solution to manage potential overflow due to insufficient parking.

Councilmember Ryan stated the City Council realizes that the site is challenging but the applicant is very intent on making this work and believes the site can meet their needs. He added the City

Council is amenable and sympathetic to the applicant's desire to remain in the community. He asked what remedy the City has if the applicant fails to meet parking requirements.

City Attorney Troy Gilchrist stated, as with any Special Use Permit, violation of conditions of approval would result in an effort to bring them into compliance, and if it continues, move into a formal written notice of the violation. He added a hearing would be scheduled and held, and decision made regarding whether the revoke the Special Use Permit.

Councilmember Butler moved and Councilmember Ryan seconded to adopt RESOLUTION NO. 2020-36 Approving Planning Commission Application No. 2020-001 Request for a Special Use Permit and Parking Variance Located at 4900 France Avenue N.

Vote on the motion by Webex: Mayor Elliott and Councilmembers Ryan, Graves, and Butler voted aye.

Motion passed unanimously.

9. COUNCIL CONSIDERATION ITEMS

-None.

10. COUNCIL REPORT

Councilmember Ryan stated he recently attended the National League of Cities conference and received notice that several attendees from Colorado tested positive for COVID-19. He added he has been self-isolated at home but has not had any indication of symptoms.

Councilmember Ryan stated he met recently with staff representatives of Senator Smith and Representative Oman, to update them and provide information on priority items from the City Council's 19-Point List. He added these included CDBG funding, as it is the largest grant received by the City of Brooklyn Center, as well as affordable housing funding, transportation funding, and Social Security. He noted that he indicated that the City Council hopes that there will be an ongoing conversation on all of these issues. He agreed to provide additional details to Mr. Boganey.

Mayor Elliott thanked Councilmember Ryan for his report. He added Social Security is an important issue not just for those who receive direct benefits, but also for financial support for families, and to ensure that Social Security is solvent for future beneficiaries.

Mayor Elliott stated he recently received communication from the U.S. Congress of Mayors, encouraging local mayors to request support for direct aid to cities from their local legislators. He added he subsequently reached out to the offices of Senators Smith and Klobuchar regarding this issue.

Mayor Elliott expressed support for the moratorium on evictions that was recently declared by Minnesota's Governor, Tim Walz. He added all other types of payments should also be frozen, and the City should continue to advocate for its residents, to ensure that credit reports are not adversely affected by the current worldwide crisis. He expressed concern that many of Brooklyn Center's residents rely on public transport, which is not available to them. He also expressed concern about the City's multi-family residential buildings, and what can be done to help residents who live there.

Mayor Elliott stated the City Council and City Staff continue to discuss ways to support and assist the City's residents, and especially senior citizens. He added the City's Fire and Police Department staff, who are charged with protecting the City, must be protected, and their needs met, as they continue to have contact with people and potentially risk exposure to the coronavirus.

Mr. Boganey expressed his appreciation for Brooklyn Center's City Staff, who have been putting in long hours and volunteering their support, as well as making important adjustments to ensure that the business of the City runs smoothly in this time of crisis.

11. ADJOURNMENT

Councilmember Butler moved and Councilmember Ryan seconded adjournment of the City Council meeting at 6:30 p.m.

Vote by Webex: Mayor Elliott and Councilmembers Ryan, Graves, and Butler voted aye.

Motion passed unanimously.

MINUTES OF THE PROCEEDINGS OF THE CITY COUNCIL
OF THE CITY OF BROOKLYN CENTER IN THE COUNTY
OF HENNEPIN AND THE STATE OF MINNESOTA

EXECUTIVE SESSION SPECIAL CITY COUNCIL MEETING
APRIL 6, 2020
WEBEX

CALL TO ORDER

The Brooklyn Center City Council met in Executive Session and was called to order by Mayor Mike Elliott at 8:15 p.m.

ROLL CALL

Mayor Mike Elliott and Councilmembers Marquita Butler, April Graves, and Dan Ryan. Kris Lawrence-Anderson was absent and excused. Also present were City Manager Curt Boganey, Deputy City Manager Reggie Edwards, Public Works Director Doran Cote, City Engineer, Mike Albers, City Attorney Troy Gilchrist, Attorney James Strommen, and City Clerk Barb Suciu.

UPDATE

City Manager Boganey stated the reconstruction project were about to begin and there was concerns from a resident regarding the health of children and others during the projects. The Mayor and City Manager met and the Mayor enacted a proclamation that paused the projects. The City has received responses from both contractors and tonight we will go into closed session to discuss proposed litigation.

Mayor Elliott moved and Councilmember Ryan seconded to go into a Closed session.

Vote on the motion by Webex: Mayor Elliott and Councilmembers Ryan, Graves, and Butler

CLOSED SPECIAL MEETING, DISCUSS PENDING LITIGATION REGARDING S.R. WEIDEMA, INC. AND R.L. LARSON EXCAVATING, INC.

The City Council met in closed Executive Session under the attorney-client privilege to discuss pending litigation – Minn. Stat. § 13D.05, subd. 3 (b). There was consensus of the City Council to proceed with further litigation.

OPEN SESSION

Councilmember Butler moved and Councilmember Ryan seconded for the city to keep the proclamation in place and contact residents in the construction raction area with the mitigation measures the contractors have proposed and reconvene the meeting on Friday, April 10 at 7:00 p.m.

Vote on the motion by Webex: Mayor Elliott and Councilmembers Ryan, and Butler

City Attorney Troy Gilchrist asked for a continuation if the meeting and that would allow the current public notice to stay in place.

Mayor Elliott moved and Councilmember Ryan to continue the Executive Session at 7:00 p.m. Friday, April 10 at 11:03 p.m.

Vote on the motion by Webex: Mayor Elliott and Councilmembers Ryan, and Butler

MINUTES OF THE PROCEEDINGS OF THE CITY COUNCIL
OF THE CITY OF BROOKLYN CENTER IN THE COUNTY
OF HENNEPIN AND THE STATE OF MINNESOTA

CONTINUED EXECUTIVE SESSION CITY COUNCIL MEETING
APRIL 10, 2020
WEBEX

CALL TO ORDER

The Brooklyn Center City Council met in Executive Session and was called to order by Mayor Mike Elliott at 8:15 p.m.

ROLL CALL

Mayor Mike Elliott and Councilmembers Marquita Butler, April Graves, Kris Lawrence-Anderson, and Dan Ryan. Also present were City Manager Curt Boganey, Deputy City Manager Reggie Edwards, Public Works Director Doran Cote, City Engineer, Mike Albers, City Attorney Troy Gilchrist, Attorney James Strommen, and City Clerk Barb Suciu.

Motion by Mayor Elliott and Councilmember Graves seconded to go into closed session to discuss litigation regarding S.R. Weidema, Inc. and R.L. Larson Excavating, Inc.

Vote on the motion by WebEx: Mayor Elliott and Councilmembers Ryan Lawrence-Anderson, Graves and Butler voted aye.

CLOSED SPECIAL MEETING, DISCUSS LITIGATION REGARDING S.R. WEIDEMA, INC. AND R.L. LARSON EXCAVATING, INC.

The City Council met in closed Executive Session under the attorney-client privilege to discuss pending litigation – Minn. Stat. § 13D.05, subd. 3 (b). There was consensus of the City Council to proceed with further litigation.

Vote on the motion by WebEx: Mayor Elliott and Councilmembers Ryan Lawrence-Anderson, Graves and Butler voted aye.

OPEN SESSION

Councilmember Ryan moved and Councilmember Graves seconded the motion to rescind the Mayoral Emergency Proclamation No. 2020-02 and Allow the Interstate and Grandview Street Reconstruction Projects to Proceed with Mitigation Measures.

Vote on the motion by WebEx: Councilmembers Ryan Lawrence-Anderson, Graves and Butler voted aye. Mayor Elliott abstained.

CONTINUATION

Councilmember Ryan moved and Councilmember Lawrence-Anderson moved to continue this Executive Session meeting on Sunday, April 12 at 3:00 p.m. if deemed necessary at 8:58 p.m.

Vote on the motion by WebEx: Mayor Elliott and Councilmembers Ryan Lawrence-Anderson, Graves and Butler voted aye.

MINUTES OF THE PROCEEDINGS OF THE CITY COUNCIL
OF THE CITY OF BROOKLYN CENTER IN THE COUNTY
OF HENNEPIN AND THE STATE OF MINNESOTA

RECONVENE SPECIAL CITY COUNCIL MEETING
APRIL 12, 2020
WEBEX

CALL TO ORDER

The Brooklyn Center City Council met in Executive Session and was called to order by Mayor Mike Elliott at 3:00 p.m.

ROLL CALL

Mayor Mike Elliott and Councilmembers Marquita Butler, April Graves, Kris Lawrence-Anderson, and Dan Ryan. Also present were City Manager Curt Boganey, Deputy City Manager Reggie Edwards, City Engineer, Mike Albers, City Attorney Troy Gilchrist and Attorney James Strommen, and City Clerk Barb Suciu.

Councilmember Butler moved and Councilmember Ryan seconded to continue the closed session from April 6, 2020, and April 10, 2020, regarding litigation regarding S.R. Weidema, Inc. and R.L. Larson Excavating, Inc.

Vote on the motion by Webex: Mayor Elliott and Councilmembers Ryan, Lawrence-Anderson, Graves, and Butler voted aye.

CONTINUE DISCUSSION FROM APRIL 6, 2020, AND APRIL 10, 2020, SPECIAL MEETINGS, DISCUSS LITIGATION REGARDING S.R. WEIDEMA, INC. AND R.L. LARSON EXCAVATING, INC.

The City Council met in closed Executive Session under the attorney-client privilege to discuss pending litigation – Minn. Stat. § 13D.05, subd. 3 (b). There was consensus of the City Council to proceed with further litigation.

OPEN SESSION

Councilmember Ryan moved and Councilmember Graves seconded the motion to approve the settlement with S.R. Weidema, Inc. and R. L. Larson, Excavating, Inc. and instruct staff to work with the contractors on any other details.

Vote on the motion by Webex: Councilmembers Ryan, Lawrence-Anderson, Graves, and Butler voted aye. Mayor Elliott abstained.

ADJOURNMENT

Councilmember Graves moved and Councilmember Ryan seconded to adjourn the Executive Session at 5:11 p.m.

Vote on the motion by Webex: Mayor Elliott and Councilmembers Ryan, Lawrence-Anderson, Graves, and Butler voted aye.

Council Regular Meeting

DATE: 5/11/2020

TO: City Council
FROM: Curt Boganey, City Manager
THROUGH: Dr. Reggie Edwards, Deputy City Manager
BY: Alix Bentrud, Deputy City Clerk

SUBJECT: Approval of Licenses

Background:

The following businesses/persons have applied for City licenses as noted. Each business/person has fulfilled the requirements of the City Ordinance governing respective licenses, submitted appropriate applications, and paid proper fees.
Applicants for rental dwelling licenses are in compliance with Chapter 12 of the City Code of Ordinances, unless comments are noted below the property address on the attached rental report.

AMUSEMENT DEVICE LICENSE

Metro Coin of Minnesota	7260 Washington Ave S Eden Prairie 55344

GARBAGE HAULER

Curbside Waste	4025 85th Ave N Brooklyn Park 55443
Darling Ingredients	9000 382nd Ave Blue Earth 56013
Dick's Sanitation Service Inc	8984 215th Street West Lakeville 55044

MECHANICAL LICENSE

4Front Energy Solutions	3230 Gorham Ave Ste 1 St Louis Park, 55426
AES Mechanical Services Group Inc	2171 AL Hwy 229 Tallasse, AL 36078
Air Mechanical Inc	16411 Aberdeen St NE Ham Lake, 55304
B&D Plbg, Htg, & A/C	4145 MacKenzie Ct St Michael, 55376
Blue Ox Heating & Air LLC	5720 International Pkwy New Hope, 55428
Burnsville Heating & A/C, Inc	3451 Burnsville Pkwy Ste 120 Burnsville, 55337
CenterPoint Energy	6161 Golden Valley Rd

	Golden Valley, 55422
Centraire Htg & A/C Inc	6811 Washington Ave S Edina, 55439
Corporate Mechanical	5113 Hillsboro Ave N New Hope, 55428
Corval Constructors, Inc	1633 Eustis St St Paul, 55108
D J'S Heating & Air Cond.	6060 LaBeaux Ave NE Albertville, 55301
Ditter Inc	820 Tower Drive Medina, 55330
Elite Refrigeration Heating & A/C, LLC	9324 November Dr St Joseph, 56374
Elk River Heating & Air Conditioning Inc	11110 Industrial Cir NW #F Elk River, 55330
Genz-Ryan Plbg & Htg	2200 W Hwy 13 Burnsville, 55337
Glowing Hearth & Home	100 Eldorado Dr Jordan, 55352
Go Fetsch Mechanical LLC	565 Shoreview Park Rd Shoreview, 55126
Harris St Paul Inc	909 Montreal Cir St Paul 55102
Hoffman Refrigeration & Heating	5660 Memorial Ave N Stillwater, 55082
Home Energy Center	2415 Annapolis Ln N Ste 170 Plymouth, 55441
Homeworks Services Co	1230 Eagan Industial Rd #117 Eagan, 55121
Horwitz Inc	7400 49th Ave N New Hope, 55428
Infinity Heating & Air Conditioning LLC	1017 Meadowwood Dr Brooklyn Park, 55444
Kraft Contracting LLC	3415 Ventura Dr Ste 100 Woodbury, 55125
McChesney Heating & Air	8201 175th Ave SE Becker, 55308
McDowall Company	PO Box Waite Park, 56387
Metropolitan Mechanical Contractors	7450 Flying Cloud Dr Eden Prairie, 55344
Minnesota Petroleum Service	682 39th Ave NE Minneapolis, 55421
Minnetonka Plumbing, Inc	520 River Street S Delano, 55328

Neighborhood Plbg & Htg	130 Broadway Ave N Foley, 56329
Northern Heating & A/C Inc	9431 Alpine Dr NW Ramsey, 55303
Quality Refrigeration	6237 Penn Ave S #100 Richfield, 55423
Quality Systems A/C & Refrigeration	16847 Welcome Ave SE Prior Lake, 55372
RTS Mechanical LLC	725 Tower Dr Hamel, 55340
Ray Welter Htg Co	4637 Chicago Ave S Minneapolis, 55407
Royalton Heating & A/C	4120 85th Ave N Brooklyn Park, 55443
Sabre Plumbing, Heating & A/C	15535 Medina Rd Plymouth, 55447
St Cloud Refrigeration	604 Lincoln Ave NE St Cloud, 56304
Schadegg Mechanical, Inc	225 Bridgepoint Dr So St Paul, 55075
South-Town Refrigeration	6325 Welcome Ave N Ste 200 Brooklyn Park, 55429
Standard Heating & A/C	130 Plymouth Ave N Minneapolis, 55411
Treated Air Conditioning	9954 166th Court Becker, 55308

SIGNHANGER'S LICENSE

Archetype Sign Makers	9611 James Ave S Bloomington, 55431
Elements Inc	10044 Flanders Ct NE Ste 100 Blaine, 55449
Jones Sign Company	1711 Scheuring Rd DePere, WI, 54115
Pajor Graphics Inc	1301 Washington Ave N Minneapolis, 55411
Scenic Sign Company	PO Box 881 St Cloud, 56302
Signart Company	2933 Mondovi Rd Eau Claire, WI, 54701
Spectrum Sign Systems Inc	8786 W 35W Service Dr NE Blaine, 55449
Topline Advertising	11775 Justen Circle #A Maple Grove, 55369

Strategic Priorities and Values:

Safe, Secure, Stable Community, Operational Excellence

ATTACHMENTS:

Description	Upload Date	Type
Rental Criteria	5/7/2019	Backup Material
5-11-2020 Rentals	5/5/2020	Backup Material

Property Code and Nuisance Violations Criteria		
License Category (Based on Property Code Only)	**Number of Units**	**Property Code Violations per Inspected Unit**
Type I – 3 Year	1-2 units	0-2
	3+ units	0-0.75
Type II – 2 Year	1-2 units	Greater than 2 but not more than 5
	3+ units	Greater than 0.75 but not more than 1.5
Type III – 1 Year	1-2 units	Greater than 5 but not more than 9
	3+ units	Greater than 1.5 but not more than 3
Type IV – 6 Months	1-2 units	Greater than 9
	3+ units	Greater than 3

b. Police Service Calls.

Police call rates will be based on the average number of valid police calls per unit per year. Police incidences for purposes of determining licensing categories shall include disorderly activities and nuisances as defined in Section 12-911, and events categorized as Part I crimes in the Uniform Crime Reporting System including homicide, rape, robbery, aggravated assault, burglary, theft, auto theft and arson.

Calls will not be counted for purposes of determining licensing categories where the victim and suspect are "Family or household members" as defined in the Domestic Abuse Act, Minnesota Statutes, Section 518B.01, Subd. 2 (b) and where there is a report of "Domestic Abuse" as defined in the Domestic Abuse Act, Minnesota Statutes, Section 518B.01, Subd. 2 (a).

License Category	**Number of Units**	**Validated Calls for Disorderly Conduct Service & Part I Crimes** (Calls Per Unit/Year)
No Category Impact	1-2	0-1
	3-4 units	0-0.25
	5 or more units	0-0.35
Decrease 1 Category	1-2	Greater than 1 but not more than 3
	3-4 units	Greater than 0.25 but not more than 1
	5 or more units	Greater than 0.35 but not more than 0.50
Decrease 2 Categories	1-2	Greater than 3
	3-4 units	Greater than 1
	5 or more units	Greater than 0.50

Rental Licenses for Council Approval on May 11, 2020								
Property Address	Dwelling Type	Renewal or Initial	Owner	Property Code Violations	License Type	Police CFS *	Final License Type **	Previous License Type ***
3141 49th Ave N	Single	Initial	Matthew Forster/Elbrus Mgt	7	III	N/A	III	
5019 61st Ave N	Single	Initial	Emmanuel Togbah	31	IV	N/A	IV	
5353 72nd Cir	Single	Initial	Donovan Gilbert / N & G Financial	0	II	N/A	II	
3818 Burquest La	Single	Initial	Ayan I Yusuf/Loving Touch Inc	4	II	N/A	II	
6418 Girard Ave N	Single	Initial	Genet Mahalu Gashaw	9	III	N/A	III	
5305 67th Ave N	Single	Renewal	Sai Yang	0	I	0	I	I
2208 69th Ave N	Single	Renewal	Eli Mash/3511 Fremont LLC - Mitigation Plan Not Met, Missing Crime Free Housing	10	IV	0	IV	IV
5712 Bryant Ave N	Single	Renewal	FYR SFR BORROW LLC	5	II	0	II	I
5834 Camden Ave N	Single	Renewal	FYR SFR BORROW LLC - met mitigation plan	13	IV	0	IV	IV
5316 Colfax Ave N	Single	Renewal	FYR SFR BORROW LLC	6	III	0	III	IV
5420 Fremont Ave N	Single	Renewal	Ross Herman	8	III	0	III	II
5426 Fremont Ave N	Single	Renewal	Matthew Klein	9	III	0	III	II
5642 Logan Ave N	Single	Renewal	MNSF II W1 LLC - missing CPTED follow up	5	II	0	IV	IV
7019 Morgan Ave N	Single	Renewal	Cory Lee McClure / Candlewood Home Buyers	5	II	0	II	II
6900 Quail Ave N	Single	Renewal	Michael Johnson	3	II	0	II	II
6924 Scott Ave N	Single	Renewal	Mohammed Mohammed	13	IV	0	IV	II

* CFS = Calls For Service for Renewal Licenses Only (Initial Licenses are not applicable to calls for service and will be listed N/A.)

** License Type Being Issued

*** Initial licenses will not sho\ Type 1 = 3 Year Type II = 2 Year Type III = 1 Year

All properties are current on City utilities and property taxes

Council Regular Meeting

DATE: 5/11/2020

TO: City Council
FROM: Curt Boganey, City Manager
THROUGH: Meg Beekman
BY: Community Development Director

SUBJECT: Ordinance Amending Chapter 3 of the City Code of Ordinances

Background:

The International Code Council (ICC) is a nonprofit member-based association that provides a wide range of building safety solutions including product evaluation, accreditation, certification, codification and training. It develops model codes and standards used worldwide. The ICC reviews their model codes and amends them ever few years. Most recently, the ICC adopted an amended set of codes in 2018.

The State of Minnesota oversees and enforces construction activity in the state through the Department of Labor and Industry. The state adopts state building codes which apply throughout the state. In 2020 the State of Minnesota adopted new code requirements that included the 2018 ICC codes with amendments.

The Department of Labor and Industry authorizes municipalities to administer and enforce various provisions of the state's building codes provided the municipality adopts the codes into city ordinance.

Chapter 3 of the Brooklyn Center City Code provides for the application, administration and enforcement of various provisions and amendments to the Minnesota State Building Code including adoption of the National Electrical Code, the Residential Energy Code, the Commercial Energy Code and the Minnesota State Mechanical Fuel Gas and Plumbing Codes in the City of Brooklyn Center.

Currently, the City is enforcing the newly adopted provisions under the State Building Code with authority provided through State Statutes; however, the state does require that cities formally adopt the amended codes within a certain time period in order to continue to administer the program. The adoption of this code will align our standards with the State Statutes and allow for standards to be consistent between agencies.

A document is attached that provides information regarding the significant changes to the codes.

The following general changes were made when the State adopted the 2020 code to replace the previously adopted 2015 code. The code included many changes that helped to clarify the interpretation of the code.

- Modification to basement egress window requirements - No egress window(s) would be required in a basement or basement bedroom(s) if there is an automatic sprinkler system installed throughout the building or if the entire basement including all portions of the means of egress to the exit discharge and all open areas on the level of discharge are protected with sprinklers.
- Clarification on when to require interconnected smoke alarms or battery operated smoke alarms.
- Modification to the calculation of required wind loads.
- Adding Roof Access requirements for solar energy systems.

- Reorganizing and clarification of deck requirement relating to materials and fasteners.
- Adds appendix Q to Residential Code relating to tiny homes - Applies to homes under 400 square feet in size, ceiling height of 6 ft-8 inches. Regulation for Lofts, Stairs, ladders and emergency exits. The adoption of this appendix doesn't grant permission for tiny homes. It only regulates how that are built, if they are permitted by the Zoning Code.
- The Minnesota Plumbing Code was replacing by the 2012 Uniform Plumbing Code.

Budget Issues:

The city will have some costs related to the purchase of new code books. $500 is budgeted in the 2021 budget.

Strategic Priorities and Values:

Safe, Secure, Stable Community

ATTACHMENTS:

Description	Upload Date	Type
2020 Changes Overview	4/16/2020	Backup Material
State Code 2020 Guide	4/16/2020	Backup Material
Ordinance	4/23/2020	Ordinance

DEPARTMENT OF LABOR AND INDUSTRY

Significant changes in the 2020 Minnesota Residential Code

The 2020 Minnesota Residential Code is effective March 31, 2020. The 2020 Minnesota Residential Code adopts the 2018 edition of the International Residential Code (IRC), with amendments. The IRC governs new construction of one- and two-family homes and buildings with three or more townhouses, provided the structure is not more than three stories above grade.

The following IRC provisions are changed by Minnesota amendments:

Administration and Definitions

- Adds a definition of transient and directs code users to the IBC for requirements for dwellings intended for transient use

Sections R 310.1 and R310.6 provisions for emergency escape and rescue openings for new and existing basements

- Emergency escape and rescue openings are required in new basements and bedrooms created in existing basements **unless** the entire basement area, all portions of the means of egress to the level of exit discharge, and all areas on the level of exit discharge are protected with an automatic sprinkler system

Sections R314 and R315 Smoke Alarms and Carbon Monoxide Detectors

- Existing homes are permitted to be equipped with battery-powered smoke alarms and carbon monoxide detectors that are not interconnected unless alterations or repairs result in the removal of interior wall or ceiling finishes
- Hardwired, interconnected smoke alarms are not required in existing homes where the basement or attic provides access to the hardwiring
- New homes continue to be required to have hardwired, interconnected smoke alarms

Table R402.2 Minimum specified compressive strength of concrete

- Clarifies that 5,000 psi concrete is not required for post footings decks or porches, wood foundations, slab-on-grade foundation walls and footings for floating slabs

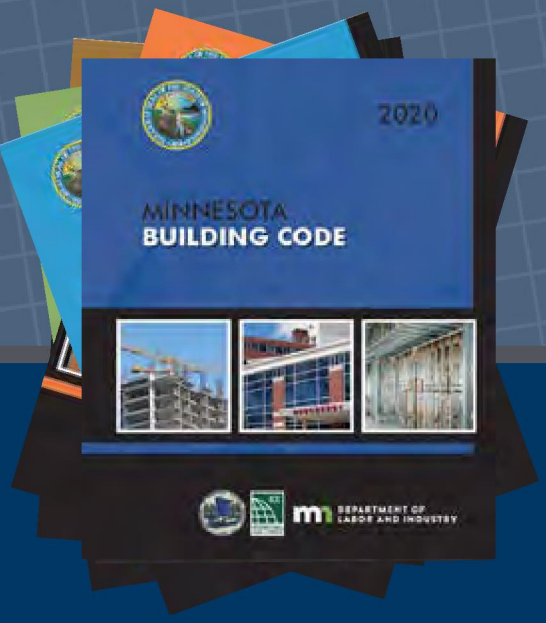
Section 404 Foundation and Retaining Walls

- Table R404.1(1) includes prescriptive requirements for foundation walls up to 10 feet in height

The 2020 Minnesota Residential Code also includes these significant changes from the 2018 IRC:

- **Section R301.2.1 Wind design criteria** require dwellings to be constructed using ultimate design wind speed (V_{ult}) instead of basic wind speed (V_{asd}). Table R301.2.1.3 provides conversions from V_{ult} to V_{asd}. The actual design wind loads will be equal or slightly less using ultimate wind design speed instead of basic wind speed.

- **Section R324 Solar Energy Systems** adds new provisions solar energy systems. Roof-mounted solar PV systems must allow for roof access, including access pathways from the lowest roof edge to the ridge and setbacks at the ridge.
- **Section R507 Exterior Decks** reorganizes and clarifies requirements for decks, including requirements for materials and fastener and fastener connections.
- **Appendix Q** addresses tiny houses by providing certain allowances for homes less than 400 square feet in size.



MINNESOTA
Guide to the State Building Code

- Administration
- Special Provisions
- Commercial Building
- Elevators and Related Devices
- Residential Building
- Existing Buildings
- Electrical
- Flood-proofing
- Energy Conservation
- Accessibility
- Mechanical and Fuel Gas
- Plumbing
- High Pressure Piping Systems
- Manufactured Homes
- Prefabricated Structures
- Industrialized/Modular Buildings
- Storm Shelters

THE GREAT SEAL OF THE STATE OF MINNESOTA
L'ETOILE DU NORD
1858

DEPARTMENT OF LABOR AND INDUSTRY



INTRODUCTION

For nearly 50 years, the Minnesota State Building Code has been the standard by which buildings have been constructed to provide our citizens with safe, energy efficient and accessible buildings.



From the many buildings built during those years, no one will know the countless lives saved from fire, structural collapse and hazardous materials; the injuries prevented from falls, shattered glass and electric shock; or the prevention of damage to buildings from roof ice, frost heave or water leakage. In addition, many hundreds of buildings are now fully accessible and usable for our family members and friends with disabilities while much less fossil fuel has had to be burned to heat and cool these same buildings.

This Guide looks back to the original intent of the legislature to provide safe and affordable housing, places to work, shop, eat, congregate, do business, recreate and worship. It reviews where these protections currently exist in the state and what codes are in place to ensure this occurs.

The purpose of this Guide is to inform and educate regulators, government officials and policy makers about the State Building Code and how it serves the public's interest by providing for the safe use of buildings. Because one of the most important roles of government is to protect its citizens, it is our responsibility to ensure this occurs in the construction of buildings.

Scott D. McLellan
State Building Official

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HISTORY

1965 A State Building Code was established that applied only to state-owned buildings.

1971 The first State Building Code was enacted into law that applied to all areas of Minnesota that enforced a building code. Up to this point, each municipality maintained its own unique building code or had none at all.

1972 The State Building Code became effective on July 1. If a municipality enforced a building code, it now had to be the State Building Code.



Photo credit: Ben Franske - Own work, GFDL, https://commons.wikimedia.org/w/index.php?curid=4390505

1977 Legislation established that the State Building Code would be enforced statewide beginning Jan. 1, 1977, but no later than Jan. 1, 1978. Subsequent legislation passed in 1978 extended the date for mandatory state-wide enforcement of the State Building Code to Jan. 1, 1979.

1979 Legislation provided that a non-metropolitan county may by negative referendum rescind enforcement of the State Building Code (except provisions for accessibility). This enabled county residents and those residing in cities that had not already adopted the code by January 1977 to participate in the vote.

- If the vote was negative, the code no longer applied to townships or cities located within the county.
- As a result of the referendums, only eight counties voted to retain the State Building Code. These were in addition to the seven mandatory metropolitan counties.

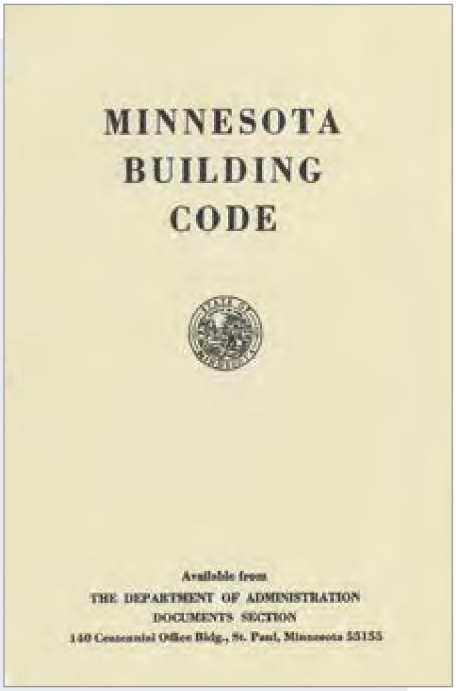
1981 Legislation allowed municipalities having a population of less than 2,500 to decide whether or not the State Building Code will apply in their jurisdiction. If these municipalities had already adopted the code, they can now rescind their ordinance adopting the State Building Code (unless they were located in one of the seven metropolitan counties mandated to enforce the State Building Code).

2008 Legislation established for the first time that the State Building Code is the standard that applies statewide for the construction and remodeling of buildings. This means that the State Building Code now applies to all work, regardless of whether or not the State Building Code is required to be enforced by a municipality. This applies to everyone who constructs or remodels buildings, both homeowners and contractors.

2008 Legislation established that as of Jan. 1, 2008, if a municipality had in effect an ordinance adopting the State Building Code, that municipality must continue to enforce the State Building Code and may not repeal its adopting ordinance. The exception is for those municipalities having a population of less than 2,500 (as permitted by the 1981 legislation).

LEGISLATIVE INTENT

Below is an excerpt from the 1971 Session Laws when the legislature first authorized creation of a State Building Code. The purpose of the code, as shown in the first and fourth paragraphs, still appears today in Minnesota Statute 326B.101. The second and third paragraphs describe factors facing the construction industry and society at the time that likely contributed to the establishment of the first State Building Code.



LAWS 1971 – REGULAR SESSION
Be in enacted by the Legislature of the State of Minnesota:

Section 1. Minnesota Statutes 1969, Section 16.83, is amended to read:

16.83 STATE BUILDING CODE; POLICY AND PURPOSE; APPROPRIATING MONEY. Sections 1 to 17 of the act are enacted to enable the commissioner of administration to promulgate and administer a state building code in accordance with the provisions hereof, which code shall govern the construction, reconstruction, alternation, and repair of state-owned buildings and other structures to which the code is applicable. It is necessary that building codes be adopted and enforced to protect the health, safety, welfare, comfort, and security of the residents of this state. However, the construction of buildings should be permitted at the least possible cost consistent with recognized standards of health and safety.

Many citizens of the state are unable to secure adequate housing at prices or rentals which they can afford. Such a situation is contrary to the public interest and threatens the health, safety, welfare, comfort, and security of the people of the state. Other persons in commerce and industry are also affected by the high cost of construction. Construction costs for buildings of all types have risen and are continuing to rise at unprecedented rates.

A multitude of laws, ordinances, rules, regulations, and codes regulating the construction of buildings and the use of materials therein is a factor contributing to the high cost of construction. Many such requirements are obsolete, complex, and unnecessary. They serve to increase costs without providing correlative benefits of safety to owners, builders, tenants, and users of buildings.

It is the purpose of this act to prescribe and provide for the administration and amendment of a state code of building construction which will provide basic and uniform performance standards, establish reasonable safeguards for health, safety, welfare, comfort, and security of the residents of this state who are occupants and users of buildings, and provide for the use of modern methods, devices, materials, and techniques which will in part tend to lower construction costs.

PURPOSE

The purpose of the State Building Code is described in Minnesota Statutes 326B.101 where it reads:

> The commissioner shall administer and amend a state code of building construction which will provide basic and uniform performance standards, establish reasonable safeguards for health, safety, welfare, comfort, and security of the residents of this state and provide for the use of modern methods, devices, materials, and techniques which will in part tend to lower construction costs. The construction of buildings should be permitted at the least possible cost consistent with recognized standards of health and safety.

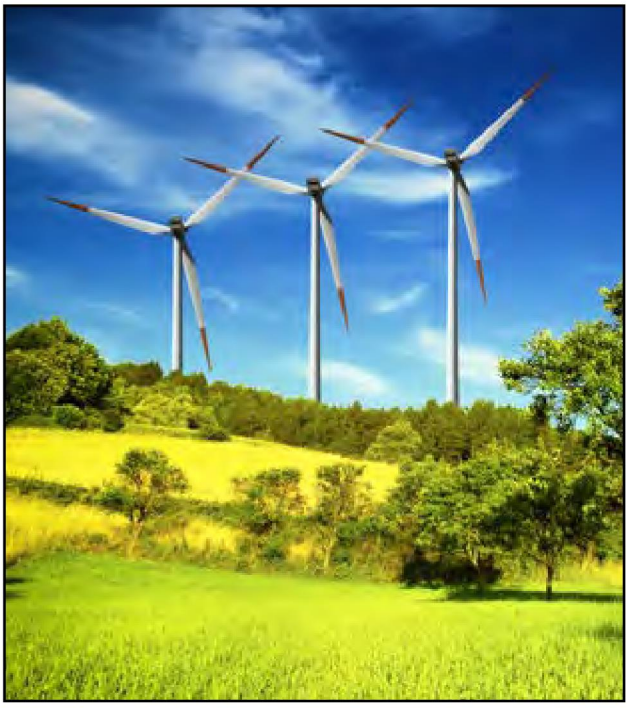
In other words:

- **Basic** – *minimum*
- **Uniform** – *everyone designs and builds to comply with the same requirements*
- **Performance standards** – *requirements should focus on the outcome not specific methods*
- **Reasonable safeguards** – *not overly complex, costly or difficult*
- **Health** – *safe clean water, proper sewer, sanitation, air quality, light, ventilation*
- **Safety** – *protection from fire, smoke, falling, wind, snow, frost, extreme temperature, electrocution, hazardous materials, panic, breaking glass, structural collapse*
- **Welfare** – *accessibility, conserves energy resources, peace of mind, habitability*
- **Comfort** – *heating facilities, soundproofing between apartments, room size*
- **Security** – *school safety, nursing home dementia units, correctional facilities*
- **Provide for the use of modern methods, devices, materials and techniques which will in part tend to lower construction costs** – *encourage and recognize innovation and technologies that provide cost savings in labor, equipment, and building materials*
- **The construction of buildings should be permitted at the least possible cost consistent with recognized standards of health and safety** – *manage adoption of nationally recognized safety and health codes to keep construction costs as low as possible*

FEDERAL IMPACT

Energy

Minnesota is obligated to review and adopt a new commercial energy code when recommended by the U.S. Department of Energy. However, when a new, more efficient residential energy code becomes available, Minnesota is only required to review and consider adopting the new code.



Manufactured Homes

Since 1976, Minnesota has been a State Administrative Agency (SAA) for the U.S. Department of Housing and Urban Development for the installation of manufactured homes. As a condition of being an SAA, Minnesota must adopt installation and dispute-resolution programs compatible with federal regulations for manufactured homes.

Prefabricated Structures

Since 1995, Minnesota has been part of an interstate compact for the regulation of prefabricated structures and modular buildings. This compact obligates Minnesota and partner states to follow specific state codes as well as uniform model rules and regulations when constructing prefabricated structures.



Accessibility

Although Minnesota is not required by the federal government to administer an accessibility code, the Americans with Disabilities Act (ADA) established both the requirement and standard that all new and remodeled buildings are required to follow. To simplify compliance for architects and building owners, Minnesota adopted a model accessibility code that is compatible with ADA.

UNIFORMITY

The State Building Code preempts and supersedes local regulation for the construction of buildings. A key purpose of the legislature establishing a single State Building Code was to promote uniformity of construction standards throughout Minnesota.

Uniformity is important for several reasons:

Reduced cost

Contractors only have to learn one code. This enables them to become more efficient in their design and construction methods, thus minimizing construction costs. Building product manufacturers are able to reduce their costs as they can design their materials to meet just one standard.

Levels the competition

As the entire construction industry uses the same standard, estimating construction costs will be equitable.

Consistent code enforcement

Building officials throughout Minnesota are trained to understand and enforce a single standard. This promotes uniform application and enforcement of the code, thus minimizing errant interpretations, construction delays and additional construction cost.

Statutory requirements for uniformity

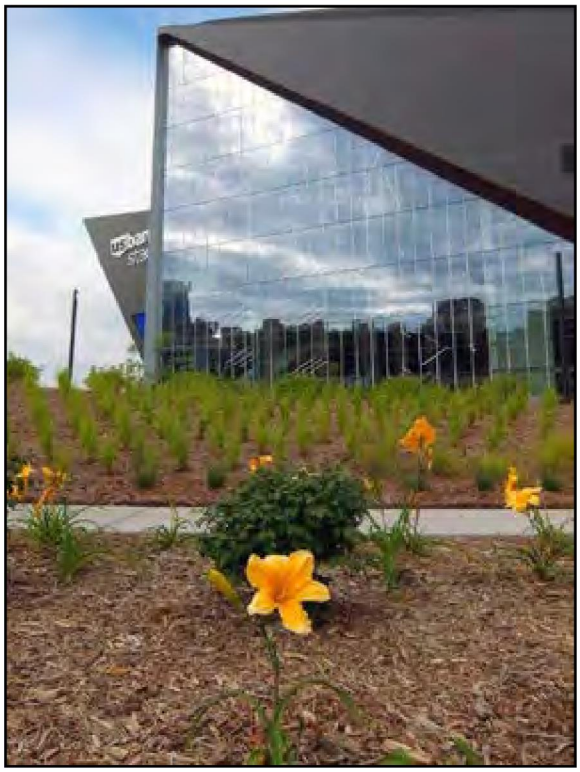
Minnesota Statute 326B.121 Subd. 1(a):
The State Building Code is the standard that applies statewide for the construction, reconstruction, alteration, repair, and use of buildings and other structures of the type governed by the code.

Minnesota Statute 326B.121 Subd. 1(b):
The State Building Code supersedes the building code of any municipality.

Minnesota Statute 326B.121 Subd. 2(c):
A municipality must not by ordinance, or through development agreement, require building code provisions regulating components or systems of any structure that are different from any provision of the State Building Code.



BENEFITS



- Provides safe and healthy buildings
- Provides peace of mind that buildings are safe to be used as intended
- Provides accessible buildings for all people, regardless of ability
- Provides energy efficient buildings
- Provides buildings that are resilient to weather extremes
- Provides reduced property loss in the event of fire, flood, wind and snow
- Provides consistency in building design, bidding process and building construction
- Provides financial institutions with an assured value of quality and safety. Most require evidence of this through the Certificate of Occupancy
- Provides insurance companies with permit, inspection and occupancy approvals to verify insurability
- Provides prospective property owners with documented improvement records that are sometimes necessary for real estate transfers and tax purposes
- Provides the Insurance Services Office (ISO) with a measurable industry standard to determine cost-effective statewide insurance ratings
- Provides FEMA with a responsible safety standard to base reconstruction costs to replace or repair disaster-destroyed property
- Provides the public with a way to verify that work is done by licensed contractors, architects and engineers
- Provides a standard for consumer protection through Minnesota's Contractor Licensing program and Contractor Recovery Fund
- Provides compatibility with the State Fire Code
- Provides quality community development through the construction of buildings that meets the needs of society, municipalities, building owners and residents

REQUIREMENTS

The State Building Code is a set of documents that regulate the construction of buildings so they are safe, energy efficient and accessible. The specific regulations contained in the State Building Code appear in one of three forms: model codes and standards, Minnesota Rules and Minnesota Statutes.

Model codes

Minnesota law requires the State Building Code to conform as much as possible to model building codes generally accepted and in use throughout the United States. A model code is a book of published construction regulations developed by members of an organization having subject-matter expertise. Model codes are intended for adoption into law by local governments, states and even countries. Because writing codes requires a great deal of work by many experienced and varied industry experts, this is usually beyond the capacity of a local government to produce on its own.

The preferred way to efficiently regulate building safety, accessibility for the disabled and energy efficiency is through the adoption and enforcement of model codes. However, because model codes are produced for widespread use throughout all parts of the country, state government must usually amend or change some provisions in order to address its own particular geography, climate and legislative mandates.

Minnesota rules

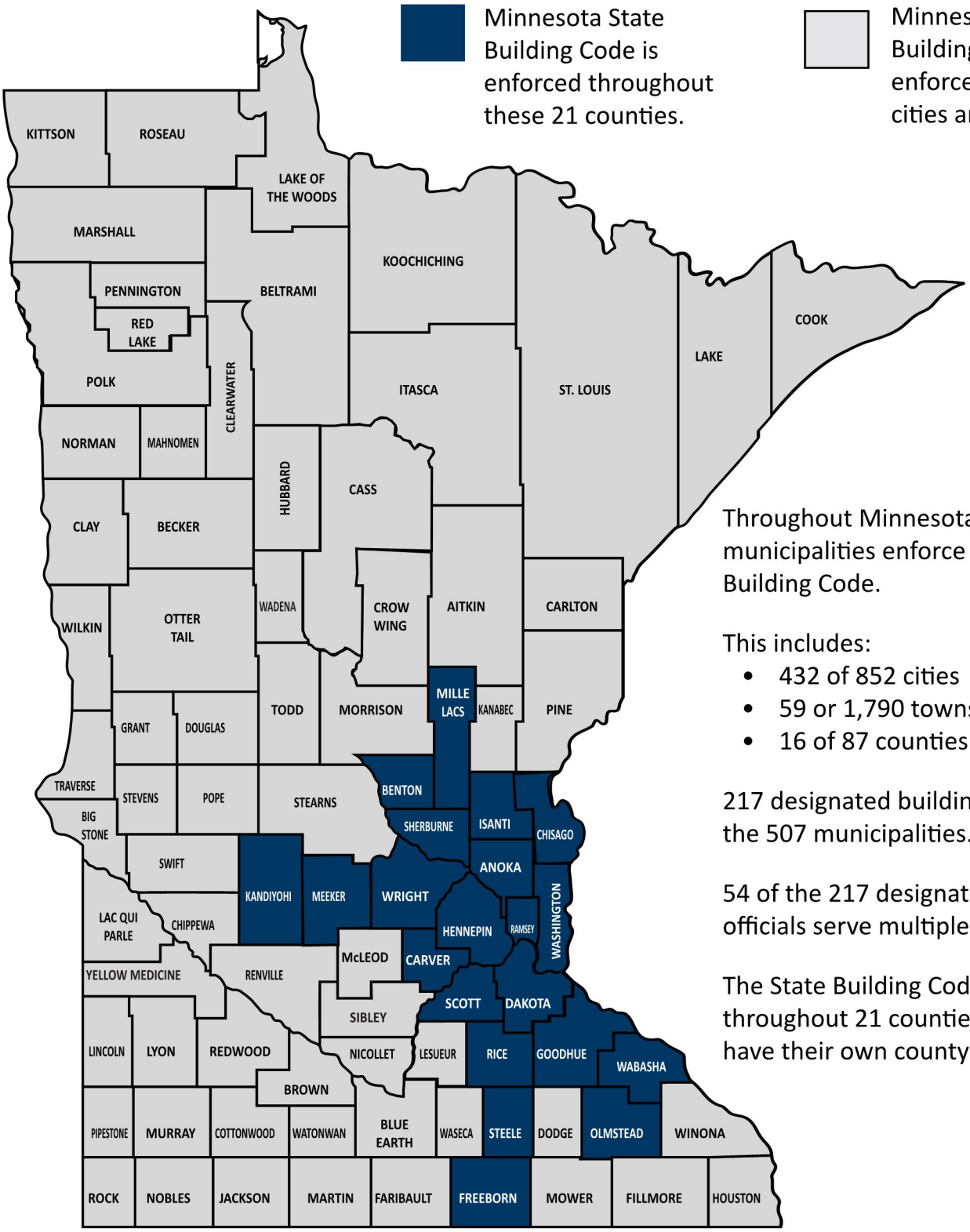
Minnesota law states that the commissioner [of the Minnesota Department of Labor and Industry] shall by rule and in consultation with the Construction Codes Advisory Council establish a code of building standards. A rule is a type of Minnesota law that is produced by a state agency through a legally prescribed process. Although authority for making a rule must be granted by the legislature, the legislature is not directly involved in the process. Adopting a model code into the State Building Code is done by rule. Another example of a rule is when the changes are made to specific requirements of the model code. Usually these are referred to as amendments or amending the model code.

Minnesota statutes

Even though the State Building Code is established by rule using model codes, the legislature can still enact specific requirements into law to regulate the construction of buildings. Most often, this occurs as a result of a tragedy or string of accidents where the State Building Code may not have provided adequate protections. Examples of some of the special provisions passed into law by the legislature include:

- bleacher safety,
- window-fall protection,
- required safety devices for automatic garage door openers,
- window-cleaning safety anchorages,
- radon control, and
- smoke detection devices.

ENFORCEMENT AREAS



Throughout Minnesota, 507 municipalities enforce the State Building Code.

This includes:

- 432 of 852 cities
- 59 or 1,790 townships
- 16 of 87 counties

217 designated building officials serve the 507 municipalities.

54 of the 217 designated building officials serve multiple municipalities.

The State Building Code is enforced throughout 21 counties, 16 of which have their own county building official.

CHAPTERS

The Minnesota State Building Code consists of 18 chapters. Most of them adopt by reference a model code or standard that has been developed by a national code-making organization. The remaining chapters contain subject matter that has been written specifically for Minnesota.

1300 – Minnesota Building Code Administration

1303 – Special Provisions

1305 – Minnesota Commercial Building Code

1307 – Elevators and Related Devices

1309 – Minnesota Residential Code

1311 – Minnesota Conservation Code for Existing Buildings

1315 – Minnesota Electrical Code

1322/23 – Minnesota Energy Code

1335 – Flood-proofing Regulations

1341 – Minnesota Accessibility Code

1346 – Minnesota Mechanical and Fuel Gas Code

1350 – Manufactured Homes

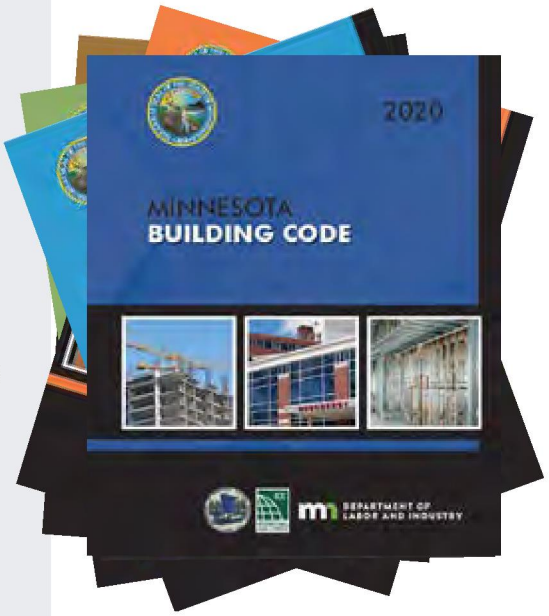
1360 – Prefabricated Structures

1361 – Industrialized/Modular Buildings

1370 – Storm Shelters (Manufactured Home Parks)

4714 – Minnesota Plumbing Code

5230 – Minnesota High Pressure Piping Systems



CODE BOOK FACT SHEET
2020 MINNESOTA BUILDING CODE ADMINISTRATION

2020 MINNESOTA BUILDING CODE ADMINISTRATION

- Regulates the administration of all Minnesota adopted codes.
- Contains detailed provisions governing building official duties, building department operations, permits, plan review, violations, fees, inspections, board of appeals and certificate of occupancy.
- Located in Minnesota Rules Chapter 1300. This rule chapter replaces the administrative chapters in each of the 2018 International Code Council (ICC) model codes adopted by Minnesota.

EFFECTIVE DATE

- Updates to Minnesota Building Code Administration are effective **March 31, 2020**.

CODE BOOK

The 2020 Minnesota Building Code Administration is incorporated into custom code books published for Minnesota by the International Code Council (ICC). There is no longer a need to separately purchase the ICC model code and Minnesota amendments and refer to them both. Now they are contained in a single reformatted Minnesota-specific code book.

The Minnesota Building Code Administration is available for free online viewing or can be purchased in soft-cover format as part of Minnesota's other published codes.



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- Visit www.dli.mn.gov/business/codes-and-laws to view the code.

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CODE BOOK FACT SHEET
2020 MINNESOTA PROVISIONS TO THE STATE BUILDING CODE

2020 MINNESOTA PROVISIONS TO THE STATE BUILDING CODE

- Addresses a number of subjects related to Minnesota's climatic conditions and other provisions not appropriately regulated in the International Residential Code (IRC) or International Building Code (IBC).
- Contains Minnesota provisions addressing restroom facilities in public buildings, parking spaces for commuter vans, automatic garage door opening systems, recycling space, footing frost protection, ground snow load, radial ice on towers, wood for exterior decks, patios and balconies, bleacher safety, simplified wind loads and radon.
- Located in Minnesota Rules Chapter 1303. This rule chapter contains special code provisions required by Minnesota statutes.

EFFECTIVE DATES

- Updates to Minnesota Provisions to the State Building Code are effective **July 31, 2020**.

CODE BOOK

The 2020 Minnesota Provisions to the State Building Code is incorporated into both the Minnesota Building Code and Minnesota Residential Code published for Minnesota by the International Code Council (ICC). There is no longer a need to separately purchase the ICC model code and Minnesota amendments and refer to them both. Now they are contained in a single reformatted Minnesota-specific code book.

The Minnesota Provisions to the State Building Code is available for free online viewing or can be purchased as part of the Minnesota Building or Minnesota Residential codes in soft-cover format.

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CODE BOOK FACT SHEET
2020 MINNESOTA BUILDING CODE

2020 MINNESOTA BUILDING CODE

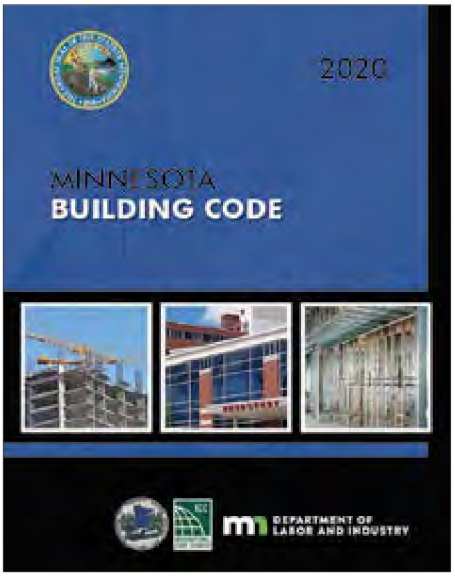
- Regulates the design, construction, addition, alteration, repair, use and location of all buildings and structures other than those regulated by the 2020 Minnesota Residential Code.
- Contains detailed provisions governing building construction. These include requirements for structural, means of egress, sanitation, life-safety, fire-safety, and moisture protection.
- Located in Minnesota Rules Chapter 1305. This rule chapter adopts by reference Chapters 2 through 33 and 35 of the 2018 International Building Code (IBC) and includes amendments to the IBC.

EFFECTIVE DATES

- Minnesota Building Code is effective **March 31, 2020**.

CODE BOOK

The 2020 Minnesota Building Code is a custom code book published for Minnesota by the International Code Council (ICC). It includes Minnesota's amendments into the body of changed sections and reads as a unified code book. It also includes Minnesota chapters about administration, radon and elevators. There is no longer a need to separately purchase the ICC model code and Minnesota amendments and refer to them both. Now they are contained in a single reformatted Minnesota-specific code book.



Code books are available for purchase and free, online viewing is available.

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CODE BOOK FACT SHEET
2020 MINNESOTA ELEVATOR AND RELATED DEVICES CODE

2020 MINNESOTA ELEVATOR AND RELATED DEVICES CODE

- Regulates the design, construction, installation, alteration, repair, removal, operation and maintenance of elevators and related devices.
- Contains detailed provisions governing passenger elevators, freight elevators, hand-powered elevators, dumbwaiters, escalators, moving walks, vertical reciprocating conveyors, stage and orchestra lifts, endless belt lifts, wheelchair lifts and other related devices.
- Located in Minnesota Rules Chapter 1307. This rule chapter incorporates certain standards of the American Society of Mechanical Engineers (ASME), Chapter 30 of the 2018 International Building Code (IBC), and Minnesota amendments in Minnesota Rules Chapter 1305.

EFFECTIVE DATE

- Minnesota Elevator and Related Devices Code anticipated effective date is **mid-2020**.

CODE BOOK

The 2020 Minnesota Elevator and Related Devices Code incorporates several ASME codes and standards with Minnesota amendments.

TO VIEW CODES ONLINE FREE

- Minnesota Rules Chapter 1307, Elevators and Related Devices, www.revisor.mn.gov/rules/1307/

TO PURCHASE CODE BOOKS

- The American Society of Mechanical Engineers at www.asme.org/codes-standards/publications-information/safety-codes-standards



CODE BOOK FACT SHEET
2020 MINNESOTA RESIDENTIAL CODE

2020 MINNESOTA RESIDENTIAL CODE

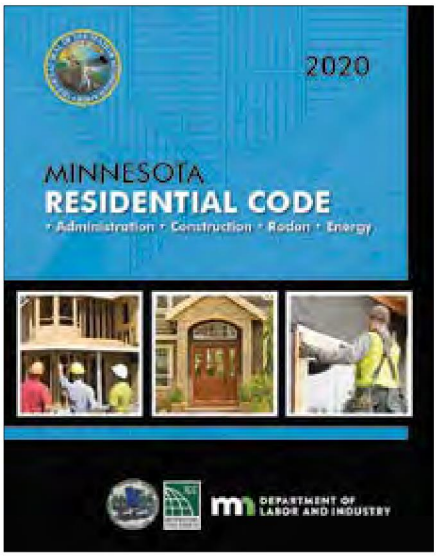
- Regulates the design, construction, addition, alteration, repair, use, and location of detached one- and two-family dwellings, certain townhouses and their accessory structures.
- Contains detailed provisions governing dwelling construction including requirements for structural, life-safety, fire-safety and moisture protection.
- Located in Minnesota Rules Chapter 1309. This rule chapter adopts by reference Chapters 2 through 10, 44, Section P2904, and Appendix K and Q from the 2018 International Residential Code (IRC) as amended in Minnesota.

EFFECTIVE DATES

- Residential Code is effective **March 31, 2020.**

CODE BOOK

The 2020 Minnesota Residential Code is a custom code book published for Minnesota by the International Code Council (ICC). It includes Minnesota's amendments into the body of changed sections and reads as a unified code book. It also includes Minnesota chapters about Administration, Radon and Energy. There is no longer a need to separately purchase the ICC model code and Minnesota amendments and refer to them both. Now they are contained in a single reformatted Minnesota-specific code book.



The Minnesota Residential Code is available for free online viewing or can be purchased in soft-cover format (English and Spanish versions).

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CODE BOOK FACT SHEET
2020 MINNESOTA CONSERVATION CODE FOR EXISTING BUILDINGS

2020 MINNESOTA CONSERVATION CODE FOR EXISTING BUILDINGS

- Regulates the design, alteration, repair, addition, change of occupancy and relocation of existing buildings and structures, including historic buildings. This code does not apply to buildings or structures regulated by the 2020 Minnesota Residential Code.
- Contains regulations for building conservation using both prescriptive and performance-based provisions with emphasis on performance. These regulations may often be less restrictive than the IBC, making building conservation and reuse of existing buildings more cost effective while maintaining building safety.
- Located in Minnesota Rules Chapter 1311. This rule chapter adopts by reference Chapters 2 through 16 of the 2018 International Existing Building Code (IEBC) and includes amendments to the IEBC.

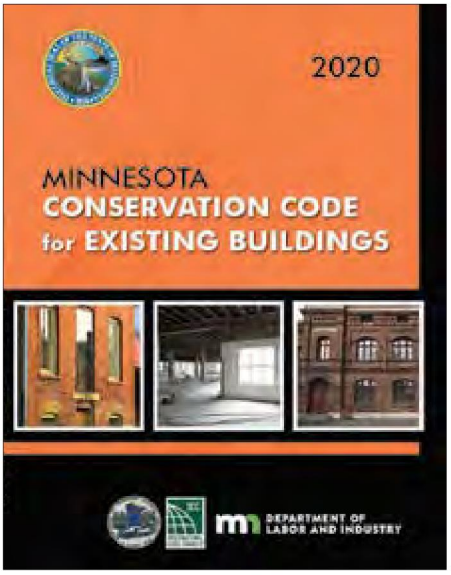
EFFECTIVE DATE

- Conservation Code for Existing Buildings is effective **March 31, 2020**.

CODE BOOK

The 2020 Minnesota Conservation Code for Existing Buildings is a custom code book published for Minnesota by the International Code Council (ICC). It includes Minnesota's amendments into the body of changed sections and reads as a unified code book. It also includes a Minnesota chapter about Administration. There is no longer a need to separately purchase the ICC model code and Minnesota amendments and refer to them both. Now they are contained in a single reformatted Minnesota-specific code book.

The Minnesota Conservation Code for Existing Buildings is available for purchase in soft-cover format. Free online viewing is also available.



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CODE BOOK FACT SHEET
2020 MINNESOTA ENERGY CODE

2020 MINNESOTA ENERGY CODE

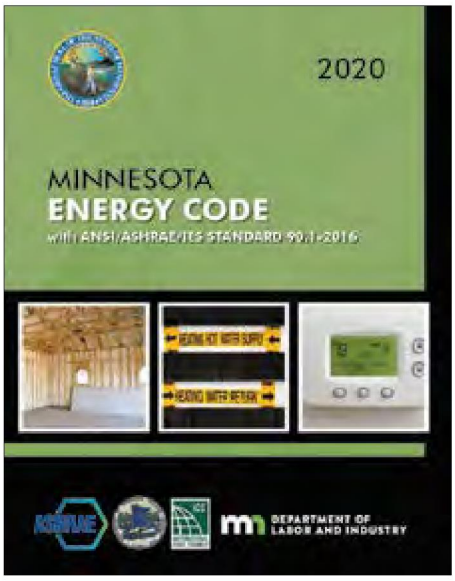
- Provides energy-conserving standards for the design, construction, alteration, renovation and repair of residential and commercial buildings.
- Contains design and construction standards regarding heat-loss control, illumination and climate control.
- Located in Minnesota Rules Chapters 1322 and 1323. This rule chapter adopts by reference Chapters 2(RE) through 5(RE) of the 2012 International Energy Conservation Code (IECC) for residential, 2(CE) through 4(CE) and 6(CE) of the 2018 IECC for commercial, and optional AHSRAE Standard 90.1-2016, the 2012 IECC and Minnesota amendments to the IECC. The IECC includes requirements for both residential and commercial buildings.

EFFECTIVE DATE

- Commercial Energy Code with ANSI/ASHRAE/IES Standard 90.1-2016 is effective **March 31, 2020**.
- Residential Energy Code is effective **Feb. 14, 2015**.

CODE BOOK

The 2020 Minnesota Energy Code is a custom code published for Minnesota by the International Code Council (ICC). It includes Minnesota's amendments into the body of changed sections and reads as a unified code book. It also includes a Minnesota chapter on Administration. There is no longer a need to separately purchase the ICC model code and Minnesota amendments and refer to them both. Now they are contained a single reformatted Minnesota-specific code book.



Code books are available for purchase and free, online viewing is also available.

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CODE BOOK FACT SHEET
2020 MINNESOTA ACCESSIBILITY CODE

2020 MINNESOTA ACCESSIBILITY CODE

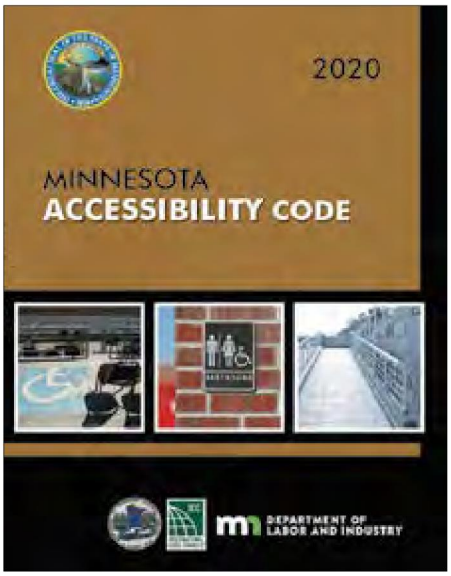
- Provides standards for the design and construction of buildings to be accessible for all persons.
- Contains detailed scoping requirements from IBC Chapter 11 and detailed technical provisions from ICC/ ANSI A117.1-2009 to ensure that buildings and facilities are designed and constructed to be accessible.
- Located in Minnesota Rules Chapter 1341. This rule chapter adopts by reference Chapter 11 of the 2018 International Building Code (IBC), Section 305 of the 2018 International Existing Building Code (IEBC), ICC/ ANSI A117.1-2009, and Minnesota amendments.

EFFECTIVE DATE

- Minnesota Accessibility Code is effective **March 31, 2020**.

CODE BOOK

The 2020 Minnesota Accessibility Code is a custom code published for Minnesota by the International Code Council (ICC). It includes Minnesota's amendments into the body of changed sections and reads as a unified code book. It also includes a Minnesota chapter about Administration. There is no longer a need to separately purchase the ICC model codes and Minnesota amendments and refer to them both. Now they are contained in a single reformatted Minnesota-specific code book.



The Minnesota Accessibility Code is available for purchase in soft-cover format. Free online viewing is also available.

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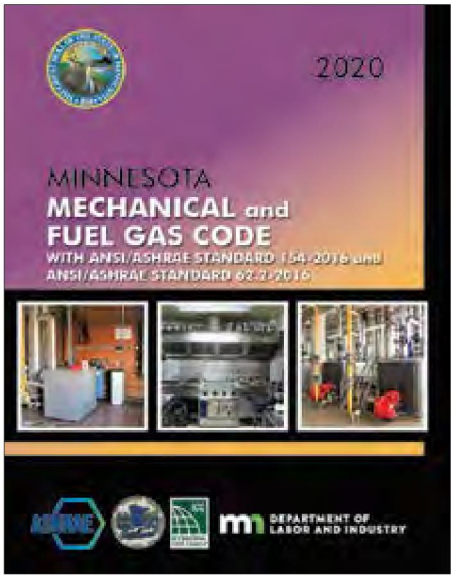
CODE BOOK FACT SHEET
2020 MINNESOTA MECHANICAL AND FUEL GAS CODE

2020 MINNESOTA MECHANICAL AND FUEL GAS CODE

- Regulates the design, installation, maintenance, alteration and inspection of building mechanical systems that are used to provide control of environmental conditions and related processes.
- Contains detailed provisions governing mechanical and fuel gas systems using prescriptive and performance-based provisions with emphasis on performance.
- Located in Minnesota Rules Chapter 1346. This rule chapter adopts by reference Chapters 2 through 15 of the 2018 International Mechanical Code, Chapters 2 through 8 of the 2018 International Fuel Gas Code (including amendments to both), chapters 1 through 9 of ANSI/ASHRAE Standard 154-2016, Ventilation for Commercial Cooking Operations, and ANSI/ASHRAE 62.2-2016, Ventilation and Acceptable Indoor Air Quality in Residential Buildings.

EFFECTIVE DATE

- Minnesota Mechanical and Fuel Gas Code is effective **April 6, 2020**.



CODE BOOK

The 2020 Minnesota Mechanical and Fuel Gas Code is a custom code published for Minnesota by the International Code Council (ICC). It includes Minnesota's amendments into the body of changed sections and reads as a unified code book. It also includes a Minnesota chapter about Administration. There is no longer a need to separately purchase the ICC model codes and Minnesota amendments and refer to them both. Now they are contained in a single reformatted Minnesota-specific code book.

The Minnesota Mechanical and Fuel Gas Code is available for free online viewing or can be purchased in soft-cover format.

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CODE BOOK FACT SHEET
2015 MINNESOTA PLUMBING CODE

2015 MINNESOTA PLUMBING CODE

- Regulates the design and installation of plumbing systems statewide for all buildings including new, addition, alteration, repair and replacement.
- Contains requirements for drain, waste, and vent systems, water supply and distribution systems, backflow prevention, water conditioning equipment, roof drainage systems, plumbing fixtures, materials and non-potable rainwater catchment systems.
- Minnesota Rules, Chapter 4714. The rule incorporates by reference Chapters 2 to 11, 14,and 17 of the 2012 edition of the Uniform Plumbing Code (UPC), and UPC Appendices A, B and I, except for IS 12-2006, IS 13-2006, IS 26-2006, SIS 1-2003 and SIS 2-2003 of Appendix I, with Minnesota amendments.

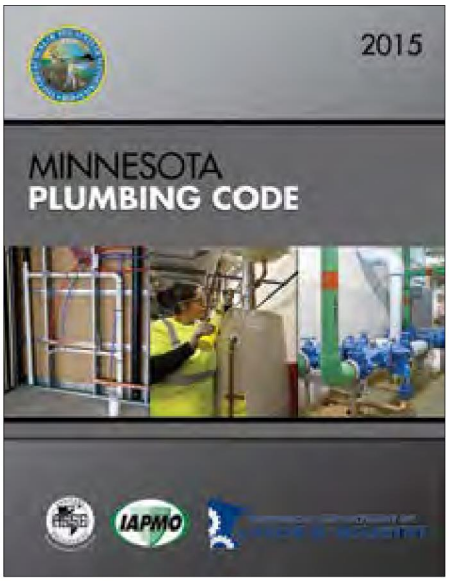
EFFECTIVE DATE

- Minnesota Plumbing Code, Chapter 4714, is effective **Jan. 23, 2016**.
- As of **Jan. 23, 2016**, Chapter 4715 is repealed.

CODE BOOK

The 2015 Minnesota Plumbing Code is published by the International Association of the Plumbing and Mechanical Officials (IAPMO) for Minnesota in a single, reformatted custom code book. It incorporates Minnesota amendments and reads as a unified code book. It also includes Chapter 4716, Plumber Licensing and Apprentice Registration, and Chapter 1300, Minnesota Administration Code.

The 2015 Minnesota Plumbing Code is anticipated to be available for purchased in January 2016 in a soft-cover format. Online viewing will be available soon after publication of the 2015 Minnesota Plumbing Code.



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- International Association of the Plumbing and Mechanical Officials Online Bookstore
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  909-472-4208
  Email: publications@iapmo.org

CODE BOOK FACT SHEET
2019 HIGH PRESSURE PIPING CODE

2019 HIGH PRESSURE PIPING CODE

- Regulates the design, construction and installation of high-pressure steam and other heating mediums, ammonia refrigeration and bioprocess piping systems.
- Contains detailed material and pressure requirements for pipe, fittings and valves as well as procedure, qualification and production welding requirements on high pressure piping (HPP) systems.
- The Board of High Pressure Piping Systems has adopted five model codes, with Minnesota amendments: ASME B31.1-2016 for high pressure steam and other heating mediums; ANSI/IIAR2-2014 and ASME B31.5-2016 for ammonia refrigeration; ASME BPE-2016 for bioprocess; and ASME Section IX-2017 for welding requirements on all high-pressure piping systems.

EFFECTIVE DATE

- Minnesota Rules Chapter 5230, containing the Minnesota High Pressure Piping Code, is effective **May 14, 2019.**

CODE BOOK

Minnesota High Pressure Piping Laws and Rules is available for free online viewing or can be purchased as part of the Minnesota Building Code in soft-cover format.

The four American Society of Mechanical Engineers (ASME) codes adopted by reference as part of the Minnesota High Pressure Piping Code are available for purchase online through ASME or other third-party vendors.

The International Institute of Ammonia Refrigeration Standard ANSI/ IIAR2-2014 is available for purchase online through IIAR.



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- American Society of Mechanical Engineers www.asme.org/shop/standards or 800-843-2763
- International Institute of Ammonia Refrigeration www.iiar.org or 703-312-4200

CODE BOOK FACT SHEET
2020 NATIONAL ELECTRICAL CODE

2020 NATIONAL ELECTRICAL CODE

- The 2020 National Electrical Code (NEC) provides the minimum installation criteria for electrical wiring for commercial, residential and industrial occupancies. The original code document was developed in 1897 as a result of united efforts of various insurance, electrical, architectural and allied interests.
- The purpose of the code is the practical safeguarding of persons and property from hazards arising from the use of electricity. Contains prescriptive installation requirements for premises wiring systems but is not intended to be a design specification or an instruction manual for untrained persons.
- The code is adopted by the Minnesota Board of Electricity as required by Minnesota Statutes 326B.32 Subd. 2 (3) pursuant to Chapter 14.

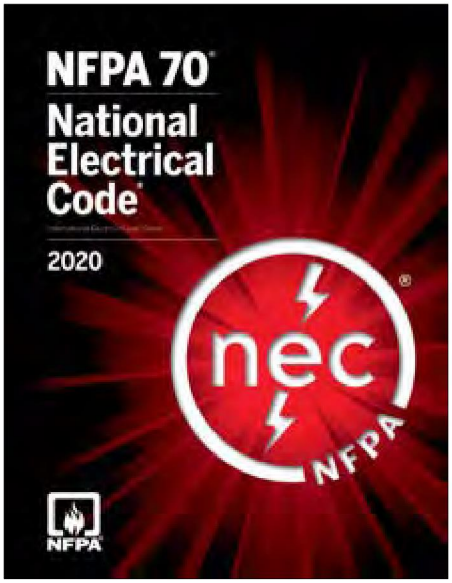
EFFECTIVE DATE

- The 2020 NEC anticipated effective date is **July 1, 2020**, but subject to change.

CODE BOOK

The 2020 NEC is published by the National Fire Protection Association (NFPA) and is adopted in Minnesota without amendment.

The NEC is available for purchase from the NFPA and free online viewing is available with user registration, membership is not required.



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- National Fire Protection Association
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  Quincy, Massachusetts 02169-7471
  1-800-344-3555

CODE BOOK FACT SHEET
INDUSTRIALIZED MODULAR BUILDINGS

INDUSTRIALIZED MODULAR BUILDINGS

- Regulates the construction, review process and approval for industrialized modular buildings built away from the site of occupancy by approved modular builders. Modular buildings may be any occupancy or construction type allowed by code.
- Provides for Minnesota to become member of the Interstate Industrialized Building Commission.
- Contained in Minnesota Rules Chapter 1361. The rule incorporates parts of the 2007 Model Rules and Regulations and 2007 Uniform Administrative Procedures of the Model Rules and Regulations for Industrialized/Modular Buildings as adopted by the Industrialized Buildings Commission.
- Regardless where it is manufactured, the building must be constructed to the Minnesota State Building Code when it is to be installed in Minnesota.
- Industrialized Modular Buildings must be constructed in accordance with the 2020 Minnesota Building Code.



EFFECTIVE DATES

- Interstate Industrialized Building Commission, 2007 Model Rules and Regulations and 2007 Uniform Procedures became effective **July 1, 2007**.
- Minnesota Rule Chapter 1361, Industrialized Modular Buildings, became effective in **1995**.

CODE BOOK

- The 2007 Model Rules and Regulations and 2007 Uniform Administrative Procedures are available online.

TO VIEW CODE ONLINE FREE

- Minnesota Rule Chapter 1361, Industrialized Modular Buildings
  www.revisor.mn.gov/rules/?id=1361

- 2007 IIBC Model Rules and Regulations and Uniform Administrative Procedures
  www.interstateibc.org/forms
-

TO PURCHASE CODE BOOKS

- Minnesota's Bookstore
  www.mnbookstore.com
  651-297-3000 or 1-800-657-3757

- International Code Council
  https://shop.iccsafe.org/state-and-local-codes/minnesota.html or 701-931-4533

CODE BOOK FACT SHEET

MINNESOTA MANUFACTURED HOME CODE

MINNESOTA MANUFACTURED HOME CODE

- Regulates the installation and sales of manufactured homes. Licensing of manufacturers, dealers and installers of manufactured homes built and installed to Code of Federal Regulations.
- Contains detailed regulations for installation and certification of manufactured homes, application forms to sell manufactured homes and record keeping of the sales and installations.
- Is contained in Minnesota Rules Chapter 1350 and the Code of Federal Regulations CFR 3280, 3282, 3285, 3286 and 3288.
- Manufactured homes are required only to be constructed to the Manufactured Home Code, CFR 3280 and 3282.



EFFECTIVE DATES

- Minnesota Rule 1350 became effective **Jan. 4, 2010**.
- CFR 3280 and 3282 became effective **June 15, 1976**.
- CFR 3288 became effective **Feb. 8, 2008**.
- CFR 3285 and 3286 became effective **Jan. 1, 2009**.

CODE BOOK

- Code of Federal Regulations is available at http://portal.hud.gov/hudportal/HUD?src=/program_offices/housing/rmra/mhs/csp.

TO VIEW CODE ONLINE FREE

- Minnesota Rule Chapter 1350, Manufactured homes www.revisor.mn.gov/rules/?id=1350

- Code of Federal Regulations https://portal.hud.gov/hudportal/HUD?src=/program_offices/housing/rmra/mhs/csp

TO PURCHASE CODE BOOKS

- The Institute for Building Technology and Safety (IBTS) at www.ibts.org/publications.html

CODE BOOK FACT SHEET
PREFABRICATED BUILDINGS

PREFABRICATED BUILDINGS

- Governs the construction of prefabricated buildings. These buildings are intended for use as one- and two-family dwellings or accessory buildings of closed construction built away from the site of occupancy typically by vocational schools or lumber yards.
- Contains detailed regulations for the submittal of documents to be reviewed and approved prior to construction. Includes requirements for inspections to determine compliance with the Minnesota State Building Code.
- Is contained in Minnesota Rules Chapter 1360.
- Prefabricated buildings must be constructed in accordance with the 2020 Minnesota Residential Code.



EFFECTIVE DATES

- Minnesota Rule Chapter 1360 became effective in **1995**.

TO VIEW CODE ONLINE FREE

- Minnesota Rule Chapter 1360, Prefabricated Buildings, is available at www.revisor.mn.gov/rules/?id=1360.

TO PURCHASE CODE BOOKS

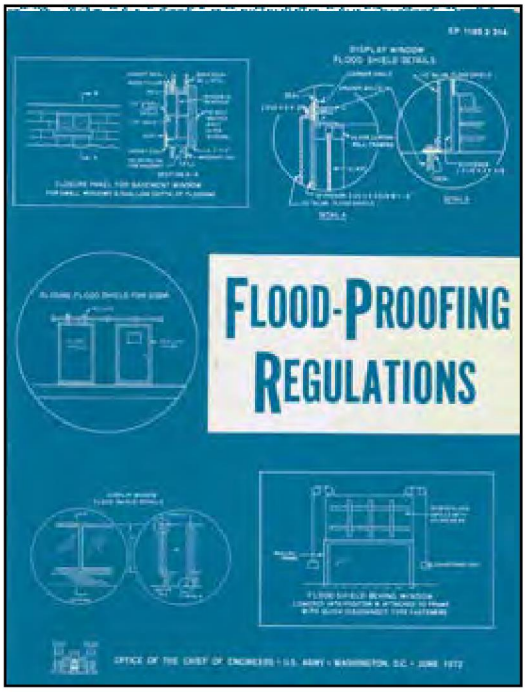
- Minnesota's Bookstore
  www.mnbookstore.com
  651-297-3000 or 1-800-657-3757

- International Code Council
  https://shop.iccsafe.org/state-and-local-codes/minnesota.html
  701-931-4533

CODE BOOK FACT SHEET
MINNESOTA FLOOD-PROOFING CODE

MINNESOTA FLOOD-PROOFING CODE

- Ensures that buildings and structures located in a flood hazard zone are properly flood-proofed or elevated in accordance with prescribed standards.
- These regulations apply to the construction, alteration and repair of any building or parts of a building or structure in the flood hazard area(s) of municipalities.
- Located in Minnesota Rules Chapter 1335. The rule adopts by reference sections 100 to 1406 of the 1972 edition of the "Flood-proofing Regulations" from the Office of the Chief Engineers, U.S. Army, Washington, D.C., and made part of the State Building Code.



EFFECTIVE DATES

- Minnesota Rule Chapter 1335, Flood-proofing, became effective **Jan. 14, 1974**.

CODE BOOK

- 1972 Flood-proofing Regulations by the Office of the Chief Engineers, U.S. Army, Washington, D.C.

TO VIEW CODES ONLINE FREE

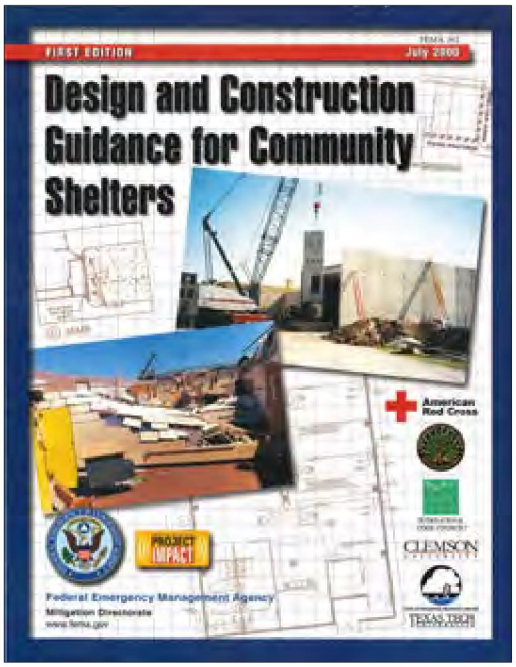
- 1972 Flood-proofing Regulations by the Office of the Chief Engineers, U.S. Army, Washington, D.C., available at www.dnr.state.mn.us/waters/watermgmt_section/floodplain/index.html.
- Minnesota Rule Chapter 1335, Flood-proofing, is available at www.revisor.mn.gov/rules/?id=1335.

CODE BOOK FACT SHEET

STORM SHELTERS

STORM SHELTERS

- Ensures that buildings or portions of buildings intended to shelter manufactured home park residents from tornadoes and extreme winds are constructed to provide required protection.
- Provides minimum standards of design and construction of manufactured home park storm shelters.
- Is contained in Minnesota Rules Chapter 1370, Storm Shelters. The rule adopts by reference FEMA 361, the Design and Construction Guidance for Community Shelters, July 2000, published by the Federal Emergency Management Agency, Washington, D.C.



EFFECTIVE DATES

- Minnesota Rule Chapter 1370, Storm Shelters, became effective **March 1, 1988**.

CODE BOOK

- It is available in the Minnesota State Law Library and the Minnesota Department of Public Safety, Division of Emergency Management, 85 State Capitol, Saint Paul, Minnesota 55155.

TO VIEW CODES ONLINE FREE

- Minnesota Rule Chapter 1370, Storm Shelters, is available at www.revisor.mn.gov/rules/?id=1370.

- www.fema.gov/fema-p-361-safe-rooms-tornadoes-and-hurricanes-guidance-community-and-residential-safe-rooms



Minnesota Department of Labor and Industry
Construction Codes and Licensing Division
443 Lafayette Road N., St. Paul, MN 55155
1-800-657-3944
www.dli.mn.gov

CITY OF BROOKLYN CENTER

Notice is hereby given that a Public Hearing will be held on the 8th day of June 2020, at 7 p.m. or as soon thereafter as the matter may be heard at the City Hall, 6301 Shingle Creek Parkway, to consider an ordinance relating to building codes in the City.

Auxiliary aids for persons with disabilities are available upon request at least 96 hours in advance. Please contact the City Clerk at 763-569-3300 to make arrangements.

ORDINANCE NO. _____

AN ORDINANCE AMENDING CHAPTER 3 OF THE CITY CODE OF ORDIANCES RELATING TO BUILDING CODES

THE CITY COUNCIL OF THE CITY OF BROOKLYN CENTER DOES ORDAIN AS FOLLOWS:

Section 1. Brooklyn Center City Code, Section 3-101, is hereby amended as follows:

CHAPTER 3 - BUILDING CODE

Section 3-101. Building Code. The Minnesota State Building Code, established pursuant to Minnesota Statutes, Sections 16B.59 to 16B.75, one copy of which is on file in the office of the city clerk is hereby adopted as the building code for the City of Brooklyn Center. Such code is hereby incorporated in this ordinance as completely as if set out in full.

A. The following chapters of the Minnesota State Building Code are adopted and incorporated as part of the building code for the City of Brooklyn Center:

1. 1300 – Administration of the State Building Code

2. 1301 – Building Official Certification

3. 1302 – Construction Approvals

4. 1303 – Minnesota Provisions of the State Building Code and Window Fall Prevention and Radon

5. 1305 – Adoption of the ~~2012~~2018 International Building Code with State Amendments

6. 1307 – Elevators and Related Devices

7. 1309 – ~~2012~~2018 International Residential Code with State Amendments

8. 1311 – ~~2012~~2018 International Existing Building Code Adopted with State Amendments

9. 1315 – Adoption of the ~~2014~~2017 National Electrical Code

10. 1322 – 2012 International Energy Conservation Code (Residential Provisions) Adopted with State Amendments

11. 1323 – International Energy Conservation Code (Commercial Provisions) Adopted with State Amendments

12. 1325 – Solar Energy Systems

13. 1335 – Floodproofing Regulations

14. 1341 – Minnesota Accessibility Code Amends ~~2012~~2018 International Building Code, Chapter 11 (is based on ICC/ANSI A117.1/2009)

15. 1346 – ~~2012~~2018 International Mechanical and Fuel Codes adopted with State Amendments

16. 1350 – Manufactured Homes

17. 1360 – Prefabricated Buildings

18. 1361 – Industrialized/Modular Buildings

19. 1370 – Storm Shelters (Manufactured Home Parks)

20. 4714 – 2012 Edition of Uniform Plumbing Code with State Amendments

21. 7511 – Minnesota Fire Code

22. Minnesota Energy Code, Minnesota Rules, Chapter 7670 as provided in Minnesota Statutes Section 16B.617, and Minnesota Rules, Chapters 7672, 7674, 7676, and 7678.

B. The following optional chapters of the Minnesota State Building Code are hereby adopted and incorporated as part of the building code for the City of Brooklyn Center:

1. International Building Code Appendix J (Grading)

2. 1306, Special Fire Protection Systems, 1306.0020 Subpart 2 Existing and New Buildings

3. 1335, Floodproofing regulations parts 1335.0600 to 1335.1200.

Section 2. Effective Date. This ordinance shall be effective after adoption and thirty days following its legal publication.

Adopted this _____ day of _____, 2020.

_____
Mayor

ATTEST: _____
City Clerk

Date of Publication _____

Effective Date _____

(~~Strikeout~~ indicates matter to be deleted, double underline indicates new matter.)

Council Regular Meeting

DATE: 5/11/2020

TO: City Council
FROM: Curt Boganey, City Manager
THROUGH: N/A
BY: Cornelius Boganey, City Manager

SUBJECT: Resolution Expressing Support for Converting Highway 252 From an at-grade Expressway to a Grade Separated Freeway

Background:

At the March 9, 2020, City Council this item was discussed and tabled to the City Council's next meeting. (See excerpts from March 9, 2020 City Council meeting minutes)

On February 10, 2020 the City Council discussed the current status of the Highway 252 Environmental Review. At the meeting, City Manager Boganey noted the most critical issue at this point is providing a consensus regarding the City Council/EDA's commitment to the conversion of Highway 252 into a freeway. The meeting minutes of the February 10, 2020 City Council Work Session indicated that "The majority Consensus of the City Council/EDA was to change Highway 252 from a highway to a freeway, but the City Council/EDA is not committed to any of the proposed plans."

Budget Issues:

There are no budgetary issues with the proposed action.

Strategic Priorities and Values:

Key Transportation Investments

ATTACHMENTS:

Description	Upload Date	Type
Resolution	5/5/2020	Resolution Letter
Excerpt from March 9, City Council meeting	5/6/2020	Backup Material

Member introduced the following resolution and moved its adoption:

RESOLUTION NO. _____

RESOLUTION EXPRESSING SUPPORT FOR CONVERTING HIGHWAY 252 FROM AN AT-GRADE EXPRESSWAY TO A GRADE SEPERATED FREEWAY

WHEREAS, Highway 252 was constructed as an at-grade expressway in 1985 and 1986; and

WHEREAS, Highway 252 began to experience operational and safety as traffic volumes increased through the 1980s and 1990s; and

WHEREAS, in the early to mid-2000s the cities of Brooklyn Park and Brooklyn Center began more intensive discussions with MnDOT regarding the congestion and safety on Highway 252; and

WHEREAS, several corridor studies and technical analysis have concluded that Highway 252 would be a safer, less congested roadway if converted from an at-grade expressway to a freeway; and

WHEREAS, the meeting minutes of the February 10, 2020 City Council Work Session indicated that "The majority Consensus of the City Council/EDA was to change Highway 252 from a highway to a freeway, but the City Council/EDA is not committed to any of the proposed plans."

NOW, THEREFORE, BE IT RESOLVED by the City Council of the City of Brooklyn Center, Minnesota, that the majority Consensus of the City Council/EDA is to change Highway 252 from an expressway to a freeway.

May 11, 2020 _____
Date Mayor

ATTEST: _____
City Clerk

The motion for the adoption of the foregoing resolution was duly seconded by member

and upon vote being taken thereon, the following voted in favor thereof:

and the following voted against the same:
whereupon said resolution was declared duly passed and adopted.

EXCERPT FROM MARCH 9, 2020 CITY COUNCIL MEETING

10b. RESOLUTION NO. 2020-35 EXPRESSING SUPPORT FOR CONVERTING HIGHWAY 252 FROM AN AT-GRADE EXPRESSWAY TO A GRADE SEPARATED FREEWAY

Mayor Elliott stated he would like the City Council to table this Resolution. He added important discussions have occurred. Additionally, he attended a meeting at the State Capitol last week with City Manager Boganey that included County Commissioner Opat; State Representatives and Senators that represent Brooklyn Center and Brooklyn Park; representatives of Minnesota Department of Transportation; Brooklyn Park Mayor Jeff Lunde and Brooklyn Park's City Engineer, as well as three members of the Minneapolis City Council. Elected officials representing Minneapolis are proposing a bill that would mandate the provision of Bus Rapid Transit (BRT) within the 252 Corridor plan.

Mayor Elliott stated Brooklyn Center will be included in this transit discussion, and a City Council review is required to determine what additional language should be included in a Resolution that would indicate support for the plan. He added he is proposing that this Resolution be tabled for further discussion and consideration.

City Attorney Troy Gilchrist stated, as a reminder of rules for tabling motions when a motion is made and seconded, it is not debatable and must go to a vote. He added tabled motion without a specific time frame must come back to the next consecutive regular meeting, or a specific date can be included. He added a Resolution that is tabled indefinitely cannot be put back on the agenda without majority approval by the City Council.

Councilmember Graves requested clarification regarding Mayor Elliott's initial comments and explanation, and how that specifically relates to the proposed Resolution.

Mayor Elliott stated the Task Force gave a presentation earlier in the meeting and presented information that studies show that, based on the increase in traffic, the 252 Corridor will have the highest levels of asthma and pollution-related illnesses. He added this statistic includes Brooklyn Center and Minneapolis. He noted traffic will be traveling from Anoka County into Brooklyn Center and on to Minneapolis.

Mayor Elliott stated the Resolution, which expresses support for conversion of 252 from a highway to a freeway, would also indicate support for the increased speed and the number of cars it will represent, as well as an increase in the number of individuals with related respiratory conditions. He added he suggests including an indication that those issues will be addressed before we can support an increase in the amount of traffic.

Councilmember Graves asked how the recent meeting referenced by Mayor Elliott is connected to the transit aspect of the project.

Mayor Elliott stated including transit would reduce the number of cars.

Councilmember Graves stated transit options are already included as part of the plans for conversion from a highway to freeway.

Mayor Elliott stated the City of Brooklyn Center's current plan does not include consideration of BRT. He added North Minneapolis has a study that indicates that transit is warranted.

Councilmember Graves asked whether the discussion at last week's meeting at the State Capitol related to the conversion of 252 to a freeway, or whether the purpose of the meeting was to ensure that transit is included as part of the conversion.

Mayor Elliott stated concerns were expressed about widening the road because that would mean more cars. He added there are general concerns about converting 252 to a freeway. He noted the City Council should have a conversation regarding conversion of 252 to a freeway and what that will mean for Brooklyn Center and adjacent communities.

Mr. Boganey stated the net result of the conversation at last Friday's meeting was that there was a general agreement that it is important to assure that provisions will be made to include mass transit opportunities as part of the 252 design. He added this type of provision will help to mitigate issues related to an increase in vehicles and carbon emissions. He noted the attendees agreed to work together to ensure that the design is sufficiently robust to allow for future mass transit options.

Councilmember Graves stated the City Council has already reviewed the information, provided by the Task Force and representatives from various agencies who have been working on this project for years, that mass transit, and the assurance that community members will have access to opportunities, is a very important concern.

Councilmember Graves stated, at its last meeting, the City Council unanimously agreed to address this Resolution at tonight's meeting.

Councilmember Graves moved and Councilmember Lawrence-Anderson seconded to adopt RESOLUTION NO. 2020-35 Expressing Support for Converting Highway 252 from an At-Grade Expressway to a Grade Separated Freeway to the City Council's next meeting.

Mayor Elliott and Councilmember Butler voted against the same. Motion failed.

Mr. Gilchrist stated the initial Resolution has not been disposed of, as the motion failed. He recommended a Resolution should be brought by an adopted motion.

Councilmember Graves stated she would like to make a motion to table until the full City Council is present to vote.

Mayor Elliott stated the motion should be continued indefinitely, and the City Council can review it again at a later date.

Mr. Gilchrist stated if the matter is tabled indefinitely, it shall not be rescheduled without at least a majority approval of the City Council. He added the City Council could agree to schedule this for their next meeting.

Mayor Elliott stated this should be tabled indefinitely, to give the City Council time to have a work session. He added discussions and developments are underway that would be useful for the City Council to understand.

Councilmember Lawrence-Anderson stated she does not support an indefinite tabling of this item. She added a specific meeting date should be stated, and she would like to see this Resolution on the City Council's next meeting agenda.

Mayor Elliott stated, before last Friday, the City Council was not aware that Minneapolis was engaged in a discussion regarding this project. He added their elected officials have put forth a bill about this project. He noted he has spent a lot of time reviewing this issue, including the meeting on Friday as well as follow-up conversations, and the City Council should allow time to fully digest before a resolution is proposed. He noted there should be enough time to subsume the information before this item is placed on a meeting agenda.

Councilmember Lawrence-Anderson stated if all pertinent information is provided to the City Council with 2 weeks to review and prepare before the next City Council meeting, that is sufficient. She requested that all information be submitted to the City Council as soon as possible to prepare for consideration at the next meeting. Councilmember Graves agreed.

Mayor Elliott stated some are privy to more information that has been reviewed in the last week than others. He added the City Council must consider all the benefits and consequences to the community, and in the end, make the right set of choices as a City Council.

Councilmember Lawrence-Anderson requested that Mayor Elliott share any information that he may have that the City Council does not have. She reiterated that all information should be provided for the City Council's review if the Mayor is privy to additional information.

Mayor Elliott stated the information he has is based on the meeting he attended last week, and subsequent conversations. He added he will do his best to get the additional information to the City Council.

Councilmember Graves stated Mayor Elliott mentioned a bill that was being introduced. She asked for the name of the bill. Mayor Elliott stated he is unsure.

Mr. Boganey stated he has a copy of the bill that he will provide for the City Council. He added the bill states that funding for the project should not go forward unless there is a requirement that bus rapid transit will be provided.

Councilmember Graves asked what other officials the Mayor has been having conversations with, so she can reach out to them for updates. She added she has spoken with Commissioner Opat.

Mayor Elliott stated he spoke with Minneapolis Councilmember Cunningham, and also Councilmember Ellison. Mr. Boganey stated the Council President was also present. Councilmember Graves stated she would reach out to those three individuals.

Councilmember Graves moved and Councilmember Lawrence-Anderson seconded to table consideration of RESOLUTION NO. 2020-35 Expressing Support for Converting Highway 252 from an At-Grade Expressway to a Grade Separated Freeway to the City Council's next meeting.

Motion passed unanimously.

Council Regular Meeting

DATE: 5/11/2020

TO: City Council
FROM: Curt Boganey, City Manager
THROUGH: Meg Beekman, Community Development Director
BY: Jimmy Loyd, Economic Development Coordinator

SUBJECT: Resolution Identifying the Need for Livable Communities Demonstration Account (LCDA) Funding and Authorizing an Application for Grant Funds

Background:

The Livable Communities Demonstration Account (LCDA) is a grant program which is offered by the Metropolitan Council through the Livable Communities Act. The program funds innovative (re)development projects that efficiently link housing, jobs, services and transit in an effort to create inspiring and livable communities. LCDA grants are offered for two purposes, both pre-development and development, with two funding rounds per year. Pre-development grant applications have a maximum funding amount of $100,000 per round, per application with a grant term of 2 years and a required 25% local match. Eligible applicants for LCDA funds include municipalities currently participating in the Metropolitan Livable Communities Housing Incentives Program, Counties, Economic Development Authorities, Housing and Redevelopment Authorities, Community Development Authorities and Port Authorities.

Eligible uses for the LCDA Pre-Development funding includes the following:

- Project Planning Activities
- Development of site plans;
- Phasing or staging plans for an identified parcel or multiple contiguous parcels;
- Design workshops for development alternatives;
- Community engagement beyond public meetings.
- Financial Analysis
- Feasibility studies of one or multiple development scenarios for an identified parcel, leading to the development of a pro-formal
- Market study to determine the demand for the proposed development project.
- Site Analysis
- Project-specific stormwater management plans;
- Soil testing to determine feasible land uses for the site (not environmental testing).
- Travel Demand Management Plan

Background

The four EDA-owned properties located at the northwest corner of 61st Avenue North and Brooklyn Boulevard, which total a combined 1.79 acres, initially generated interest from Thor Living, LLC (later Coalition Development, LLC) in 2018, who presented plans to the City Council for a 113-unit, mixed income apartment building. Although Coalition Development, LLC secured a Preliminary Development Agreement and Purchase Agreement from the City, they were unable to follow through with the contingency period conditions outlined under the Purchase Agreement (e.g. secure financing, receive all necessary land use

approvals from the City) by October 23, 2019; therefore, the Purchase Agreement was no longer valid.

Development Plan

The configuration as currently proposed on the site plan contemplates the redevelopment of the northwest corner of 61st Avenue North and Brooklyn Boulevard into a four story, 83-88 unit apartment building, although the developer (J O Companies, LLC) has indicated the potential for up to 88 units of housing.

As proposed, 51-percent of the units in the development would be three-bedrooms, which is unique given that one and two-bedroom units are more often the norm. As the project is intended to provide housing options to those making 50 to 60% AMI (Area Median Income) and 25-percent of the units set aside for project-based Section 8, the larger three-bedroom units would be attractive for families looking for rental options in Brooklyn Center.

The building amenities would include a fitness center, business/community center, and the units would feature in-unit washers and dryers, balconies, and be pet-friendly. The grounds would allow space for community gardens and leverage a direct connection to Wangstad Park, located west of the property.

The application for LCDA pre-development funds for JO Companies would be used for community engagement, market analysis and site analysis/planning and financial analysis. The grant application has a total request of $90,000 from the Metropolitan Council, which would require an additional $22,500 commitment from the City of Brooklyn Center if the grant application is approved and funded. The grant funding will allow for the developer to hire experts who specialize in the listed grant activities while bringing additional experience to the development team. The work by the consultants that would be hired would make JO Companies more competitive for future development grant opportunities offered through the Metropolitan Council and Hennepin County.

While the City currently has multiple development projects in the pipeline, this project is unique in that it encapsulates a distinct mix of uses which, if successful would be highly innovative, and also aligns well with the City's strategic priorities. Further, this project would likely not move forward without the assistance of the grant funds.

Budget Issues:

There will be a required match of $22,500 from the City as a requirement of this grant, which will be funded from TIF 3 funds.

Strategic Priorities and Values:

Targeted Redevelopment

ATTACHMENTS:

Description	Upload Date	Type
Resolution	5/5/2020	Resolution Letter
Met Council Pre Development Application	5/5/2020	Backup Material

Member _____ introduced the following resolution and moved its adoption:

RESOLUTION NO. 2020- ___

RESOLUTION IDENTIFYING THE NEED FOR LIVABLE COMMUNITIES DEMONSTRATION ACCOUNT ("LCDA") FUNDING AND AUTHORIZING AN APPLICATION FOR GRANT FUNDS

WHEREAS, the City of Brooklyn Center is a participant in the Metropolitan Livable Communities Act ("LCA") Local Housing Incentives Program for 2020 as determined by the Metropolitan Council, and is therefore eligible to apply for LCA Livable Communities Demonstration Account and Tax Base Revitalization Account Transit Oriented Development (Collectively, "TOD") funds; and

WHEREAS, the City has identified a proposed project within the City that meets LCDA purposes and criteria and is consistent with and promotes the purposes of the Metropolitan Livable Communities Act and the policies of the Metropolitan Council's adopted metropolitan development guide; and

WHEREAS, the City has the institutional, managerial and financial capability to adequately manage an LCDA grant; and

WHEREAS, the City certifies that it will comply with all applicable laws and regulations as stated in the grant agreement; and

WHEREAS, the City acknowledges LCDA grants are intended to fund projects or project components that can serve as models, examples or prototypes for LCDA development or redevelopment elsewhere in the Region, and therefore represents that the proposed project or key components of the proposed project can be replicated in other metropolitan-area communities; and

WHERES, only a limited amount of grant funding is available through the Metropolitan Council's Livable Communities LCDA initiative during each funding cycle and the Metropolitan Council has determined it is appropriate to allocate those scarce grant funds only to eligible projects that would not occur without the availability of LCDA grant funding.

NOW, THEREFORE, BE IT RESOLVED that, after appropriate examination and due consideration, the governing body of the City:

1. Finds that it is in the best interests of the City's development goals and priorities for the following proposed LCDA project to occur at this particular site at this particular time:

   JO Companies – Brooklyn Center

2. Finds that that LCDA Project component(s) for which Livable Communities LCDA funding is sought:

a. Will not occur solely through private or other public investment within the reasonable foreseeable future; and
b. Will occur within the term of the grant award (two years for Pre-Development grants, and three years for Development grants,) only if Livable Communities LCDA funding is made available for this project at this time.

3. Authorizes the Business and Workforce Development Specialist to submit on behalf of the City an application for Metropolitan Council Livable Communities LCDA grant funds for the LCDA project components identified in the application, and to execute such agreements as may be necessary to implement the LCDA Project on behalf of the City.

May 13, 2019
Date

Mayor

ATTEST: _____
City Clerk

The motion for the adoption of the foregoing resolution was duly seconded by Commissioner

and upon vote being taken thereon, the following voted in favor thereof:

and the following voted against the same:

whereupon said resolution was declared duly passed and adopted.

Application

14100 - 2020 Spring LCDA Pre-Development - Final Application

14218 - 61st and Brooklyn Blvd

LCDA Pre-Development

Status:	Submitted	**Submitted Date:**	05/01/2020 9:51 AM

Applicant Information

Primary Contact:

Name:*	Vdoxwdwrq#	Jimmy Iluw#Qdp h#	L P lggdn#Qdp h#	Loyd Odvw#Qdp h#
Title:*	Economic Development Coordinator			
Department:				
Email:*	jloyd@ci.brooklyn-center.mn.us			
Address:*	6301 Shingle Creek Parkway			
*	Brooklyn Center Flw| #	Minnesota Vwdwh2Surylqfh#	55411 Srvwdd#Frgh2] ls#	
Phone:*	763-569-3301 Skrqh#		H{wl#	
Fax:				
What Grant Programs are you most interested in?*	LCDA Pre-Development			

Organization Information

Name:*	BROOKLYN CENTER, CITY OF
Jurisdictional Agency (if different):	
Organization Type:	City

Organization Website:

Address:* 6301 SHINGLE CREEK PKWY

*	BROOKLYN CENTER F lw\ #	Minnesota Vwdwh2Sur ylgfh#	55430 Srvwdo#Frgh2] ls#

County:* Hennepin

Phone:* 763-569-3320

H{wl#

Fax:

Primary Grantee Information

Grantee Type* City

City in which the project is located* Brooklyn Center
Li#wkh#flw\ #qdp h#grhv#grw#dsshdu#lq#wklv#dbw/#frqwdfw#wkh#dssursuldwh#OFD#surjudp #frruglqdwru1

If more than one governmental entity is collaborating on this application, please explain and list the names of all participants

Who will be the Project Manager at the city, county or local development authority for this project?

Contact name* Jimmy Loyd

Mailing address* 6301 Shingle Creek Parkway

City* Brooklyn Center

Phone* 763-569-3301
Gr#qrw#hqwhu#sxqfwxdwrq#hqwhu#dv#%9848884545%,

Email address* jloyd@ci.brooklyn-center.mn.us
Diwhu#hqwhulqj#wklv#lqirup dwrq/#fdlfn#VDYH#lq#wkh#Frp p dqg#Edu#dw#wkh#wrs#ri#wkh#vfuhhq1#

Developer

Organization name	Street address	City, state, zip		Contact name	Phone	Email
JO Companies			MN	Johnny Opara	612-743-5392	johnny.opara@jocompanies.org

Other project contacts

Name	Title	Organization	Street address	City, state, Zip			Phone	Email
Meg Beekman	Community Development Director	CIty of Brooklyn Center	6301 Shingle Creek Parkway	Brooklyn Center	MN	55430	763-569-3305	mbeekman@ci.brooklyn-center.mn.us

Section A: Project Information

A.1 Project Location

Address or Intersection of Project:* 61st and Brooklyn Blvd

A.2 Livable Communities Goals

Provide an overview of the proposed development project the pre-development activities will inform. How will the proposed project meet Livable Communities goals? Specifically address how it will intensify land use and increase land use diversity; improve the pedestrian and/or bicycle environment; provide connections to surrounding land uses and job centers; and conserve natural resources. *

The development team is proposing a 4 story, 88-unit (83-88 unit mix range) workforce housing development in Brooklyn Center. The income/unit mix will consist of 50%-60% AMI. 51% of the units in the proposed development are 3-bedrooms which is rare but needed for the growing, multi-generational community in Brooklyn Center.

The building amenities include a community garden, fitness center, business/community center, in-unit washer and dryer, pet-friendly, and balconies. The site is located on the corner of Brooklyn Blvd and 61st Ave.

As part of the Livable Communites Goal, the developer and City plan to partner on making city owned Wangstead Park one of the many destinations for the residents. Wangstead Park is located directly adjacent to the property and will be a wonderful shared amenity for the proposed development. Since the development will be aimed directly at families, this partnership will give more open outdoor space for children to explore in the commnity.

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Describe the current and future land uses on the site. Specify types of uses, number and condition of existing buildings, site history, etc. *

The 1.7 acre site is currently vacant with no structures on the site. The first of the four parcel property was aquired starting 2012 with the last property being acquired in 2019.

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A.3: Housing

Does the proposed project include housing? * Yes

If yes, how will the project help to meet your negotiated affordable lifecycle housing goals? Be as specific as possible in describing current and proposed housing mix.

This project will help us not only add new multi family to accompany our single family housing stock, but it will also bring more affordable options for families in Brooklyn Center.

The project will have the following unit mix. (Bedrooms, Unit Count, and AMI level)

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1BR	4 Units	50% AMI
1BR	1 Unit	50% AMI
1BR	10 Units	60% AMI
2BR	9 Units	50% AMI
2BR	1 Unit	50% AMI
2BR	18 Units	60% AMI
3BR	9	50% AMI
3BR	1	50% AMI
3BR	35	60% AMI

How will the proposed development project better connect jobs and housing? *

This project will connect residents to their jobs within the communities and beyond. The project is located within feet of the 723 bus transit line which travels to key destinations like North Hennepin Community College and along Brooklyn Blvd where many residents work. For those who live outside of the city, but would like to live in Brooklyn Center to reduce their work commute this housing option would allow for such a move. In a longer time horizon, the hope is new development like this will encourage businesses to open up in brooklyn park and stay for a long time to come.

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A.4 Pre-Development Grant Request

Request amount	Description of use	Match amount	Match method	Estimated Commitment Date
$40,000.00	Project Planning (site plan development, design workshops, community engagement)	$10,000.00	Combination	
$30,000.00	Financial Analysis (market feasibility and pro forma creation)	$8,250.00	Cash	
$30,000.00	Site Analysis (Storm water management and soil testing)	$8,250.00	Combination	
$100,000.00		$26,500.00		

A.5 Grant-Funded Activities Detail

Grant-Funded Activity	How does this activity support incorporating LCDA principles into the larger development project? LCDA principles can be found in the LCDA Pre-Development Application Guide.	What is the product you expect from this grant activity? (e.g. 3 site plan alternatives, Market study with 2-3 development scenarios)
Development of Site Plans or Development Staging Plans	This activity helps inform the development in respect to achieving these following LCDA goals. Interrelate two or more of the following: development or redevelopment, affordable housing, and employment growth; Intensify land uses and lead to more compact development or redevelopment; Achieve a mix of housing opportunities;	From this grant activity, we expect to have multiple site plan possibilities to create the best development for the site. One has been created, but once more information is discovered, the plan may need to be altered. It is good to have more than one option available.
Market or Feasibility Study to develop and evaluate development scenario(s)	This activity helps inform the development in respect to achieving these following LCDA goals. Interrelate two or more of the following: development or redevelopment, affordable housing, and employment growth; Intensify land uses and lead to	We expect to have a detailed market study which will better inform the developer on the potential customer base and where their needs are most heavily weighed. It will also show the developer more in depth what the

	more compact development or redevelopment; Achieve a mix of housing opportunities;	rents can be and if more affordability is needed, and what cap that could potentially create.
Design Workshops/Community Engagement for Development Project or Zoning Ordinance	This activity helps inform the development in respect to achieving these following LCDA goals. Interrelate two or more of the following: development or redevelopment, affordable housing, and employment growth; Intensify land uses and lead to more compact development or redevelopment; Achieve a mix of housing opportunities;	The product we expect from this activity is a robust design workshop and community engagement that is facilitated by a consultant who will be able to encourage active participation, log the results, and implement into the larger plan.
Soil testing on project site to determine feasible land uses (not related to contamination)	This activity helps inform the development in respect to achieving these following LCDA goals. Interrelate two or more of the following: development or redevelopment, affordable housing, and employment growth; Intensify land uses and lead to more compact development or redevelopment; Achieve a mix of housing opportunities;	We expect to have some level of soil testing completed on this site to determine any remediation efforts. We expect to also create a storm water management plan for the site as well.
Other Project Study	This activity helps inform the development in respect to achieving these following LCDA goals. Interrelate two or more of the following: development or redevelopment, affordable housing, and employment growth; Intensify land uses and lead to more compact development or redevelopment; Achieve a mix of housing opportunities;	With a financial analysis, we expect to produce a finalized pro forma and TIF analysis.

B: Readiness

B.1: Comprehensive Plan

What elements of your comprehensive plan does your proposed project address? *

This project addresses multiple elements of the City's 2040 Comprehensive Plan. The 2040 Plan created an Overlay District for Brooklyn Boulevard and its surrounding parcels. Brooklyn Boulevard is currently a mix of single-family homes, retail and service uses. The 2040 Plan envisions higher intensity land uses along the corridor, a mix of housing types and affordability, neighborhood serving commercial uses, and a more bicycle and pedestrian-oriented environment connected by human-scaled green spaces and culturally-appropriate public art. In addition, one of the housing goals identified in the 2040 Plan is to promote a diverse housing stock that provides accessible housing to all residents. This project directly supports the implementation of the vision for the Brooklyn Boulevard corridor by significantly increasing density of the site, incorporating connections to both the adjacent Wangstead Park and the planned regional trail along the corridor, and integrating creative partnerships to accomplish more deeply affordable units. Further, the project is providing a much needed housing product which the City has identified a clear need for; legally-binding affordable housing and three-bedroom apartment units.

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Is there a small area plan in place for your project area? *

No

B.2: Capacity

Does the project applicant have the capacity to successfully manage the grant? If yes, please describe.*

The project applicant JO Companies has the capacity to successfully manage the grant. Mr. Opara has put togeter a development team of experienced members who have over 30 years of experince in real estate development and asset management. As a supportive partner of the project, the city will be also help as we contribute to the project over the grant period.

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Who will primarily manage the grant activities?*

Johnny Opara of JO Companies

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Does the project team (applicant staff, consultants, etc.) have the capacity to successfully carry out the grant activities in the 24-month grant period? If yes, please describe. *

The project team has the capacity to successfully carry out the grant activities in the 24 month grant period. They have already engaged consultants in design, finance, legal and construction. As the project moves forward, the engaged consultants and partners will be utlized for the necessary grant activities and there should not be any gaps in technical knowledge.

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How will the applicant (City/County/Development Authority) and the rest of the project team work together to ensure that grant activities are carried out successfully?*

The city of Brooklyn Center EDA is committed to providing assistance for financial analysis for city resources, providing zoning and design element consultation to assist with the site planning and also help with community engagement efforts. The city plans to hold regular meetings with project team members as a central hub for communication on the project. The City of Brooklyn Center is committed to being a partner with the developer as the project moves along.

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Will there be a sub-recipient agreement between the grant applicant and the developer?	Yes

B.3: Project Timeline

Please provide a timeline of when in the 24-month grant term your grant requested activities will occur. Break activities into what will be completed in the first 6 months, 12 months, and 18 months and include additional project milestones as they relate to the future development project. *

0-6 months: Completion of market study and financial analysis, soil testing, site planning and community engagement event planning

8-12 months: Community engagement, design workshops, continued financial analysis if necessary.

11-18 months: Final design and financial analysis for finance packaging.

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C: Demonstration Value

What specific, demonstrated community need does this project fill? How did you determine that need?*

The community need this project fills is bringing newer multifamily housing to the market. Until recently, there had not been new multi family development for over 40 years. The older housing stock limits not only the ability to grow the population base, but it limits the economic diversity as well. Aspiring to bring a unique product to the market, the developer proposes to bulid a majority of the units as three bedrooms. The grant funds will be used to determine the best unit mix and rents based on the market data.

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Describe unique or innovate elements of your project or process that best meet identified community needs. *

One of the best innovative elements of the project is its partnership with the neighboring senior living facility. The developer had the foresight to reach out and see how children and their families can interact with the seinor living residents. Often times seniors can be lonely and not have a lot of visitors. They have a lot of wisdom and life experience they can pass down, and younger residents have high energy levels and often time look for organized opportunities to be a part of. Specifics of the partnership have not been outlined, but each party is committed to working with one another once this project is built.

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What can the region learn from your project and/or process? How will you document those findings? *

The largest opportunity for learning for a region is how multigenerational neighborhoods can coexist. If given the opportunity and resources, people can actively integrate and engage one another in the community across generations. Plans to document these findings will need to be established, but telling a story through pictures and narration could be the best way to show how the partnership worked.

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D: Catalytic Value

How will LCDA Pre-Development funds move the future development project forward?*

LCDA Pre-Development funds will move the future development project forward by allowing more indepth planning and analysis to design and create a project that best serves the community. The money will ensure the project gains more support by understanding the market and financial implications to create solutions earlier instead of discovering there is no path to development later in the process.

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Do you believe this project will catalyze additional private investment? *

Yes

Describe how the development project may catalyze additional intensification and private investment in the project area. How would this potential future investment inform your understanding of how the risk of displacement is influenced by the development project?*

By bringing new housing online, businesses and retailers will have more of an incentive to relocate or start new in Brooklyn Center. They would be able to take advantage of a growing population base for workforce needs and consumer needs. This future investment would not encourage displacement, but rather create capacity to bring more people into the community. The risk of displacement becomes less because the site is vacant, and we will not be displacing residents. We can show how the utilization of vacant or blighted land can be leveraged to help the city build capacity for residents and businesses.

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E: Partnerships and Process

Have you started a community engagement process?*

No

If you have not started an engagement process, do you have a defined community engagement plan? Please describe your plan, including specific engagement goals, how your plan will achieve those goals, and partnerships you plan to pursue.

Since this is an EDA owned site there will need to be a public hearing for any landsale. The development team plans to partner with community based organizations for engagement. Additional engagement will include community listening sessions at various stages of pre development. The goal is to engage 100 residents within a mile radius of the property to participate. The developer plans to meet the goal of 100 residents by sending out regular communication in partership with the city of Brooklyn Center and with chosen community based organizations.

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Are you partnering directly with community members and/or community based organizations? If yes, please describe. *

There are plans to leverage community based organizations who have deeper relationships with residents of mutilple cutlures. There have been organizations identified but not selected as of this time.

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How does or will your engagement processes mitigate existing racial, ethnic, cultural, or linguistic barriers and include people of diverse ages, races, ethnicities, incomes, national origins, and abilities?*

By using multiple community based cultural organizations to market the listening sessions and other engagement activities, we hope to mitigate ethnic, cultural and linguistic barriers. Having engagement activities at various times allows for people to attend sessions that better suit their schedule and the goal is to allow as many people to participate as possible.

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How does or will your engagement process identify and engage those most impacted by the grant funded grant activity or future development project?*

The engagement process will examine the demographic of the community and who lives near the proposed site. The goal is to specifically invite nearby residents to any engagement sessions. The developers objective is to be a partner with the community and not just a neighbor.

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How will the project incorporate and be responsive to community input and vision? Be specific about the input as well as how you will evaluate which elements will be included in the project. How will you communicate this process to your community? If you have already started your engagement process, please describe how you have incorporated community vision thus far, how you evaluated which elements were included and which were not, and how you are communicating this to your community. *

The project will incorporate and be responsive to the commnity input by documenting feedback during engagement sessions. The process will be expalined to community menbers clealry as they paricipate. The development team plans to enage a consultant to help them craft a complete plan to best serve the commnuity.

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Will there be additional community engagement? No
*

F: Parcel Information

F.1 Parcels

PIN	Address	County
3411921430050	6101 Brooklyn Blvd Brooklyn Center, MN 55429	Hennepin
3411921430049	6107 Brooklyn Blvd Brooklyn Center, MN 55429	Hennepin
3411921430051	3600 61st Ave N Brooklyn Center, MN 55429	Hennepin
3411921430052	3606 61st Ave N Brooklyn Center, MN 55429	Hennepin

F.2: Site Area

What is the gross square footage of the project site?* 77403

77403

What is the NET BUILDABLE area in square feet within the project site?*

Excluded area* 0

If any area has been excluded, describe why.

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Section G.1: Required Attachments

Attachment	Description	File Name	Type	File Size
Parcel Map (from Make-a-Map - compressed PDF)	Parcel Map	LCA Parcel Map 61st Brooklyn BLVD.pdf	pdf	2.0 MB
Aerial View (from Make-a-Map - compressed PDF)	Aerial Map	LCA Aerial Map.pdf	pdf	3.8 MB
Overview Map (from Make-a-Map - compressed PDF)	Overview Map	LCA Overview Map 61st Brooklyn BLVD.pdf	pdf	7.9 MB
Resolution of Local Support	Letter of Support	Signed Letter of Support for JO Companies.pdf	pdf	65 KB
Asset Map (Compressed PDF)	Asset Map of community assets within a 1/2 mile radius of project site.	61stBrooklynBoulevard_AssetMap.pdf	pdf	1.1 MB

Section G.2: Other Attachments

Attachment	Description	File Name	Type	File Size
Site Plan (compressed pdf)	Concept Packet with site plan and elevations	19-1218 JO - Brooklyn Center Concept Packet.pdf	pdf	7.5 MB
Elevation (compressed pdf)				
Small area plan adopted by the city. Relevant sections to the project site only. (compressed PDF)				
A "Before Photo" of the site showing the existing conditions; prior to development activities. An "After Photo", from the same vantage point will be requested after the project is completed if a grant award is made.				
Project Partner Acknowledgement Letter				

Certification

By checking this box you agree that you, the named applicant, have read the information Yes

presented in the application and that all information is correct to the best of your knowledge. As the named applicant you are responsible for the information presented in the application and agree that the application will be evaluated on the information you present.
*

Council Regular Meeting

DATE: 5/11/2020

TO: City Council
FROM: Curt Boganey, City Manager
THROUGH: N/A
BY: Cornelius Boganey, City Manager

SUBJECT: Resolution In Support of the Medicare for All Act of 2019 and Resolution Supporting the MN Health Plan

Background:

Earlier in the year, Council Member Graves discussed support for the Medicare for All Act of 2019. and expressed the City Council might consider approving a resolution in support of this legislation.

Before you tonight, is the resolution supporting the Medicare for All Act of 2019 (H.R. 1384 and S. 1129). Additionally, there is a resolution supporting the Minnesota Health Plan (HF 1200 and SF 1125)

Budget Issues:

- No budget implications

Strategic Priorities and Values:

Enhanced Community Image

ATTACHMENTS:

Description	Upload Date	Type
Resolution Medicare for All	5/6/2020	Resolution Letter
Resolution Supporting the MN Health Plan	5/6/2020	Resolution Letter
HR 1384	5/6/2020	Backup Material
S 1129	5/6/2020	Backup Material
HF 1200	5/6/2020	Backup Material
SF 1125	5/6/2020	Backup Material

Member introduced the following resolution and moved its adoption:

RESOLUTION NO. _____

RESOLUTION IN SUPPORT OF THE MEDICARE FOR ALL ACT OF 2019

WHEREAS, the number of Americans without health insurance is still nearly 30 million, while more than 40 million Americans remain underinsured, despite important gains made since the implementation of the Affordable Care Act; and

WHEREAS, every person in the City of Brooklyn Center/Hennepin County deserves high quality health care; and

WHEREAS, the never-ending rising costs of health care add challenges to our already strapped municipal budget and our small businesses, which keep our communities thriving; and

WHEREAS the Medicare for All Act of 2019 would provide national health insurance for every person in the United States for all necessary medical care including prescription drugs; hospital, surgical and outpatient services; primary and preventive care; emergency services; reproductive care; dental and vision care; and long-term care; and

WHEREAS the Medicare for All Act of 2019 would provide coverage without copays, deductibles or other out-of-pocket costs, and would slash bureaucracy, protect the doctor-patient relationship and assure patients a free choice of doctors; and

WHEREAS, recent polls show that a majority of Americans support Medicare-for-All; and

WHEREAS, the Medicare for All Act of 2019 will guarantee that all residents of the City of Brooklyn Center/Hennepin County will be fully covered for health care without copays, deductibles or other out-of-pocket costs, and would save millions in taxpayer dollars now spent on premiums that provide often inadequate health insurance coverage for government employees; and

WHEREAS, the quality of life for the residents of the City of Brooklyn Center/Hennepin County will vastly improve because they would be able to get the ongoing care they need, instead of waiting until they have a medical emergency that could upend their lives as well as further burden local resources;

NOW THEREFORE BE IT RESOLVED, that the City of Brooklyn Center/Hennepin County enthusiastically supports the Medicare for All Act of 2019 (H.R. 1384 and S. 1129) and calls on our federal legislators to work toward its immediate enactment, assuring appropriate and efficient health care for all residents of the United States.

BE IT FURTHER RESOLVED, that the City of Brooklyn Center/Hennepin County expresses its enthusiastic support for the Minnesota Health Plan (SF1125/ HF1200) and calls upon our state legislators to work toward its immediate enactment.

May 11, 2020
Date

Mayor

ATTEST: _____
City Clerk

The motion for the adoption of the foregoing resolution was duly seconded by member

and upon vote being taken thereon, the following voted in favor thereof:

and the following voted against the same:
whereupon said resolution was declared duly passed and adopted.

Member introduced the following resolution and moved its adoption:

RESOLUTION NO. _____

RESOLUTION SUPPORTING THE PROPOSED MINNESOTA HEALTH PLAN (CURRENTLY SF 1125/HF 1200)

WHEREAS, health care is a universal human need, total health spending in the U.S. has reached an unsustainable 17.9% of GDP of which one-third can be attributed to administrative costs—much of that due to our wasteful multi-payer system--two-thirds of health spending is already publicly funded, and effective price negotiation is virtually nonexistent; and

WHEREAS, Minnesotans would be best served by a health care system that covers everyone, allows patients to choose their providers, sets premiums based on ability to pay, ensures adequate numbers of providers across the entire state to guarantee timely access to care; and

WHEREAS, comprehensive care means all medically necessary care, and includes dental, vision, hearing, mental health, chemical dependency treatment, prescription drugs, medical equipment and supplies, diagnostic and surgical procedures, women's health, maternal and child health, emergency care, long-term care, rehabilitative services, and home care; and

WHEREAS, overall population health would be improved by a system that focuses on preventive care and early intervention to improve health, as well as management of chronic diseases; and

WHEREAS, significant cost savings through reduction in administrative burden and effective price controls could be achieved with a simple, understandable funding and payment system;

THEREFORE, BE IT RESOLVED that the City of Brooklyn Center supports the proposed Minnesota Health Plan (currently SF 1125/HF 1200) a commonsense, comprehensive, affordable, universal health care system that fulfills these important principles and criteria.

BE IT FURTHER RESOLVED the City of Brooklyn Center supports enactment of HR 1384 and S 1129 (Medicare for All Act of 2019) at the national level.

January 27, 2019
Date

_____
Mayor

ATTEST: _____
City Clerk

The motion for the adoption of the foregoing resolution was duly seconded by member

and upon vote being taken thereon, the following voted in favor thereof:

and the following voted against the same:
whereupon said resolution was declared duly passed and adopted.

I

116TH CONGRESS
1ST SESSION

H. R. 1384

To establish an improved Medicare for All national health insurance program.

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 27, 2019

Ms. JAYAPAL (for herself, Mrs. DINGELL, Ms. ADAMS, Ms. BARRAGÁN, Ms. BASS, Mrs. BEATTY, Mr. BEYER, Mr. BLUMENAUER, Ms. BONAMICI, Mr. BRENDAN F. BOYLE of Pennsylvania, Mr. BROWN of Maryland, Mr. CARSON of Indiana, Mr. CARTWRIGHT, Ms. JUDY CHU of California, Mr. CICILLINE, Ms. CLARK of Massachusetts, Ms. CLARKE of New York, Mr. CLAY, Mr. CLEAVER, Mr. COHEN, Mr. DANNY K. DAVIS of Illinois, Mr. DEFAZIO, Ms. DEGETTE, Mr. DESAULNIER, Mr. MICHAEL F. DOYLE of Pennsylvania, Mr. ENGEL, Ms. ESCOBAR, Mr. ESPAILLAT, Ms. FRANKEL, Ms. FUDGE, Ms. GABBARD, Mr. GALLEGO, Mr. GARCÍA of Illinois, Mr. GOLDEN, Mr. GOMEZ, Mr. GONZALEZ of Texas, Mr. GREEN of Texas, Mr. GRIJALVA, Ms. HAALAND, Mr. HARDER of California, Mr. HASTINGS, Mrs. HAYES, Mr. HIGGINS of New York, Ms. HILL of California, Ms. NORTON, Mr. HUFFMAN, Ms. JACKSON LEE, Mr. JOHNSON of Georgia, Mr. KEATING, Ms. KELLY of Illinois, Mr. KENNEDY, Mr. KHANNA, Mrs. KIRKPATRICK, Mr. LANGEVIN, Mrs. LAWRENCE, Ms. LEE of California, Mr. LEVIN of California, Mr. LEVIN of Michigan, Mr. LEWIS, Mr. TED LIEU of California, Mr. LOWENTHAL, Mrs. LOWEY, Mrs. CAROLYN B. MALONEY of New York, Mr. MCGOVERN, Mr. MCNERNEY, Mr. MEEKS, Ms. MENG, Mr. NADLER, Mrs. NAPOLITANO, Mr. NEGUSE, Ms. OCASIO-CORTEZ, Ms. OMAR, Mr. PANETTA, Mr. PAYNE, Mr. PERLMUTTER, Ms. PINGREE, Mr. POCAN, Ms. PORTER, Ms. PRESSLEY, Mr. RASKIN, Ms. ROYBAL-ALLARD, Mr. RUSH, Mr. RYAN, Mr. SABLAN, Ms. SÁNCHEZ, Mr. SARBANES, Ms. SCHAKOWSKY, Mr. SCHIFF, Mr. SCOTT of Virginia, Mr. SERRANO, Mr. SMITH of Washington, Ms. SPEIER, Mr. SWALWELL of California, Mr. TAKANO, Mr. THOMPSON of California, Mr. THOMPSON of Mississippi, Ms. TITUS, Ms. TLAIB, Mr. TONKO, Mr. VEASEY, Ms. VELÁZQUEZ, Mr. VISCLOSKY, Ms. WATERS, Mrs. WATSON COLEMAN, Mr. WELCH, Ms. WILD, and Ms. WILSON of Florida) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, Education and Labor, Rules, Oversight and Reform, and Armed Services, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To establish an improved Medicare for All national health insurance program.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Medicare for All Act of 2019''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—ESTABLISHMENT OF THE MEDICARE FOR ALL PROGRAM; UNIVERSAL COVERAGE; ENROLLMENT

Sec. 101. Establishment of the Medicare for All Program.
Sec. 102. Universal coverage.
Sec. 103. Freedom of choice.
Sec. 104. Non-discrimination.
Sec. 105. Enrollment.
Sec. 106. Effective date of benefits.
Sec. 107. Prohibition against duplicating coverage.

TITLE II—COMPREHENSIVE BENEFITS, INCLUDING PREVENTIVE BENEFITS AND BENEFITS FOR LONG-TERM CARE

Sec. 201. Comprehensive benefits.
Sec. 202. No cost-sharing.
Sec. 203. Exclusions and limitations.
Sec. 204. Coverage of long-term care services.

TITLE III—PROVIDER PARTICIPATION

Sec. 301. Provider participation and standards; whistleblower protections.
Sec. 302. Qualifications for providers.
Sec. 303. Use of private contracts.

TITLE IV—ADMINISTRATION

Subtitle A—General Administration Provisions

Sec. 401. Administration.
Sec. 402. Consultation.
Sec. 403. Regional administration.
Sec. 404. Beneficiary ombudsman.

Sec. 405. Conduct of related health programs.

Subtitle B—Control Over Fraud and Abuse

Sec. 411. Application of Federal sanctions to all fraud and abuse under the Medicare for All Program.

TITLE V—QUALITY ASSESSMENT

Sec. 501. Quality standards.
Sec. 502. Addressing health care disparities.

TITLE VI—HEALTH BUDGET; PAYMENTS; COST CONTAINMENT MEASURES

Subtitle A—Budgeting

Sec. 601. National health budget.

Subtitle B—Payments to Providers

Sec. 611. Payments to institutional providers based on global budgets.
Sec. 612. Payment to individual providers through fee-for-service.
Sec. 613. Ensuring accurate valuation of services under the Medicare physician fee schedule.
Sec. 614. Payment prohibitions; capital expenditures; special projects.
Sec. 615. Office of primary health care.
Sec. 616. Payments for prescription drugs and approved devices and equipment.

TITLE VII—UNIVERSAL MEDICARE TRUST FUND

Sec. 701. Universal Medicare Trust Fund.

TITLE VIII—CONFORMING AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

Sec. 801. Prohibition of employee benefits duplicative of benefits under the Medicare for All Program; coordination in case of workers' compensation.
Sec. 802. Application of continuation coverage requirements under ERISA and certain other requirements relating to group health plans.
Sec. 803. Effective date of title.

TITLE IX—ADDITIONAL CONFORMING AMENDMENTS

Sec. 901. Relationship to existing Federal health programs.
Sec. 902. Sunset of provisions related to the State Exchanges.
Sec. 903. Sunset of provisions related to pay for performance programs.

TITLE X—TRANSITION

Subtitle A—Medicare for All Transition Over 2 Years and Transitional Buy-In Option

Sec. 1001. Medicare for all transition over two years.
Sec. 1002. Establishment of the Medicare transition buy-in.

Subtitle B—Transitional Medicare Reforms

Sec. 1011. Eliminating the 24-month waiting period for Medicare coverage for individuals with disabilities.
Sec. 1012. Ensuring continuity of care.

TITLE XI—MISCELLANEOUS

Sec. 1101. Definitions.
Sec. 1102. Rules of construction.

TITLE I—ESTABLISHMENT OF THE MEDICARE FOR ALL PROGRAM; UNIVERSAL COVERAGE; ENROLLMENT

SEC. 101. ESTABLISHMENT OF THE MEDICARE FOR ALL PROGRAM.

There is hereby established a national health insurance program to provide comprehensive protection against the costs of health care and health-related services, in accordance with the standards specified in, or established under, this Act.

SEC. 102. UNIVERSAL COVERAGE.

(a) IN GENERAL.—Every individual who is a resident of the United States is entitled to benefits for health care services under this Act. The Secretary shall promulgate a rule that provides criteria for determining residency for eligibility purposes under this Act.

(b) TREATMENT OF OTHER INDIVIDUALS.—The Secretary may make eligible for benefits for health care services under this Act other individuals not described in subsection (a), and regulate the eligibility of such individuals, to ensure that every person in the United States has ac-

cess to health care. In regulating such eligibility, the Secretary shall ensure that individuals are not allowed to travel to the United States for the sole purpose of obtaining health care items and services provided under the program established under this Act.

SEC. 103. FREEDOM OF CHOICE.

Any individual entitled to benefits under this Act may obtain health services from any institution, agency, or individual qualified to participate under this Act.

SEC. 104. NON-DISCRIMINATION.

(a) IN GENERAL.—No person shall, on the basis of race, color, national origin, age, disability, marital status, citizenship status, primary language use, genetic conditions, previous or existing medical conditions, religion, or sex, including sex stereotyping, gender identity, sexual orientation, and pregnancy and related medical conditions (including termination of pregnancy), be excluded from participation in or be denied the benefits of the program established under this Act (except as expressly authorized by this Act for purposes of enforcing eligibility standards described in section 102), or be subject to any reduction of benefits or other discrimination by any participating provider (as defined in section 301), or any entity conducting, administering, or funding a health program or

activity, including contracts of insurance, pursuant to this Act.

(b) CLAIMS OF DISCRIMINATION.—

(1) IN GENERAL.—The Secretary shall establish a procedure for adjudication of administrative complaints alleging a violation of subsection (a).

(2) JURISDICTION.—Any person aggrieved by a violation of subsection (a) by a covered entity may file suit in any district court of the United States having jurisdiction of the parties. A person may bring an action under this paragraph concurrently as such administrative remedies as established in paragraph (1).

(3) DAMAGES.—If the court finds a violation of subsection (a), the court may grant compensatory and punitive damages, declaratory relief, injunctive relief, attorneys' fees and costs, or other relief as appropriate.

(c) CONTINUED APPLICATION OF LAWS.—Nothing in this title (or an amendment made by this title) shall be construed to invalidate or otherwise limit any of the rights, remedies, procedures, or legal standards available to individuals aggrieved under section 1557 of the Patient Protection and Affordable Care Act (42 U.S.C. 18116), title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et

seq.), title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000e et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), or the Age Discrimination Act of 1975 (42 U.S.C. 611 et seq.). Nothing in this title (or an amendment to this title) shall be construed to supersede State laws that provide additional protections against discrimination on any basis described in subsection (a).

SEC. 105. ENROLLMENT.

(a) IN GENERAL.—The Secretary shall provide a mechanism for the enrollment of individuals eligible for benefits under this Act. The mechanism shall—

(1) include a process for the automatic enrollment of individuals at the time of birth in the United States (or upon establishment of residency in the United States);

(2) provide for the enrollment, as of the dates described in section 106, of all individuals who are eligible to be enrolled as of such dates, as applicable; and

(3) include a process for the enrollment of individuals made eligible for health care services under section 102(b).

(b) ISSUANCE OF UNIVERSAL MEDICARE CARDS.—In conjunction with an individual's enrollment for benefits under this Act, the Secretary shall provide for the issuance of a Universal Medicare card that shall be used for purposes of identification and processing of claims for benefits under this program. The card shall not include an individual's Social Security number.

SEC. 106. EFFECTIVE DATE OF BENEFITS.

(a) IN GENERAL.—Except as provided in subsection (b), benefits shall first be available under this Act for items and services furnished 2 years after the date of the enactment of this Act.

(b) COVERAGE FOR CERTAIN INDIVIDUALS.—

(1) IN GENERAL.—For any eligible individual who—

(A) has not yet attained the age of 19 as of the date that is 1 year after the date of the enactment of this Act; or

(B) has attained the age of 55 as of the date that is 1 year after the date of the enactment of this Act,

benefits shall first be available under this Act for items and services furnished as of such date.

(2) OPTION TO CONTINUE IN OTHER COVERAGE DURING TRANSITION PERIOD.—Any person who is

eligible to receive benefits as described in paragraph (1) may opt to maintain any coverage described in section 901, private health insurance coverage, or coverage offered pursuant to subtitle A of title X (including the amendments made by such subtitle) until the date described in subsection (a).

SEC. 107. PROHIBITION AGAINST DUPLICATING COVERAGE.

(a) IN GENERAL.—Beginning on the effective date described in section 106(a), it shall be unlawful for—

(1) a private health insurer to sell health insurance coverage that duplicates the benefits provided under this Act; or

(2) an employer to provide benefits for an employee, former employee, or the dependents of an employee or former employee that duplicate the benefits provided under this Act.

(b) CONSTRUCTION.—Nothing in this Act shall be construed as prohibiting the sale of health insurance coverage for any additional benefits not covered by this Act, including additional benefits that an employer may provide to employees or their dependents, or to former employees or their dependents.

TITLE II—COMPREHENSIVE BENEFITS, INCLUDING PREVENTIVE BENEFITS AND BENEFITS FOR LONG-TERM CARE

SEC. 201. COMPREHENSIVE BENEFITS.

(a) IN GENERAL.—Subject to the other provisions of this title and titles IV through IX, individuals enrolled for benefits under this Act are entitled to have payment made by the Secretary to an eligible provider for the following items and services if medically necessary or appropriate for the maintenance of health or for the diagnosis, treatment, or rehabilitation of a health condition:

(1) Hospital services, including inpatient and outpatient hospital care, including 24-hour-a-day emergency services and inpatient prescription drugs.

(2) Ambulatory patient services.

(3) Primary and preventive services, including chronic disease management.

(4) Prescription drugs and medical devices, including outpatient prescription drugs, medical devices, and biological products.

(5) Mental health and substance abuse treatment services, including inpatient care.

(6) Laboratory and diagnostic services.

(7) Comprehensive reproductive, maternity, and newborn care.

(8) Pediatrics.

(9) Oral health, audiology, and vision services.

(10) Rehabilitative and habilitative services and devices.

(11) Emergency services and transportation.

(12) Early and periodic screening, diagnostic, and treatment services, as described in sections 1902(a)(10)(A), 1902(a)(43), 1905(a)(4)(B), and 1905(r) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A); 1396a(a)(43); 1396d(a)(4)(B); 1396d(r)).

(13) Necessary transportation to receive health care services for persons with disabilities or low-income individuals (as determined by the Secretary).

(14) Long-term care services and support (as described in section 204).

(b) REVISION AND ADJUSTMENT.—The Secretary shall, at least annually, and on a regular basis, evaluate whether the benefits package should be improved or adjusted to promote the health of beneficiaries, account for changes in medical practice or new information from medical research, or respond to other relevant developments in health science, and shall make recommendations to

Congress regarding any such improvements or adjustments.

(c) HEARINGS.—

(1) IN GENERAL.—The Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives shall, not less frequently than annually, hold a hearing on the recommendations submitted by the Secretary under subsection (b).

(2) EXERCISE OF RULEMAKING AUTHORITY.—Paragraph (1) is enacted—

(A) as an exercise of rulemaking power of the House of Representatives, and, as such, shall be considered as part of the rules of the House, and such rules shall supersede any other rule of the House only to the extent that rule is inconsistent therewith; and

(B) with full recognition of the constitutional right of either House to change such rules (so far as relating to the procedure in such House) at any time, in the same manner, and to the same extent as in the case of any other rule of the House.

(d) COMPLEMENTARY AND INTEGRATIVE MEDICINE.—

(1) IN GENERAL.—In carrying out subsection (b), the Secretary shall consult with the persons described in paragraph (2) with respect to—

(A) identifying specific complementary and integrative medicine practices that are appropriate to include in the benefits package; and

(B) identifying barriers to the effective provision and integration of such practices into the delivery of health care, and identifying mechanisms for overcoming such barriers.

(2) CONSULTATION.—In accordance with paragraph (1), the Secretary shall consult with—

(A) the Director of the National Center for Complementary and Integrative Health;

(B) the Commissioner of Food and Drugs;

(C) institutions of higher education, private research institutes, and individual researchers with extensive experience in complementary and alternative medicine and the integration of such practices into the delivery of health care;

(D) nationally recognized providers of complementary and integrative medicine; and

(E) such other officials, entities, and individuals with expertise on complementary and

integrative medicine as the Secretary determines appropriate.

(e) STATES MAY PROVIDE ADDITIONAL BENEFITS.—Individual States may provide additional benefits for the residents of such States, as determined by such State, and may provide benefits to individuals not eligible for benefits under this Act, at the expense of the State, subject to the requirements specified in section 1102.

SEC. 202. NO COST-SHARING.

(a) IN GENERAL.—The Secretary shall ensure that no cost-sharing, including deductibles, coinsurance, copayments, or similar charges, is imposed on an individual for any benefits provided under this Act.

(b) NO BALANCE BILLING.—No provider may impose a charge to an enrolled individual for covered services for which benefits are provided under this Act.

SEC. 203. EXCLUSIONS AND LIMITATIONS.

(a) IN GENERAL.—Benefits for items and services are not available under this Act unless the items and services meet the standards developed by the Secretary pursuant to section 201(a).

(b) TREATMENT OF EXPERIMENTAL ITEMS AND SERVICES AND DRUGS.—

(1) IN GENERAL.—In applying subsection (a), the Secretary shall make national coverage deter-

minations with respect to items and services that are experimental in nature. Such determinations shall be consistent with the national coverage determination process as defined in section 1869(f)(1)(B) of the Social Security Act (42 U.S.C. 1395ff(f)(1)(B)).

(2) APPEALS PROCESS.—The Secretary shall establish a process by which individuals can appeal coverage decisions. The process shall, as much as is feasible, follow the process for appeals under the Medicare program described in section 1869 of the Social Security Act (42 U.S.C. 1395ff).

(c) APPLICATION OF PRACTICE GUIDELINES.—

(1) IN GENERAL.—In the case of items and services for which the Department of Health and Human Services has recognized a national practice guideline, such items and services shall be deemed to meet the standards specified in section 201(a) if they have been provided in accordance with such guideline. For purposes of this subsection, an item or service not provided in accordance with a practice guideline shall be deemed to have been provided in accordance with the guideline if the health care provider providing the item or service—

(A) exercised appropriate professional judgment in accordance with the laws and re-

quirements of the State in which such item or service is furnished in deviating from the guideline;

(B) acted in the best interest of the individual receiving the item or service; and

(C) acted in a manner consistent with the individual's wishes.

(2) OVERRIDE OF STANDARDS.—

(A) IN GENERAL.—An individual's treating physician or other health care professional authorized to exercise independent professional judgment in implementing a patient's medical or nursing care plan in accordance with the scope of practice, licensure, and other law of the State where items and services are to be furnished may override practice standards established pursuant to section 201(a) or practice guidelines described in paragraph (1), including such standards and guidelines that are implemented by a provider through the use of health information technology, such as electronic health record technology, clinical decision support technology, and computerized order entry programs.

(B) LIMITATION.—An override described in subparagraph (A) shall, in the professional judgment of such physician, nurse, or health care professional, be—

(i) consistent with such physician's, nurse's, or health care professional's determination of medical necessity and appropriateness or nursing assessment;

(ii) in the best interests of the individual; and

(iii) consistent with the individual's wishes.

SEC. 204. COVERAGE OF LONG-TERM CARE SERVICES.

(a) IN GENERAL.—Subject to the other provisions of this Act, individuals enrolled for benefits under this Act are entitled to the following long-term services and supports and to have payment made by the Secretary to an eligible provider for such services and supports if medically necessary and appropriate and in accordance with the standards established in this Act, for maintenance of health or for care, services, diagnosis, treatment, or rehabilitation that is related to a medically determinable condition, whether physical or mental, of health, injury, or age that—

(1) causes a functional limitation in performing one or more activities of daily living; or

(2) requires a similar need of assistance in performing instrumental activities of daily living due to cognitive or other impairments.

(b) ELIGIBILITY.—The Secretary shall promulgate rules that provide for the following:

(1) The determination of individual eligibility for long-term services and supports under this section.

(2) The assessment of the long-term services and supports needed for eligible individuals.

(c) SERVICES AND SUPPORTS.—Long-term services and supports under this section shall be tailored to an individual's needs, as determined through assessment, and shall be defined by the Secretary to—

(1) include any long-term nursing services for the enrollee, whether provided in an institution or in a home and community-based setting;

(2) provide coverage for a broad spectrum of long-term services and supports, including for home and community-based services and other care provided through non-institutional settings;

(3) provide coverage that meets the physical, mental, and social needs of recipients while allowing

recipients their maximum possible autonomy and their maximum possible civic, social, and economic participation;

(4) prioritize delivery of long-term services and supports through home and community-based services over institutionalization;

(5) unless an individual elects otherwise, ensure that recipients will receive home and community based long-term services and supports (as defined in subsection (f)(4)), regardless of the individuals's type or level of disability, service need, or age;

(6) be provided with the goal of enabling persons with disabilities to receive services in the least restrictive and most integrated setting appropriate to the individual's needs;

(7) be provided in such a manner that allows persons with disabilities to maintain their independence, self-determination, and dignity;

(8) provide long-term services and supports that are of equal quality and equally accessible across geographic regions; and

(9) ensure that long-term services and supports provide recipient's the option of self-direction of services from either the recipient or care coordinators of the recipient's choosing.

(d) PUBLIC CONSULTATION.—In developing regulations to implement this section, the Secretary shall consult with an advisory commission on long-term services and supports that includes—

(1) people with disabilities who use long-term services and supports and older adults who use long-term services and supports;

(2) representatives of people with disabilities and representatives of older adults;

(3) groups that represent the diversity of the population of people living with disabilities, including gender, racial, and economic diversity;

(4) providers of long-term services and supports, including family attendants and family caregivers, and members of organized labor;

(5) disability rights organizations; and

(6) relevant academic institutions and researchers.

(e) BUDGETING AND PAYMENTS.—Budgeting and payments for long-term services and supports provided under this section shall be made in accordance with the provisions under title VI.

(f) DEFINITIONS.—In this section:

(1) The term ''long-term services and supports'' means long-term care, treatment, maintenance, or

services needed to support the activities of daily living and instrumental activities of daily living, including all long-term services and supports available under section 1915 of the Social Security Act (42 U.S.C. 1396n), home and community-based services, and any additional services and supports identified by the Secretary to support people with disabilities to live, work, and participate in their communities.

(2) The term ''activities of daily living'' means basic personal everyday activities, including tasks such as eating, toileting, grooming, dressing, bathing, and transferring.

(3) The term ''instrumental activities of daily living'' means activities related to living independently in the community, including but not limited to, meal planning and preparation, managing finances, shopping for food, clothing, and other essential items, performing essential household chores, communicating by phone or other media, and traveling around and participating in the community.

(4) The term ''home and community-based services'' means the home and community-based services that are coverable under subsections (c), (d), (i), and (k) of section 1915 of the Social Security Act (42 U.S.C. 1396n), and as defined by the

Secretary, including as defined in the home and community-based services settings rule in sections 441.530 and 441.710 of title 42, Code of Federal Regulations (or a successor regulation).

TITLE III—PROVIDER PARTICIPATION

SEC. 301. PROVIDER PARTICIPATION AND STANDARDS; WHISTLEBLOWER PROTECTIONS.

(a) IN GENERAL.—An individual or other entity furnishing any covered item or service under this Act is not a qualified provider unless the individual or entity—

(1) is a qualified provider of the items or services under section 302;

(2) has filed with the Secretary a participation agreement described in subsection (b); and

(3) meets, as applicable, such other qualifications and conditions with respect to a provider of services under title XVIII of the Social Security Act as described in section 1866 of the Social Security Act (42 U.S.C. 1395cc).

(b) REQUIREMENTS IN PARTICIPATION AGREEMENT.—

(1) IN GENERAL.—A participation agreement described in this subsection between the Secretary

and a provider shall provide at least for the following:

(A) Items and services to eligible persons shall be furnished by the provider without discrimination, in accordance with section 104(a). Nothing in this subparagraph shall be construed as requiring the provision of a type or class of items or services that are outside the scope of the provider's normal practice.

(B) No charge will be made to any enrolled individual for any covered items or services other than for payment authorized by this Act.

(C) The provider agrees to furnish such information as may be reasonably required by the Secretary, in accordance with uniform reporting standards established under section 401(b)(1), for—

(i) quality review by designated entities;

(ii) making payments under this Act, including the examination of records as may be necessary for the verification of information on which such payments are based;

(iii) statistical or other studies required for the implementation of this Act; and

(iv) such other purposes as the Secretary may specify.

(D) In the case of a provider that is not an individual, the provider agrees not to employ or use for the provision of health services any individual or other provider that has had a participation agreement under this subsection terminated for cause. The Secretary may authorize such employment or use on a case-by-case basis.

(E) In the case of a provider paid under a fee-for-service basis for items and services furnished under this Act, the provider agrees to submit bills and any required supporting documentation relating to the provision of covered items and services within 30 days after the date of providing such items and services.

(F) In the case of an institutional provider paid pursuant to section 611, the provider agrees to submit information and any other required supporting documentation as may be reasonably required by the Secretary within 30

days after the date of providing such items and services and in accordance with the uniform reporting standards established under section 401(b)(1), including information on a quarterly basis that—

(i) relates to the provision of covered items and services; and

(ii) describes items and services furnished with respect to specific individuals.

(G) In the case of a provider that receives payment for items and services furnished under this Act based on diagnosis-related coding, procedure coding, or other coding system or data, the provider agrees—

(i) to disclose to the Secretary any system or index of coding or classifying patient symptoms, diagnoses, clinical interventions, episodes, or procedures that such provider utilizes for global budget negotiations under title VI or for meeting any other payment, documentation, or data collection requirements under this Act; and

(ii) not to use any such system or index to establish financial incentives or disincentives for health care professionals,

or that is proprietary, interferes with the medical or nursing process, or is designed to increase the amount or number of payments.

(H) The provider complies with the duty of provider ethics and reporting requirements described in paragraph (2).

(I) In the case of a provider that is not an individual, the provider agrees that no board member, executive, or administrator of such provider receives compensation from, owns stock or has other financial investments in, or serves as a board member of any entity that contracts with or provides items or services, including pharmaceutical products and medical devices or equipment, to such provider.

(2) PROVIDER DUTY OF ETHICS.—Each health care provider, including institutional providers, has a duty to advocate for and to act in the exclusive interest of each individual under the care of such provider according to the applicable legal standard of care, such that no financial interest or relationship impairs any health care provider's ability to furnish necessary and appropriate care to such individual.

To implement the duty established in this paragraph, the Secretary shall—

(A) promulgate reasonable reporting rules to evaluate participating provider compliance with this paragraph;

(B) prohibit participating providers, spouses, and immediate family members of participating providers, from accepting or entering into any arrangement for any bonus, incentive payment, profit-sharing, or compensation based on patient utilization or based on financial outcomes of any other provider or entity; and

(C) prohibit participating providers or any board member or representative of such provider from serving as board members for or receiving any compensation, stock, or other financial investment in an entity that contracts with or provides items or services (including pharmaceutical products and medical devices or equipment) to such provider.

(3) TERMINATION OF PARTICIPATION AGREEMENT.—

(A) IN GENERAL.—Participation agreements may be terminated, with appropriate notice—

(i) by the Secretary for failure to meet the requirements of this Act;

(ii) in accordance with the provisions described in section 411; or

(iii) by a provider.

(B) TERMINATION PROCESS.—Providers shall be provided notice and a reasonable opportunity to correct deficiencies before the Secretary terminates an agreement unless a more immediate termination is required for public safety or similar reasons.

(C) PROVIDER PROTECTIONS.—

(i) PROHIBITION.—The Secretary may not terminate a participation agreement or in any other way discriminate against, or cause to be discriminated against, any covered provider or authorized representative of the provider, on account of such provider or representative—

(I) providing, causing to be provided, or being about to provide or cause to be provided to the provider, the Federal Government, or the attorney general of a State information relating to any violation of, or any act

or omission the provider or representative reasonably believes to be a violation of, any provision of this title (or an amendment made by this title);

(II) testifying or being about to testify in a proceeding concerning such violation;

(III) assisting or participating, or being about to assist or participate, in such a proceeding; or

(IV) objecting to, or refusing to participate in, any activity, policy, practice, or assigned task that the provider or representative reasonably believes to be in violation of any provision of this Act (including any amendment made by this Act), or any order, rule, regulation, standard, or ban under this Act (including any amendment made by this Act).

(ii) COMPLAINT PROCEDURE.—A provider or representative who believes that he or she has been discriminated against in violation of this section may seek relief in accordance with the procedures, notifica-

tions, burdens of proof, remedies, and statutes of limitation set forth in section 2087(b) of title 15, United States Code.

(c) WHISTLEBLOWER PROTECTIONS.—

(1) RETALIATION PROHIBITED.—No person may discharge or otherwise discriminate against any employee because the employee or any person acting pursuant to a request of the employee—

(A) notified the Secretary or the employee's employer of any alleged violation of this title, including communications related to carrying out the employee's job duties;

(B) refused to engage in any practice made unlawful by this title, if the employee has identified the alleged illegality to the employer;

(C) testified before or otherwise provided information relevant for Congress or for any Federal or State proceeding regarding any provision (or proposed provision) of this title;

(D) commenced, caused to be commenced, or is about to commence or cause to be commenced a proceeding under this title;

(E) testified or is about to testify in any such proceeding; or

(F) assisted or participated or is about to assist or participate in any manner in such a proceeding or in any other manner in such a proceeding or in any other action to carry out the purposes of this title.

(2) ENFORCEMENT ACTION.—Any employee covered by this section who alleges discrimination by an employer in violation of paragraph (1) may bring an action, subject to the statute of limitations in the anti-retaliation provisions of the False Claims Act and the rules and procedures, legal burdens of proof, and remedies applicable under the employee protections provisions of the Surface Transportation Assistance Act.

(3) APPLICATION.—

(A) Nothing in this subsection shall be construed to diminish the rights, privileges, or remedies of any employee under any Federal or State law or regulation, including the rights and remedies against retaliatory action under the False Claims Act (31 U.S.C. 3730(h)), or under any collective bargaining agreement. The rights and remedies in this section may not be waived by any agreement, policy, form, or condition of employment.

(B) Nothing in this subsection shall be construed to preempt or diminish any other Federal or State law or regulation against discrimination, demotion, discharge, suspension, threats, harassment, reprimand, retaliation, or any other manner of discrimination, including the rights and remedies against retaliatory action under the False Claims Act (31 U.S.C. 3730(h)).

(4) DEFINITIONS.—In this subsection:

(A) EMPLOYER.—The term ''employer'' means any person engaged in profit or nonprofit business or industry, including one or more individuals, partnerships, associations, corporations, trusts, professional membership organization including a certification, disciplinary, or other professional body, unincorporated organizations, nongovernmental organizations, or trustees, and subject to liability for violating the provisions of this Act.

(B) EMPLOYEE.—The term ''employee'' means any individual performing activities under this Act on behalf of an employer.

SEC. 302. QUALIFICATIONS FOR PROVIDERS.

(a) IN GENERAL.—A health care provider is considered to be qualified to furnish covered items and services under this Act if the provider is licensed or certified to furnish such items and services in the State in which such items or services are furnished and meets—

(1) the requirements of such State's law to furnish such items and services; and

(2) applicable requirements of Federal law to furnish such items and services.

(b) LIMITATION.—An entity or provider shall not be qualified to furnish covered items and services under this Act if the entity or provider provides no items and services directly to individuals, including—

(1) entities or providers that contract with other entities or providers to provide such items and services; and

(2) entities that are currently approved to coordinate care plans under the Medicare Advantage program established in part C of title XVIII of the Social Security Act (42 U.S.C. 1851 et seq.) but do not directly provide items and services of such care plans.

(c) MINIMUM PROVIDER STANDARDS.—

(1) IN GENERAL.—The Secretary shall establish, evaluate, and update national minimum stand-

ards to ensure the quality of items and services provided under this Act and to monitor efforts by States to ensure the quality of such items and services. A State may establish additional minimum standards which providers shall meet with respect to items and services provided in such State.

(2) NATIONAL MINIMUM STANDARDS.—The Secretary shall establish national minimum standards under paragraph (1) for institutional providers of services and individual health care practitioners. Except as the Secretary may specify in order to carry out this Act, a hospital, skilled nursing facility, or other institutional provider of services shall meet standards applicable to such a provider under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.). Such standards also may include, where appropriate, elements relating to—

(A) adequacy and quality of facilities;

(B) mandatory minimum safe registered nurse-to-patient staffing ratios and optimal staffing levels for physicians and other health care practitioners;

(C) training and competence of personnel (including requirements related to the number

of or type of required continuing education hours);

(D) comprehensiveness of service;

(E) continuity of service;

(F) patient waiting time, access to services, and preferences; and

(G) performance standards, including organization, facilities, structure of services, efficiency of operation, and outcome in palliation, improvement of health, stabilization, cure, or rehabilitation.

(3) TRANSITION IN APPLICATION.—If the Secretary provides for additional requirements for providers under this subsection, any such additional requirement shall be implemented in a manner that provides for a reasonable period during which a previously qualified provider is permitted to meet such an additional requirement.

(4) ABILITY TO PROVIDE SERVICES.—With respect to any entity or provider certified to provide items and services described in section 201(a)(7), the Secretary may not prohibit such entity or provider from participating for reasons other than such entity's or provider's ability to provide such items and services.

(d) FEDERAL PROVIDERS.—Any provider qualified to provide health care items and services through the Department of Veterans Affairs or Indian Health Service is a qualifying provider under this section with respect to any individual who qualifies for such items and services under applicable Federal law.

SEC. 303. USE OF PRIVATE CONTRACTS.

(a) IN GENERAL.—This section shall apply beginning 2 years after the date of the enactment of this Act.

(b) PARTICIPATING PROVIDERS.—

(1) PRIVATE CONTRACTS FOR COVERED ITEMS AND SERVICES FOR ELIGIBLE INDIVIDUALS.—An institutional or individual provider with an agreement in effect under section 301 may not bill or enter into any private contract with any individual eligible for benefits under the Act for any item or service that is a benefit under this Act.

(2) PRIVATE CONTRACTS FOR NONCOVERED ITEMS AND SERVICES FOR ELIGIBLE INDIVIDUALS.—An institutional or individual provider with an agreement in effect under section 301 may bill or enter into a private contract with an individual eligible for benefits under the Act for any item or service that is not a benefit under this Act only if—

(A) the contract and provider meet the requirements specified in paragraphs (3) and (4), respectively;

(B) such item or service is not payable or available under this Act; and

(C) the provider receives—

(i) no reimbursement under this Act directly or indirectly for such item or service, and

(ii) receives no amount for such item or service from an organization which receives reimbursement for such items or service under this Act directly or indirectly.

(3) CONTRACT REQUIREMENTS.—Any contract to provide items and services described in paragraph (2) shall—

(A) be in writing and signed by the individual (or authorized representative of the individual) receiving the item or service before the item or service is furnished pursuant to the contract;

(B) not be entered into at a time when the individual is facing an emergency health care situation; and

(C) clearly indicate to the individual receiving such items and services that by signing such a contract the individual—

(i) agrees not to submit a claim (or to request that the provider submit a claim) under this Act for such items or services;

(ii) agrees to be responsible for payment of such items or services and understands that no reimbursement will be provided under this Act for such items or services;

(iii) acknowledges that no limits under this Act apply to amounts that may be charged for such items or services; and

(iv) acknowledges that the provider is providing services outside the scope of the program under this Act.

(4) AFFIDAVIT.—A participating provider who enters into a contract described in paragraph (2) shall have in effect during the period any item or service is to be provided pursuant to the contract an affidavit that shall—

(A) identify the provider who is to furnish such noncovered item or service, and be signed by such provider;

(B) state that the provider will not submit any claim under this Act for any noncovered item or service provided to any individual enrolled under this Act; and

(C) be filed with the Secretary no later than 10 days after the first contract to which such affidavit applies is entered into.

(5) ENFORCEMENT.—If a provider signing an affidavit described in paragraph (4) knowingly and willfully submits a claim under this title for any item or service provided or receives any reimbursement or amount for any such item or service provided pursuant to a private contract described in paragraph (2) with respect to such affidavit—

(A) any contract described in paragraph (2) shall be null and void;

(B) no payment shall be made under this title for any item or service furnished by the provider during the 1-year period beginning on the date the affidavit was signed; and

(C) any payment received under this title for any item or service furnished during such period shall be remitted.

(6) PRIVATE CONTRACTS FOR INELIGIBLE INDIVIDUALS.—An institutional or individual provider

with an agreement in effect under section 301 may bill or enter into a private contract with any individual ineligible for benefits under the Act for any item or service.

(c) NONPARTICIPATING PROVIDERS.—

(1) PRIVATE CONTRACTS FOR COVERED ITEMS AND SERVICES FOR ELIGIBLE INDIVIDUALS.—An institutional or individual provider with no agreement in effect under section 301 may bill or enter into any private contract with any individual eligible for benefits under the Act for any item or service that is a benefit under this Act described in title II only if the contract and provider meet the requirements specified in paragraphs (2) and (3), respectively.

(2) ITEMS REQUIRED TO BE INCLUDED IN CONTRACT.—Any contract to provide items and services described in paragraph (1) shall—

(A) be in writing and signed by the individual (or authorized representative of the individual) receiving the item or service before the item or service is furnished pursuant to the contract;

(B) not be entered into at a time when the individual is facing an emergency health care situation; and

(C) clearly indicate to the individual receiving such items and services that by signing such a contract the individual—

(i) acknowledges that the individual has the right to have such items or services provided by other providers for whom payment would be made under this Act;

(ii) agrees not to submit a claim (or to request that the provider submit a claim) under this Act for such items or services even if such items or services are otherwise covered by this Act;

(iii) agrees to be responsible for payment of such items or services and understands that no reimbursement will be provided under this Act for such items or services;

(iv) acknowledges that no limits under this Act apply to amounts that may be charged for such items or services; and

(v) acknowledges that the provider is providing services outside the scope of the program under this Act.

(3) AFFIDAVIT.—A provider who enters into a contract described in paragraph (1) shall have in ef-

fect during the period any item or service is to be provided pursuant to the contract an affidavit that shall—

(A) identify the provider who is to furnish such covered item or service, and be signed by such provider;

(B) state that the provider will not submit any claim under this Act for any covered item or service provided to any individual enrolled under this Act during the 2-year period beginning on the date the affidavit is signed; and

(C) be filed with the Secretary no later than 10 days after the first contract to which such affidavit applies is entered into.

(4) ENFORCEMENT.—If a provider signing an affidavit described in paragraph (3) knowingly and willfully submits a claim under this title for any item or service provided or receives any reimbursement or amount for any such item or service provided pursuant to a private contract described in paragraph (1) with respect to such affidavit—

(A) any contract described in paragraph (1) shall be null and void; and

(B) no payment shall be made under this title for any item or service furnished by the

provider during the 2-year period beginning on the date the affidavit was signed.

(5) PRIVATE CONTRACTS FOR NONCOVERED ITEMS AND SERVICES FOR ANY INDIVIDUAL.—An institutional or individual provider with no agreement in effect under section 301 may bill or enter into a private contract with any individual for a item or service that is not a benefit under this Act.

TITLE IV—ADMINISTRATION

Subtitle A—General Administration Provisions

SEC. 401. ADMINISTRATION.

(a) GENERAL DUTIES OF THE SECRETARY.—

(1) IN GENERAL.—The Secretary shall develop policies, procedures, guidelines, and requirements to carry out this Act, including related to—

(A) eligibility for benefits;

(B) enrollment;

(C) benefits provided;

(D) provider participation standards and qualifications, as described in title III;

(E) levels of funding;

(F) methods for determining amounts of payments to providers of covered items and services, consistent with subtitle B;

(G) a process for appealing or petitioning for a determination of coverage or noncoverage of items and services under this Act;

(H) planning for capital expenditures and service delivery;

(I) planning for health professional education funding;

(J) encouraging States to develop regional planning mechanisms; and

(K) any other regulations necessary to carry out the purposes of this Act.

(2) REGULATIONS.—Regulations authorized by this Act shall be issued by the Secretary in accordance with section 553 of title 5, United States Code.

(3) ACCESSIBILITY.—The Secretary shall have the obligation to ensure the timely and accessible provision of items and services that all eligible individuals are entitled to under this Act.

(b) UNIFORM REPORTING STANDARDS; ANNUAL REPORT; STUDIES.—

(1) UNIFORM REPORTING STANDARDS.—

(A) IN GENERAL.—The Secretary shall establish uniform State reporting requirements and national standards to ensure an adequate national database containing information per-

taining to health services practitioners, approved providers, the costs of facilities and practitioners providing items and services, the quality of such items and services, the outcomes of such items and services, and the equity of health among population groups. Such database shall include, to the maximum extent feasible without compromising patient privacy, health outcome measures used under this Act, and to the maximum extent feasible without excessively burdening providers, a description of the standards and qualifications, levels of finding, and methods described in subparagraphs (D) through (F) of subsection (a)(1).

(B) REQUIRED DATA DISCLOSURES.—In establishing reporting requirements and standards under subparagraph (A), the Secretary shall require a provider with an agreement in effect under section 301 to disclose to the Secretary, in a time and manner specified by the Secretary, the following (as applicable to the type of provider):

(i) Any data the provider is required to report or does report to any State or local agency, or, as of January 1, 2019, to

the Secretary or any entity that is part of the Department of Health and Human Services, except data that are required under the programs terminated in section 903.

(ii) Annual financial data that includes information on employees (including the number of employees, hours worked, and wage information) by job title and by each patient care unit or department within each facility (including outpatient units or departments); the number of registered nurses per staffed bed by each such unit or department; information on the dollar value and annual spending (including purchases, upgrades, and maintenance) for health information technology; and risk-adjusted and raw patient outcome data (including data on medical, surgical, obstetric, and other procedures).

(C) REPORTS.—The Secretary shall regularly analyze information reported to the Secretary and shall define rules and procedures to allow researchers, scholars, health care providers, and others to access and analyze data

for purposes consistent with quality and outcomes research, without compromising patient privacy.

(2) ANNUAL REPORT.—Beginning 2 years after the date of the enactment of this Act, the Secretary shall annually report to Congress on the following:

(A) The status of implementation of the Act.

(B) Enrollment under this Act.

(C) Benefits under this Act.

(D) Expenditures and financing under this Act.

(E) Cost-containment measures and achievements under this Act.

(F) Quality assurance.

(G) Health care utilization patterns, including any changes attributable to the program.

(H) Changes in the per-capita costs of health care.

(I) Differences in the health status of the populations of the different States, including income and racial characteristics, and other population health inequities.

(J) Progress on quality and outcome measures, and long-range plans and goals for achievements in such areas.

(K) Plans for improving service to medically underserved populations.

(L) Transition problems as a result of implementation of this Act.

(M) Opportunities for improvements under this Act.

(3) STATISTICAL ANALYSES AND OTHER STUDIES.—The Secretary may, either directly or by contract—

(A) make statistical and other studies, on a nationwide, regional, State, or local basis, of any aspect of the operation of this Act;

(B) develop and test methods of delivery of items and services as the Secretary may consider necessary or promising for the evaluation, or for the improvement, of the operation of this Act; and

(C) develop methodological standards for policymaking.

(c) AUDITS.—

(1) IN GENERAL.—The Comptroller General of the United States shall conduct an audit of the De-

partment of Health and Human Services every fifth fiscal year following the effective date of this Act to determine the effectiveness of the program in carrying out the duties under subsection (a).

(2) REPORTS.—The Comptroller General of the United States shall submit a report to Congress concerning the results of each audit conducted under this subsection.

SEC. 402. CONSULTATION.

The Secretary shall consult with Federal agencies, Indian tribes and urban Indian health organizations, and private entities, such as labor organizations representing health care workers, professional societies, national associations, nationally recognized associations of health care experts, medical schools and academic health centers, consumer groups, and business organizations in the formulation of guidelines, regulations, policy initiatives, and information gathering to ensure the broadest and most informed input in the administration of this Act. Nothing in this Act shall prevent the Secretary from adopting guidelines, consistent with the provisions of section 203(c), developed by such a private entity if, in the Secretary's judgment, such guidelines are generally accepted as reasonable and prudent and consistent with this Act.

SEC. 403. REGIONAL ADMINISTRATION.

(a) COORDINATION WITH REGIONAL OFFICES.—The Secretary shall establish and maintain regional offices for purposes of carrying out the duties specified in subsection (c) and promoting adequate access to, and efficient use of, tertiary care facilities, equipment, and services by individuals enrolled under this Act. Wherever possible, the Secretary shall incorporate regional offices of the Centers for Medicare & Medicaid Services for this purpose.

(b) APPOINTMENT OF REGIONAL DIRECTORS.—In each such regional office there shall be—

(1) one regional director appointed by the Secretary; and

(2) one deputy director appointed by the regional director to represent the Indian and Alaska Native tribes in the region, if any.

(c) REGIONAL OFFICE DUTIES.—Each regional director shall—

(1) provide an annual health care needs assessment with respect to the region under the director's jurisdiction to the Secretary after a thorough examination of health needs and in consultation with public health officials, clinicians, patients, and patient advocates;

(2) recommend any changes in provider reimbursement or payment for delivery of health services

determined appropriate by the regional director, subject to the provisions of title VI; and

(3) establish a quality assurance mechanism in each such region in order to minimize both underutilization and overutilization of health care items and services and to ensure that all providers meet quality standards established pursuant to this Act.

SEC. 404. BENEFICIARY OMBUDSMAN.

(a) IN GENERAL.—The Secretary shall appoint a Beneficiary Ombudsman who shall have expertise and experience in the fields of health care and education of, and assistance to, individuals enrolled under this Act.

(b) DUTIES.—The Beneficiary Ombudsman shall—

(1) receive complaints, grievances, and requests for information submitted by individuals enrolled under this Act or eligible to enroll under this Act with respect to any aspect of the Medicare for All Program;

(2) provide assistance with respect to complaints, grievances, and requests referred to in paragraph (1), including assistance in collecting relevant information for such individuals, to seek an appeal of a decision or determination made by a regional office or the Secretary; and

(3) submit annual reports to Congress and the Secretary that describe the activities of the Ombudsman and that include such recommendations for improvement in the administration of this Act as the Ombudsman determines appropriate. The Ombudsman shall not serve as an advocate for any increases in payments or new coverage of services, but may identify issues and problems in payment or coverage policies.

SEC. 405. CONDUCT OF RELATED HEALTH PROGRAMS.

In performing functions with respect to health personnel education and training, health research, environmental health, disability insurance, vocational rehabilitation, the regulation of food and drugs, and all other matters pertaining to health, the Secretary shall direct the activities of the Department of Health and Human Services toward contributions to the health of the people complementary to this Act.

Subtitle B—Control Over Fraud and Abuse

SEC. 411. APPLICATION OF FEDERAL SANCTIONS TO ALL FRAUD AND ABUSE UNDER THE MEDICARE FOR ALL PROGRAM.

The following sections of the Social Security Act shall apply to this Act in the same manner as they apply to

title XVIII or State plans under title XIX of the Social Security Act:

(1) Section 1128 (relating to exclusion of individuals and entities).

(2) Section 1128A (civil monetary penalties).

(3) Section 1128B (criminal penalties).

(4) Section 1124 (relating to disclosure of ownership and related information).

(5) Section 1126 (relating to disclosure of certain owners).

(6) Section 1877 (relating to physician referrals).

TITLE V—QUALITY ASSESSMENT

SEC. 501. QUALITY STANDARDS.

(a) IN GENERAL.—All standards and quality measures under this Act shall be implemented and evaluated by the Center for Clinical Standards and Quality of the Centers for Medicare & Medicaid Services (referred to in this title as the ''Center'') or such other agency determined appropriate by the Secretary, in coordination with the Agency for Healthcare Research and Quality and other offices of the Department of Health and Human Services.

(b) DUTIES OF THE CENTER.—The Center shall perform the following duties:

(1) Review and evaluate each practice guideline developed under part B of title IX of the Public Health Service Act. In so reviewing and evaluating, the Center shall determine whether the guideline should be recognized as a national practice guideline in accordance with and subject to the provisions of section 203(c).

(2) Review and evaluate each standard of quality, performance measure, and medical review criterion developed under part B of title IX of the Public Health Service Act (42 U.S.C. 299 et seq.). In so reviewing and evaluating, the Center shall determine whether the standard, measure, or criterion is appropriate for use in assessing or reviewing the quality of items and services provided by health care institutions or health care professionals. The use of Quality-Adjusted Life Years, Disability-Adjusted Life Years, or other similar mechanisms that discriminate against people with disabilities is prohibited for use in any value or cost-effectiveness assessments. The Center shall consider the evidentiary basis for the standard, and the validity, reliability, and feasibility of measuring the standard.

(3) Adoption of methodologies for profiling the patterns of practice of health care professionals and for identifying and notifying outliers.

(4) Development of minimum criteria for competence for entities that can qualify to conduct ongoing and continuous external quality reviews in the administrative regions. Such criteria shall require such an entity to be administratively independent of the individual or board that administers the region and shall ensure that such entities do not provide financial incentives to reviewers to favor one pattern of practice over another. The Center shall ensure coordination and reporting by such entities to ensure national consistency in quality standards.

(5) Submission of a report to the Secretary annually specifically on findings from outcomes research and development of practice guidelines that may affect the Secretary's determination of coverage of services under section 401(a)(1)(G).

SEC. 502. ADDRESSING HEALTH CARE DISPARITIES.

(a) EVALUATING DATA COLLECTION APPROACHES.—The Center shall evaluate approaches for the collection of data under this Act, to be performed in conjunction with existing quality reporting requirements and programs under this Act, that allow for the ongoing, accu-

rate, and timely collection of data on disparities in health care services and performance on the basis of race, ethnicity, gender, geography, disability, or socioeconomic status. In conducting such evaluation, the Center shall consider the following objectives:

(1) Protecting patient privacy.

(2) Minimizing the administrative burdens of data collection and reporting on providers under this Act.

(3) Improving data on race, ethnicity, gender, geography, and socioeconomic status.

(b) REPORTS TO CONGRESS.—

(1) REPORT ON EVALUATION.—Not later than 18 months after the date on which benefits first become available as described in section 106(a), the Center shall submit to Congress and the Secretary a report on the evaluation conducted under subsection (a). Such report shall, taking into consideration the results of such evaluation—

(A) identify approaches (including defining methodologies) for identifying and collecting and evaluating data on health care disparities on the basis of race, ethnicity, gender, geography, or socioeconomic status under the Medicare for All Program; and

(B) include recommendations on the most effective strategies and approaches to reporting quality measures, as appropriate, on the basis of race, ethnicity, gender, geography, or socioeconomic status.

(2) REPORT ON DATA ANALYSES.—Not later than 4 years after the submission of the report under subsection (b)(1), and every 4 years thereafter, the Center shall submit to Congress and the Secretary a report that includes recommendations for improving the identification of health care disparities based on the analyses of data collected under subsection (c).

(c) IMPLEMENTING EFFECTIVE APPROACHES.—Not later than 2 years after the date on which benefits first become available as described in section 106(a), the Secretary shall implement the approaches identified in the report submitted under subsection (b)(1) for the ongoing, accurate, and timely collection and evaluation of data on health care disparities on the basis of race, ethnicity, gender, geography, or socioeconomic status.

TITLE VI—HEALTH BUDGET; PAYMENTS; COST CONTAINMENT MEASURES

Subtitle A—Budgeting

SEC. 601. NATIONAL HEALTH BUDGET.

(a) NATIONAL HEALTH BUDGET.—

(1) IN GENERAL.—By not later than September 1 of each year, beginning with the year prior to the date on which benefits first become available as described in section 106(a), the Secretary shall establish a national health budget, which specifies a budget for the total expenditures to be made for covered health care items and services under this Act.

(2) DIVISION OF BUDGET INTO COMPONENTS.—The national health budget shall consist of the following components:

(A) An operating budget.

(B) A capital expenditures budget.

(C) A special projects budget for purposes of allocating funds for capital expenditures and staffing needs of providers located in rural or medically underserved areas (as defined in section 330(b)(3) of the Public Health Service Act (42 U.S.C. 254b(b)(3))), including areas designated as health professional shortage areas

(as defined in section 332(a) of the Public Health Service Act (42 U.S.C. 254e(a))).

(D) Quality assessment activities under title V.

(E) Health professional education expenditures.

(F) Administrative costs, including costs related to the operation of regional offices.

(G) A reserve fund to respond to the costs of treating an epidemic, pandemic, natural disaster, or other such health emergency, or market-shift adjustments related to patient volume.

(H) Prevention and public health activities.

(3) ALLOCATION AMONG COMPONENTS.—The Secretary shall allocate the funds received for purposes of carrying out this Act among the components described in paragraph (2) in a manner that ensures—

(A) that the operating budget allows for every participating provider in the Medicare for All Program to meet the needs of their respective patient populations;

(B) that the special projects budget is sufficient to meet the health care needs within areas described in paragraph (2)(C) through

the construction, renovation, and staffing of health care facilities in a reasonable timeframe;

(C) a fair allocation for quality assessment activities; and

(D) that the health professional education expenditure component is sufficient to provide for the amount of health professional education expenditures sufficient to meet the need for covered health care services.

(4) REGIONAL ALLOCATION.—The Secretary shall annually provide each regional office with an allotment the Secretary determines appropriate for purposes of carrying out this Act in such region, including payments to providers in such region, capital expenditures in such region, special projects in such region, health professional education in such region, administrative expenses in such region, and prevention and public health activities in such region.

(5) OPERATING BUDGET.—The operating budget described in paragraph (2)(A) shall be used for—

(A) payments to institutional providers pursuant to section 611; and

(B) payments to individual providers pursuant to section 612.

(6) CAPITAL EXPENDITURES BUDGET.—The capital expenditures budget described in paragraph (2)(B) shall be used for—

(A) the construction or renovation of health care facilities, excluding congregate or segregated facilities for individuals with disabilities who receive long-term care services and support; and

(B) major equipment purchases.

(7) SPECIAL PROJECTS BUDGET.—The special projects budget shall be used for the construction of new facilities, major equipment purchases, and staffing in rural or medically underserved areas (as defined in section 330(b)(3) of the Public Health Service Act (42 U.S.C. 254b(b)(3))), including areas designated as health professional shortage areas (as defined in section 332(a) of the Public Health Service Act (42 U.S.C. 254e(a))).

(8) TEMPORARY WORKER ASSISTANCE.—

(A) IN GENERAL.—For up to 5 years following the date on which benefits first become available as described in section 106(a), at least 1 percent of the budget shall be allocated to programs providing assistance to workers who perform functions in the administration of the

health insurance system, or related functions within health care institutions or organizations who may be affected by the implementation of this Act and who may experience economic dislocation as a result of the implementation of this Act.

(B) CLARIFICATION.—Assistance described in subparagraph (A) shall include wage replacement, retirement benefits, job training, and education benefits.

(b) DEFINITIONS.—In this section:

(1) CAPITAL EXPENDITURES.—The term ''capital expenditures'' means expenses for the purchase, lease, construction, or renovation of capital facilities and for major equipment.

(2) HEALTH PROFESSIONAL EDUCATION EXPENDITURES.—The term ''health professional education expenditures'' means expenditures in hospitals and other health care facilities to cover costs associated with teaching and related research activities, including the impact of workforce diversity on patient outcomes.

Subtitle B—Payments to Providers

SEC. 611. PAYMENTS TO INSTITUTIONAL PROVIDERS BASED ON GLOBAL BUDGETS.

(a) IN GENERAL.—Not later than the beginning of each fiscal quarter during which an institutional provider of care (including hospitals, skilled nursing facilities, Federally qualified health centers, home health agencies, and independent dialysis facilities) is to furnish items and services under this Act, the Secretary shall pay to such institutional provider a lump sum in accordance with the succeeding provisions of this subsection and consistent with the following:

(1) PAYMENT IN FULL.—Such payment shall be considered as payment in full for all operating expenses for items and services furnished under this Act, whether inpatient or outpatient, by such provider for such quarter, including outpatient or any other care provided by the institutional provider or provided by any health care provider who provided items and services pursuant to an agreement paid through the global budget as described in paragraph (3).

(2) QUARTERLY REVIEW.—The regional director, on a quarterly basis, shall review whether requirements of the institutional provider's participa-

tion agreement and negotiated global budget have been performed and shall determine whether adjustments to such institutional provider's payment are warranted. This review shall include consideration for additional funding necessary for unanticipated items and services for individuals with complex medical needs or market-shift adjustments related to patient value. The review shall also include an assessment of any adjustments made to ensure that accuracy and need for adjustment was appropriate.

(3) AGREEMENTS FOR SALARIED PAYMENTS FOR CERTAIN PROVIDERS.—Certain group practices and other health care providers, as determined by the Secretary, with agreements to provide items and services at a specified institutional provider paid a global budget under this subsection may elect to be paid through such institutional provider's global budget in lieu of payment under section 612 of this title. Any—

(A) individual health care professional of such group practice or other provider receiving payment through an institutional provider's global budget shall be paid on a salaried basis that is equivalent to salaries or other compensa-

tion rates negotiated for individual health care professionals of such institutional provider; and

(B) any group practice or other health care provider that receives payment through an institutional provider global budget under this paragraph shall be subject to the same reporting and disclosure requirements of the institutional provider.

(b) PAYMENT AMOUNT.—

(1) IN GENERAL.—The amount of each payment to a provider described in subsection (a) shall be determined before the start of each fiscal year through negotiations between the provider and the regional director with jurisdiction over such provider. Such amount shall be based on factors specified in paragraph (2).

(2) PAYMENT FACTORS.—Payments negotiated pursuant to paragraph (1) shall take into account, with respect to a provider—

(A) the historical volume of services provided for each item and services in the previous 3-year period;

(B) the actual expenditures of such provider in such provider's most recent cost report

under title XVIII of the Social Security Act for each item and service compared to—

(i) such expenditures for other institutional providers in the director's jurisdiction; and

(ii) normative payment rates established under comparative payment rate systems, including any adjustments, for such items and services;

(C) projected changes in the volume and type of items and services to be furnished;

(D) wages for employees, including any necessary increases mandatory minimum safe registered nurse-to-patient ratios and optimal staffing levels for physicians and other health care workers;

(E) the provider's maximum capacity to provide items and services;

(F) education and prevention programs;

(G) permissible adjustment to the provider's operating budget due to factors such as—

(i) an increase in primary or specialty care access;

(ii) efforts to decrease health care disparities in rural or medically underserved areas;

(iii) a response to emergent epidemic conditions; and

(iv) proposed new and innovative patient care programs at the institutional level; and

(H) any other factor determined appropriate by the Secretary.

(3) LIMITATION.—Payment amounts negotiated pursuant to paragraph (1) may not—

(A) take into account capital expenditures of the provider or any other expenditure not directly associated with the provision of items and services by the provider to an individual;

(B) be used by a provider for capital expenditures or such other expenditures;

(C) exceed the provider's capacity to provide care under this Act; or

(D) be used to pay or otherwise compensate any board member, executive, or administrator of the institutional provider who has any interest or relationship prohibited

under section 301(b)(2) of this Act or disclosed under section 301 of this Act.

(4) OPERATING EXPENSES.—For purposes of this subsection, ''operating expenses'' of a provider include the following:

(A) The cost of all items and services associated with the provision of inpatient care and outpatient care, including the following:

(i) Wages and salary costs for physicians, nurses, and other health care practitioners employed by an institutional provider, including mandatory minimum safe registered nurse-to-patient staffing ratios and optimal staffing levels for physicians and other healthcare workers.

(ii) Wages and salary costs for all ancillary staff and services.

(iii) Costs of all pharmaceutical products administered by health care clinicians at the institutional provider's facilities or through services provided in accordance with State licensing laws or regulations under which the institutional provider operates.

(iv) Purchasing and maintenance of medical devices, supplies, and other health care technologies, including diagnostic testing equipment.

(v) Costs of all incidental services necessary for safe patient care and handling.

(vi) Costs of patient care, education, and prevention programs, including occupational health and safety programs, public health programs, and necessary staff to implement such programs, for the continued education and health and safety of clinicians and other individuals employed by the institutional provider.

(B) Administrative costs for the institutional provider.

(5) LIMITATION ON COMPENSATION.—Compensation costs for any employee or any contractor or any subcontractor employee of an institutional provider receiving global budgets under this section shall meet the compensation cap established in section 702 of the Bipartisan Budget Act of 2013 (41 U.S.C. 4304(a)(16)) and implementing regulations.

(6) REGIONAL NEGOTIATIONS PERMITTED.—Subject to section 614, a regional director may nego-

tiate changes to an institutional provider's global budget, including any adjustments to address unforeseen market-shifts related to patient volume.

(c) BASELINE RATES AND ADJUSTMENTS.—

(1) IN GENERAL.—The Secretary shall use existing prospective payment systems under title XVIII of the Social Security Act to serve as the comparative payment rate system in global budget negotiations described in subsection (b). The Secretary shall update such comparative payment rate systems annually.

(2) SPECIFICATIONS.—In developing the comparative payment rate system, the Secretary shall use only the operating base payment rates under each such prospective payment systems with applicable adjustments.

(3) LIMITATION.—The comparative rate system established under this subsection shall not include the value-based payment adjustments and the capital expenses base payment rates that may be included in such a prospective payment system.

(4) INITIAL YEAR.—In the first year that global budget payments under this Act are available to institutional providers and for purposes of selecting a comparative payment rate system used during initial

global budget negotiations for each institutional provider, the Secretary shall take into account the appropriate prospective payment system from the most recent year under title XVIII of the Social Security Act to determine what operating base payment the institutional provider would have been paid for covered items and services furnished the preceding year with applicable adjustments, excluding value-based payment adjustments, based on such prospective payment system.

SEC. 612. PAYMENT TO INDIVIDUAL PROVIDERS THROUGH FEE-FOR-SERVICE.

(a) IN GENERAL.—In the case of a provider not described in section 611(a) (including those in group practices who are not receiving payment on a salaried basis described in section 611(a)(3)), payment for items and services furnished under this Act for which payment is not otherwise made under section 611 shall be made by the Secretary in amounts determined under the fee schedule established pursuant to subsection (b). Such payment shall be considered to be payment in full for such items and services, and a provider receiving such payment may not charge the individual receiving such item or service in any amount.

(b) FEE SCHEDULE.—

(1) ESTABLISHMENT.—Not later than 1 year after the date of the enactment of this Act, and in consultation with providers and regional office directors, the Secretary shall establish a national fee schedule for items and services payable under this Act. The Secretary shall evaluate the effectiveness of the fee-for-service structure and update such fee schedule annually.

(2) AMOUNTS.—In establishing payment amounts for items and services under the fee schedule established under paragraph (1), the Secretary shall take into account—

(A) the amounts payable for such items and services under title XVIII of the Social Security Act; and

(B) the expertise of providers and value of items and services furnished by such providers.

(c) ELECTRONIC BILLING.—The Secretary shall establish a uniform national system for electronic billing for purposes of making payments under this subsection.

(d) PHYSICIAN PRACTICE REVIEW BOARD.—Each director of a regional office, in consultation with representatives of physicians practicing in that region, shall establish and appoint a physician practice review board to assure quality, cost effectiveness, and fair reimbursements for

physician-delivered items and services. The use of Quality-Adjusted Life Years, Disability-Adjusted Life Years, or other similar mechanisms that discriminate against people with disabilities is prohibited for use in any value or cost-effectiveness assessments.

SEC. 613. ENSURING ACCURATE VALUATION OF SERVICES UNDER THE MEDICARE PHYSICIAN FEE SCHEDULE.

(a) STANDARDIZED AND DOCUMENTED REVIEW PROCESS.—Section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)) is amended by adding at the end the following new subparagraph:

"(P) STANDARDIZED AND DOCUMENTED REVIEW PROCESS.—

"(i) IN GENERAL.—Not later than one year after the date of enactment of this subparagraph, the Secretary shall establish, document, and make publicly available, in consultation with the Office of Primary Health Care, a standardized process for reviewing the relative values of physicians' services under this paragraph.

"(ii) MINIMUM REQUIREMENTS.—The standardized process shall include, at a minimum, methods and criteria for identi-

fying services for review, prioritizing the review of services, reviewing stakeholder recommendations, and identifying additional resources to be considered during the review process.''.

(b) PLANNED AND DOCUMENTED USE OF FUNDS.—Section 1848(c)(2)(M) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(M)) is amended by adding at the end the following new clause:

''(x) PLANNED AND DOCUMENTED USE OF FUNDS.—For each fiscal year (beginning with the first fiscal year beginning on or after the date of enactment of this clause), the Secretary shall provide to Congress a written plan for using the funds provided under clause (ix) to collect and use information on physicians' services in the determination of relative values under this subparagraph.''.

(c) INTERNAL TRACKING OF REVIEWS.—

(1) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary shall submit to Congress a proposed plan for systematically and internally tracking the Secretary's review of the relative values of physicians' services,

such as by establishing an internal database, under section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)), as amended by this section.

(2) MINIMUM REQUIREMENTS.—The proposal shall include, at a minimum, plans and a timeline for achieving the ability to systematically and internally track the following:

(A) When, how, and by whom services are identified for review.

(B) When services are reviewed or reviewed or when new services are added.

(C) The resources, evidence, data, and recommendations used in reviews.

(D) When relative values are adjusted.

(E) The rationale for final relative value decisions.

(d) FREQUENCY OF REVIEW.—Section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)) is amended—

(1) in subparagraph (B)(i), by striking ''5'' and inserting ''4''; and

(2) in subparagraph (K)(i)(I), by striking ''periodically'' and inserting ''annually''.

(e) CONSULTATION WITH MEDICARE PAYMENT ADVISORY COMMISSION.—

(1) IN GENERAL.—Section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)) is amended—

(A) in subparagraph (B)(i), by inserting ''in consultation with the Medicare Payment Advisory Commission,'' after ''The Secretary,''; and

(B) in subparagraph (K)(i)(I), as amended by subsection (d)(2), by inserting '', in coordination with the Medicare Payment Advisory Commission,'' after ''annually''.

(2) CONFORMING AMENDMENTS.—Section 1805 of the Social Security Act (42 U.S.C. 1395b–6) is amended—

(A) in subsection (b)(1)(A), by inserting the following before the semicolon at the end: ''and including coordinating with the Secretary in accordance with section 1848(c)(2) to systematically review the relative values established for physicians' services, identify potentially misvalued services, and propose adjustments to the relative values for physicians' services''; and

(B) in subsection (e)(1), in the second sentence, by inserting ''or the Ranking Minority Member'' after ''the Chairman''.

(f) PERIODIC AUDIT BY THE COMPTROLLER GENERAL.—Section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)), as amended by subsection (a), is amended by adding at the end the following new subparagraph:

"(Q) PERIODIC AUDIT BY THE COMPTROLLER GENERAL.—

"(i) IN GENERAL.—The Comptroller General of the United States (in this subsection referred to as the 'Comptroller General') shall periodically audit the review by the Secretary of relative values established under this paragraph for physicians' services.

"(ii) ACCESS TO INFORMATION.—The Comptroller General shall have unrestricted access to all deliberations, records, and data related to the activities carried out under this paragraph, in a timely manner, upon request.".

SEC. 614. PAYMENT PROHIBITIONS; CAPITAL EXPENDITURES; SPECIAL PROJECTS.

(a) SENSE OF CONGRESS.—It is the sense of Congress that tens of millions of people in the United States do not receive healthcare services while billions of dollars

that could be spent on providing health care are diverted to profit. There is a moral imperative to correct the massive deficiencies in our current health system and to eliminate profit from the provision of health care.

(b) PROHIBITIONS.—Payments to providers under this Act may not take into account, include any process for the provision of funding for, or be used by a provider for—

(1) marketing of the provider;

(2) the profit or net revenue of the provider, or increasing the profit or net revenue of the provider;

(3) incentive payments, bonuses, or other compensation based on patient utilization of items and services or any financial measure applied with respect to the provider (or any group practice, integrated health care delivery system, or other provider with which the provider contracts or has a pecuniary interest), including any value-based payment or employment-based compensation;

(4) any agreement or arrangement described in section 203(a)(4) of the Labor-Management Reporting and Disclosure Act of 1959 (29 U.S.C. 433(a)(4)); or

(5) political or contributions prohibited under section 317 of the Federal Elections Campaign Act of 1971 (52 U.S.C. 30119(a)(1)).

(c) PAYMENTS FOR CAPITAL EXPENDITURES.—

(1) IN GENERAL.—The Secretary shall pay, from amounts made available for capital expenditures pursuant to section 601(a)(2)(B), such sums determined appropriate by the Secretary to providers who have submitted an application to the regional director of the region or regions in which the provider operates or seeks to operate in a time and manner specified by the Secretary for purposes of funding capital expenditures of such providers.

(2) PRIORITY.—The Secretary shall prioritize allocation of funding under paragraph (1) to projects that propose to use such funds to improve service in a medically underserved area (as defined in section 330(b)(3) of the Public Health Service Act (42 U.S.C. 254b(b)(3))) or to address health disparities among racial, income, or ethnic groups, or based on geographic regions.

(3) LIMITATION.—The Secretary shall not grant funding for capital expenditures under this subsection for capital projects that are financed directly or indirectly through the diversion of private

or other non-Medicare for All Program funding that results in reductions in care to patients, including reductions in registered nursing staffing patterns and changes in emergency room or primary care services or availability.

(4) CAPITAL PROJECTS FUNDED BY CHARITABLE DONATIONS.—Operating expenses and funds shall not by used by an institutional provider receiving payment for capital expenditures under this subsection for a capital project funded by charitable donations without the approval of the regional director or directors of the region or regions where the capital project is located.

(d) PROHIBITION AGAINST CO-MINGLING OPERATING AND CAPITAL FUNDS.—Providers that receive payment under this title shall be prohibited from using, with respect to funds made available under this Act—

(1) funds designated for operating expenditures for capital expenditures or for profit; or

(2) funds designated for capital expenditures for operating expenditures.

(e) PAYMENTS FOR SPECIAL PROJECTS.—

(1) IN GENERAL.—The Secretary shall allocate to each regional director, from amounts made available for special projects pursuant to section

601(a)(2)(C), such sums determined appropriate by the Secretary for purposes of funding projects described in such section, including the construction, renovation, or staffing of health care facilities, in rural, underserved, or health professional or medical shortage areas within such region. Each regional director shall, prior to distributing such funds in accordance with paragraph (2), present a budget describing how such funds will be distributed to the Secretary.

(2) DISTRIBUTION.—A regional director shall distribute funds to providers operating in the region of such director's jurisdiction in a manner determined appropriate by the director.

(f) PROHIBITION ON FINANCIAL INCENTIVE METRICS IN PAYMENT DETERMINATIONS.—The Secretary may not utilize any quality metrics or standards for the purposes of establishing provider payment methodologies, programs, modifiers, or adjustments for provider payments under this title.

SEC. 615. OFFICE OF PRIMARY HEALTH CARE.

(a) IN GENERAL.—There is established within the Agency for Healthcare Research and Quality an Office of Primary Health Care, responsible for coordinating with the Secretary, the Health Resources and Services Admin-

istration, and other offices in the Department as necessary, in order to—

(1) coordinate health professional education policies and goals, in consultation with the Secretary to achieve the national goals specified in subsection (b);

(2) develop and maintain a system to monitor the number and specialties of individuals through their health professional education, any postgraduate training, and professional practice;

(3) develop, coordinate, and promote policies that expand the number of primary care practitioners, registered nurses, midlevel practitioners, and dentists;

(4) recommend the appropriate training, technical assistance, and patient protection enhancements of primary care health professionals, including registered nurses, to achieve uniform high quality and patient safety; and

(5) consult with the Secretary on the allocation of the special projects budget under section 601(a)(2)(C).

(b) NATIONAL GOALS.—Not later than 1 year after the date of enactment of this Act, the Office of Primary Health Care shall set forth national goals to increase ac-

cess to high quality primary health care, particularly in underserved areas and for underserved populations.

(c) CLARIFICATION.—Nothing in this—

(1) section shall be construed to preempt any provision of State law establishing practice standards or guidelines for health care professionals, including professional licensing or practice laws or regulations; and

(2) Act shall be construed to require that any State impose additional educational standards or guidelines for health care professionals.

SEC. 616. PAYMENTS FOR PRESCRIPTION DRUGS AND APPROVED DEVICES AND EQUIPMENT.

The prices to be paid for covered pharmaceuticals, medical supplies, medical technologies, and medically necessary equipment covered under this Act shall be negotiated annually by the Secretary.

(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary shall, for fiscal years beginning on or after the date of the enactment of this subsection, negotiate with pharmaceutical manufacturers the prices (including discounts, rebates, and other price concessions) that may be charged to the Medicare for All Program during a negotiated price period (as specified by the Secretary) for cov-

ered drugs for eligible individuals under the Medicare for All Program. In negotiating such prices under this section, the Secretary shall take into account the following factors:

(A) The comparative clinical effectiveness and cost effectiveness, when available from an impartial source, of such drug.

(B) The budgetary impact of providing coverage of such drug.

(C) The number of similarly effective drugs or alternative treatment regimens for each approved use of such drug.

(D) The total revenues from global sales obtained by the manufacturer for such drug and the associated investment in research and development of such drug by the manufacturer.

(2) FINALIZATION OF NEGOTIATED PRICE.—The negotiated price of each covered drug for a negotiated price period shall be finalized not later than 30 days before the first fiscal year in such negotiated price period.

(3) COMPETITIVE LICENSING AUTHORITY.—

(A) IN GENERAL.—Notwithstanding any exclusivity under clause (iii) or (iv) of section 505(j)(5)(F) of the Federal Food, Drug, and

Cosmetic Act, clause (iii) or (iv) of section 505(c)(3)(E) of such Act, section 351(k)(7)(A) of the Public Health Service Act, or section 527(a) of the Federal Food, Drug, and Cosmetic Act, or by an extension of such exclusivity under section 505A of such Act or section 505E of such Act, and any other provision of law that provides for market exclusivity (or extension of market exclusivity) with respect to a drug, in the case that the Secretary is unable to success fully negotiate an appropriate price for a covered drug for a negotiated price period, the Secretary shall authorize the use of any patent, clinical trial data, or other exclusivity granted by the Federal Government with respect to such drug as the Secretary determines appropriate for purposes of manufacturing such drug for sale under Medicare for All Program. Any entity making use of a competitive license to use patent, clinical trial data, or other exclusivity under this section shall provide to the manufacturer holding such exclusivity reasonable compensation, as determined by the Secretary based on the following factors:

(i) The risk-adjusted value of any Federal Government subsidies and investments in research and development used to support the development of such drug.

(ii) The risk-adjusted value of any investment made by such manufacturer in the research and development of such drug.

(iii) The impact of the price, including license compensation payments, on meeting the medical need of all patients at a reasonable cost.

(iv) The relationship between the price of such drug, including compensation payments, and the health benefits of such drug.

(v) Other relevant factors determined appropriate by the Secretary to provide reasonable compensation.

(B) REASONABLE COMPENSATION.—The manufacturer described in subparagraph (A) may seek recovery against the United States in the United States Court of Federal Claims.

(C) INTERIM PERIOD.—Until 1 year after a drug described in subparagraph (A) is ap-

proved under section 505(j) of the Federal Food, Drug, and Cosmetic Act or section 351(k) of the Public Health Service Act and is provided under license issued by the Secretary under such subparagraph, the Medicare for All Program shall not pay more for such drug than the average of the prices available, during the most recent 12-month period for which data is available prior to the beginning of such negotiated price period, from the manufacturer to any wholesaler, retailer, provider, health maintenance organization, nonprofit entity, or governmental entity in the ten OECD (Organization for Economic Cooperation and Development) countries that have the largest gross domestic product with a per capita income that is not less than half the per capita income of the United States.

(D) AUTHORIZATION FOR SECRETARY TO PROCURE DRUGS DIRECTLY.—The Secretary may procure a drug manufactured pursuant to a competitive license under subparagraph (A) for purposes of this Act.

(4) FDA REVIEW OF LICENSED DRUG APPLICATIONS.—The Secretary shall prioritize review of ap-

plications under section 505(j) of the Federal Food, Drug, and Cosmetic Act for drugs licensed under paragraph (3)(A).

(5) PROHIBITION OF ANTICOMPETITIVE BEHAVIOR.—No drug manufacturer may engage in anticompetitive behavior with another manufacturer that may interfere with the issuance and implementation of a competitive license or run contrary to public policy.

(6) REQUIRED REPORTING.—The Secretary may require pharmaceutical manufacturers to disclose to the Secretary such information that the Secretary determines necessary for purposes of carrying out this subsection.

TITLE VII—UNIVERSAL MEDICARE TRUST FUND

SEC. 701. UNIVERSAL MEDICARE TRUST FUND.

(a) IN GENERAL.—There is hereby created on the books of the Treasury of the United States a trust fund to be known as the Universal Medicare Trust Fund (in this section referred to as the ''Trust Fund''). The Trust Fund shall consist of such gifts and bequests as may be made and such amounts as may be deposited in, or appropriated to, such Trust Fund as provided in this Act.

(b) APPROPRIATIONS INTO TRUST FUND.—

(1) TAXES.—There are appropriated to the Trust Fund for each fiscal year beginning with the fiscal year which includes the date on which benefits first become available as described in section 106, out of any moneys in the Treasury not otherwise appropriated, amounts equivalent to 100 percent of the net increase in revenues to the Treasury which is attributable to the amendments made by sections 801 and 902. The amounts appropriated by the preceding sentence shall be transferred from time to time (but not less frequently than monthly) from the general fund in the Treasury to the Trust Fund, such amounts to be determined on the basis of estimates by the Secretary of the Treasury of the taxes paid to or deposited into the Treasury, and proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than the amounts that should have been so transferred.

(2) CURRENT PROGRAM RECEIPTS.—

(A) INITIAL YEAR.—Notwithstanding any other provision of law, there is appropriated to the Trust Fund for the fiscal year containing January 1 of the first year following the date of the enactment of this Act, an amount equal

to the aggregate amount appropriated for the preceding fiscal year for the following (increased by the consumer price index for all urban consumers for the fiscal year involved):

(i) The Medicare program under title XVIII of the Social Security Act (other than amounts attributable to any premiums under such title).

(ii) The Medicaid program under State plans approved under title XIX of such Act.

(iii) The Federal Employees Health Benefits program, under chapter 89 of title 5, United States Code.

(iv) The TRICARE program, under chapter 55 of title 10, United States Code.

(v) The maternal and child health program (under title V of the Social Security Act), vocational rehabilitation programs, programs for drug abuse and mental health services under the Public Health Service Act, programs providing general hospital or medical assistance, and any other Federal program identified by the Secretary, in consultation with the Sec-

retary of the Treasury, to the extent the programs provide for payment for health services the payment of which may be made under this Act.

(B) SUBSEQUENT YEARS.—Notwithstanding any other provision of law, there is appropriated to the trust fund for the fiscal year containing January 1 of the second year following the date of the enactment of this Act, and for each fiscal year thereafter, an amount equal to the amount appropriated to the Trust Fund for the previous year, adjusted for reductions in costs resulting from the implementation of this Act, changes in the consumer price index for all urban consumers for the fiscal year involved, and other factors determined appropriate by the Secretary.

(3) RESTRICTIONS SHALL NOT APPLY.—Any other provision of law in effect on the date of enactment of this Act restricting the use of Federal funds for any reproductive health service shall not apply to monies in the Trust Fund.

(c) INCORPORATION OF PROVISIONS.—The provisions of subsections (b) through (i) of section 1817 of the Social Security Act (42 U.S.C. 1395i) shall apply to the Trust

Fund under this section in the same manner as such provisions applied to the Federal Hospital Insurance Trust Fund under such section 1817, except that, for purposes of applying such subsections to this section, the ''Board of Trustees of the Trust Fund'' shall mean the ''Secretary''.

(d) TRANSFER OF FUNDS.—Any amounts remaining in the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) or the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t) after the payment of claims for items and services furnished under title XVIII of such Act have been completed, shall be transferred into the Universal Medicare Trust Fund under this section.

TITLE VIII—CONFORMING AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

SEC. 801. PROHIBITION OF EMPLOYEE BENEFITS DUPLICATIVE OF BENEFITS UNDER THE MEDICARE FOR ALL PROGRAM; COORDINATION IN CASE OF WORKERS' COMPENSATION.

(a) IN GENERAL.—Part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974

(29 U.S.C. 1131 et seq.) is amended by adding at the end the following new section:

"SEC. 522. PROHIBITION OF EMPLOYEE BENEFITS DUPLICATIVE OF UNIVERSAL MEDICARE PROGRAM BENEFITS; COORDINATION IN CASE OF WORKERS' COMPENSATION.

"(a) IN GENERAL.—Subject to subsection (b), no employee benefit plan may provide benefits that duplicate payment for any items or services for which payment may be made under the Medicare for All Act of 2019.

"(b) REIMBURSEMENT.—Each workers compensation carrier that is liable for payment for workers compensation services furnished in a State shall reimburse the Medicare for All Program for the cost of such services.

"(c) DEFINITIONS.—In this subsection—

"(1) the term 'workers compensation carrier' means an insurance company that underwrite workers compensation medical benefits with respect to one or more employers and includes an employer or fund that is financially at risk for the provision of workers compensation medical benefits;

"(2) the term 'workers compensation medical benefits' means, with respect to an enrollee who is an employee subject to the workers compensation laws of a State, the comprehensive medical benefits

for work-related injuries and illnesses provided for under such laws with respect to such an employee; and

''(3) the term 'workers compensation services' means items and services included in workers compensation medical benefits and includes items and services (including rehabilitation services and long-term care services) commonly used for treatment of work-related injuries and illnesses.''.

(b) CONFORMING AMENDMENT.—Section 4(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1003(b)) is amended by adding at the end the following: ''Paragraph (3) shall apply subject to section 522(b) (relating to reimbursement of the Medicare for All Program by workers compensation carriers).''.

(c) CLERICAL AMENDMENT.—The table of contents in section 1 of such Act is amended by inserting after the item relating to section 521 the following new item:

''Sec. 522. Prohibition of employee benefits duplicative of Universal Medicare Program benefits; coordination in case of workers' compensation.''.

SEC. 802. APPLICATION OF CONTINUATION COVERAGE REQUIREMENTS UNDER ERISA AND CERTAIN OTHER REQUIREMENTS RELATING TO GROUP HEALTH PLANS.

(a) IN GENERAL.—Part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974

(29 U.S.C. 1161 et seq.) shall apply only with respect to any employee health benefit plan that does not duplicate payments for any items or services for which payment may be made under the this Act.

(b) CONFORMING AMENDMENT.—Section 601 of part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (19 U.S.C. 1161) is amended by adding the following subsection at the end:

''(c) Subsection (a) shall apply to any group health plan that does not duplicate payments for any items or services for which payment may be made under the Universal Health Insurance Act of 2017.''.

SEC. 803. EFFECTIVE DATE OF TITLE.

The provisions of and amendments made by this title shall take effect on the date described in section 106(a).

TITLE IX—ADDITIONAL CONFORMING AMENDMENTS

SEC. 901. RELATIONSHIP TO EXISTING FEDERAL HEALTH PROGRAMS.

(a) MEDICARE, MEDICAID, AND STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP).—

(1) IN GENERAL.—Notwithstanding any other provision of law and with respect to an individual eligible to enroll under this Act, subject to paragraphs (2) and (3)—

(A) no benefits shall be available under title XVIII of the Social Security Act for any item or service furnished beginning on the date that is 2 years after the date of the enactment of this Act;

(B) no individual is entitled to medical assistance under a State plan approved under title XIX of such Act for any item or service furnished on or after such date;

(C) no individual is entitled to medical assistance under a State child health plan under title XXI of such Act for any item or service furnished on or after such date; and

(D) no payment shall be made to a State under section 1903(a) or 2105(a) of such Act with respect to medical assistance or child health assistance for any item or service furnished on or after such date.

(2) TRANSITION.—In the case of inpatient hospital services and extended care services during a continuous period of stay which began before the effective date of benefits under section 106, and which had not ended as of such date, for which benefits are provided under title XVIII of the Social Security Act, under a State plan under title XIX of such Act,

or under a State child health plan under title XXI of such Act, the Secretary shall provide for continuation of benefits under such title or plan until the end of the period of stay.

(3) SCHOOL PROGRAMS.—All school related health programs, centers, initiatives, services, or other activities or work provided under title XIX or title XXI of the Social Security Act as of January 1, 2019, shall be continued and covered by the Medicare for All Program.

(b) FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM.—No benefits shall be made available under chapter 89 of title 5, United States Code, with respect to items and services furnished to any individual eligible to enroll under this Act.

(c) TRICARE.—No benefits shall be made available under sections 1079 and 1086 of title 10, United States Code, for items or services furnished to any individual eligible to enroll under this Act.

(d) TREATMENT OF BENEFITS FOR VETERANS AND NATIVE AMERICANS.—

(1) IN GENERAL.—Nothing in this Act shall affect the eligibility of veterans for the medical benefits and services provided under title 38, United States Code, or of Indians for the medical benefits

and services provided by or through the Indian Health Service.

(2) REEVALUATION.—No reevaluation of the Indian Health Service shall be undertaken without consultation with tribal leaders and stakeholders.

SEC. 902. SUNSET OF PROVISIONS RELATED TO THE STATE EXCHANGES.

Effective on the date that is 2 years after the date of the enactment of this Act, the Federal and State Exchanges established pursuant to title I of the Patient Protection and Affordable Care Act (Public Law 111–148) shall terminate, and any other provision of law that relies upon participation in or enrollment through such an Exchange, including such provisions of the Internal Revenue Code of 1986, shall cease to have force or effect.

SEC. 903. SUNSET OF PROVISIONS RELATED TO PAY FOR PERFORMANCE PROGRAMS.

(a) Effective on the date described in section 106(a), the Federal programs related to pay for performance programs and value-based purchasing shall terminate, and any other provision of law that relies upon participation in or enrollment in such program shall cease to have force or effect. Programs that shall terminate include—

(1) the Merit-based Incentive Payment System established pursuant to subsection (q) of section

1848 of the Social Security Act (42 U.S.C. 1395w–4(q));

(2) the incentives for meaningful use of certified EHR technology established pursuant to subsection (a)(7) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4(a)(7));

(3) the incentives for adoption and meaningful use of certified EHR technology established pursuant to subsection (o) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4(o));

(4) alternative payment models established under section 1833(z) of the Social Security Act (42 U.S.C. 1395(z)); and

(5) the following programs as established pursuant to the following sections of the Patient Protection and Affordable Care Act:

(A) Section 2701 (adult health quality measures).

(B) Section 2702 (payment adjustments for health care acquired conditions).

(C) Section 2706 (Pediatric Accountable Care Organization Demonstration Projects for the purposes of receiving incentive payments).

(D) Section 3002(b) (42 U.S.C. 1395w–4(a)(8)) (incentive payments for quality reporting).

(E) Section 3001(a) (42 U.S.C. 1395ww(o)) (Hospital Value-Based Purchasing).

(F) Section 3006 (value-based purchasing program for skilled nursing facilities and home health agencies).

(G) Section 3007 (42 U.S.C. 1395w–4(p)) (value based payment modifier under physician fee schedule).

(H) Section 3008 (42 U.S.C. 1395ww(p)) (payment adjustments for health care-acquired condition).

(I) Section 3022 (42 U.S.C. 1395jjj) (Medicare shared savings programs).

(J) Section 3023 (42 U.S.C. 1395cc–4) (National Pilot Program on Payment Bundling).

(K) Section 3024 (42 U.S.C. 1395cc–5) (Independence at home demonstration program).

(L) Section 3025 (42 U.S.C. 1395ww(q)) (hospital readmissions reduction program).

(M) Section 10301 (plans for value-based purchasing program for ambulatory surgical centers).

TITLE X—TRANSITION

Subtitle A—Medicare for All Transition Over 2 Years and Transitional Buy-In Option

SEC. 1001. MEDICARE FOR ALL TRANSITION OVER TWO YEARS.

Title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.) is amended by adding at the end the following new section:

"SEC. 1899C. MEDICARE FOR ALL TRANSITION OVER 2 YEARS.

"(a) TRANSITION.—

"(1) IN GENERAL.—Every individual who meets the requirements described in paragraph (3) shall be eligible to enroll in the Medicare for All Program under this section during the transition period starting one year after the date of enactment of the Medicare for All Act of 2019.

"(2) BENEFITS.—An individual enrolled under this section is entitled to the benefits established under title II of the Medicare for All Act of 2019.

"(3) REQUIREMENTS FOR ELIGIBILITY.—The requirements described in this paragraph are the following:

"(A) The individual meets the eligibility requirements established by the Secretary under title I of the Medicare for All Act of 2019.

"(B) The individual has attained the applicable year of age, or is currently enrolled in Medicare at the time of the transition to Medicare for All.

"(4) APPLICABLE YEAR OF AGE DEFINED.—For purposes of this section, the term 'applicable year of age' means one year after the date of enactment of the Medicare for All Act of 2019, the age of 55 or older, the age 18 or younger.

"(b) ENROLLMENT; COVERAGE.—The Secretary shall establish enrollment periods and coverage under this section consistent with the principles for establishment of enrollment periods and coverage for individuals under other provisions of this title. The Secretary shall establish such periods so that coverage under this section shall first begin on January 1 of the year on which an individual first becomes eligible to enroll under this section.

"(c) SATISFACTION OF INDIVIDUAL MANDATE.—For purposes of applying section 5000A of the Internal Rev-

enue Code of 1986, the coverage provided under this section constitutes minimum essential coverage under subsection (f)(1)(A)(i) of such section 5000A.

"(d) CONSULTATION.—In promulgating regulations to implement this section, the Secretary shall consult with interested parties, including groups representing beneficiaries, health care providers, employers, and insurance companies.".

SEC. 1002. ESTABLISHMENT OF THE MEDICARE TRANSITION BUY-IN.

(a) IN GENERAL.—To carry out the purpose of this section, for the year beginning one year after the date of enactment of this Act and ending with the effective date described in section 106(a), the Secretary, acting through the Administrator of the Centers for Medicare & Medicaid (referred to in this section as the "Administrator"), shall establish, and provide for the offering through the Exchanges, an option to buy in to the Medicare for All Program (in this Act referred to as the "Medicare Transition buy-in").

(b) ADMINISTERING THE MEDICARE TRANSITION BUY-IN.—

(1) ADMINISTRATOR.—The Administrator shall administer the Medicare Transition buy-in in accordance with this section.

(2) APPLICATION OF ACA REQUIREMENTS.—Consistent with this section, the Medicare Transition buy-in shall comply with requirements under title I of the Patient Protection and Affordable Care Act (and the amendments made by that title) and title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.) that are applicable to qualified health plans offered through the Exchanges, subject to the limitation under subsection (e)(2).

(3) OFFERING THROUGH EXCHANGES.—The Medicare Transition buy-in shall be made available only through the Exchanges, and shall be available to individuals wishing to enroll and to qualified employers (as defined in section 1312(f)(2) of the Patient Protection and Affordable Care Act (42 U.S.C. 18032)) who wish to make such plan available to their employees.

(4) ELIGIBILITY TO PURCHASE.—Any United States resident may enroll in the Medicare Transition buy-in.

(c) BENEFITS; ACTUARIAL VALUE.—In carrying out this section, the Administrator shall ensure that the Medicare Transition buy-in provides—

(1) coverage for the benefits required to be covered under title II of this Act; and

(2) coverage of benefits that are actuarially equivalent to 90 percent of the full actuarial value of the benefits provided under the plan.

(d) PROVIDERS AND REIMBURSEMENT RATES.—

(1) IN GENERAL.—With respect to the reimbursement provided to health care providers for covered benefits, as described in section 201, provided under the Medicare Transition buy-in, the Administrator shall reimburse such providers at rates determined for equivalent items and services under the Medicare for All fee-for-service schedule established in section 612(b) of this Act.

(2) PRESCRIPTION DRUGS.—Any payment rate under this subsection for a prescription drug shall be at the prices negotiated under section 616 of this Act.

(3) PARTICIPATING PROVIDERS.—

(A) IN GENERAL.—A health care provider that is a participating provider of services or supplier under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) or under a State Medicaid plan under title XIX of such Act (42 U.S.C. 1396 et seq.) on the date of enactment of this

Act shall be a participating provider in the Medicare Transition buy-in.

(B) ADDITIONAL PROVIDERS.—The Administrator shall establish a process to allow health care providers not described in subparagraph (A) to become participating providers in the Medicare Transition buy-in. Such process shall be similar to the process applied to new providers under the Medicare program.

(e) PREMIUMS.—

(1) DETERMINATION.—The Administrator shall determine the premium amount for enrolling in the Medicare Transition buy-in, which—

(A) may vary according to family or individual coverage, age, and tobacco status (consistent with clauses (i), (iii), and (iv) of section 2701(a)(1)(A) of the Public Health Service Act (42 U.S.C. 300gg(a)(1)(A))); and

(B) shall take into account the cost-sharing reductions and premium tax credits which will be available with respect to the plan under section 1402 of the Patient Protection and Affordable Care Act (42 U.S.C. 18071) and section 36B of the Internal Revenue Code of 1986, as amended by subsection (g).

(2) LIMITATION.—Variation in premium rates of the Medicare Transition buy-in by rating area, as described in clause (ii) of section 2701(a)(1)(A)(iii) of the Public Health Service Act (42 U.S.C. 300gg(a)(1)(A)) is not permitted.

(f) TERMINATION.—This section shall cease to have force or effect on the effective date described in section 106(a).

(g) TAX CREDITS AND COST-SHARING SUBSIDIES.—

(1) PREMIUM ASSISTANCE TAX CREDITS.—

(A) CREDITS ALLOWED TO MEDICARE TRANSITION BUY-IN ENROLLEES IN NON-EXPANSION STATES.—Paragraph (1) of section 36B(c) of the Internal Revenue Code of 1986 is amended by redesignating subparagraphs (C) and (D) as subparagraphs (D) and (E), respectively, and by inserting after subparagraph (B) the following new subparagraph:

"(C) SPECIAL RULES FOR MEDICARE TRANSITION BUY-IN ENROLLEES.—

"(i) IN GENERAL.—In the case of a taxpayer who is covered, or whose spouse or dependent (as defined in section 152) is covered, by the Medicare Transition buy-in established under section 1002(a) of the

Medicare for All Act of 2019 for all months in the taxable year, subparagraph (A) shall be applied without regard to 'but does not exceed 400 percent'.

"(ii) ENROLLEES IN MEDICAID NON-EXPANSION STATES.—In the case of a taxpayer residing in a State which (as of the date of the enactment of the Medicare for All Act of 2019) does not provide for eligibility under clause (i)(VIII) or (ii)(XX) of section 1902(a)(10)(A) of the Social Security Act for medical assistance under title XIX of such Act (or a waiver of the State plan approved under section 1115) who is covered, or whose spouse or dependent (as defined in section 152) is covered, by the Medicare Transition buy-in established under section 1002(a) of the Medicare for All Act of 2019 for all months in the taxable year, subparagraphs (A) and (B) shall be applied by substituting '0 percent' for '100 percent' each place it appears.".

(B) PREMIUM ASSISTANCE AMOUNTS FOR TAXPAYERS ENROLLED IN MEDICARE TRANSITION BUY-IN.—

(i) IN GENERAL.—Subparagraph (A) of section 36B(b)(3) of such Code is amended—(I) by redesignating clause (ii) as clause (iii), (II) by striking ''clause (ii)'' in clause (i) and inserting ''clauses (ii) and (iii)'', and (III) by inserting after clause (i) the following new clause:

''(ii) SPECIAL RULES FOR TAXPAYERS ENROLLED IN MEDICARE TRANSITION BUY-IN.—In the case of a taxpayer who is covered, or whose spouse or dependent (as defined in section 152) is covered, by the Medicare Transition buy-in established under section 1002(a) of the Medicare for All Act of 2019 for all months in the taxable year, the applicable percentage for any taxable year shall be determined in the same manner as under clause (i), except that the following table shall apply in lieu of the table contained in such clause:

''In the case of household income (expressed as a percent of poverty line) within the following income tier:	The initial premium percentage is—	The final premium percentage is—
Up to 100 percent	2.00	2.00
100 percent up to 138 percent	2.04	2.04
138 percent up to 150 percent	3.06	4.08
150 percent and above	4.08	5.00.''.

(ii) CONFORMING AMENDMENT.—Subclause (I) of clause (iii) of section 36B(b)(3) of such Code, as redesignated by subparagraph (A)(i), is amended by inserting ", and determined after the application of clause (ii)" after "after application of this clause".

(2) COST-SHARING SUBSIDIES.—Subsection (b) of section 1402 of the Patient Protection and Affordable Care Act (42 U.S.C. 18071(b)) is amended—

(A) by inserting ", or in the Medicare Transition buy-in established under section 1002(a) of the Medicare for All Act of 2019," after "coverage" in paragraph (1);

(B) by redesignating paragraphs (1) (as so amended) and (2) as subparagraphs (A) and (B), respectively, and by moving such subparagraphs 2 ems to the right;

(C) by striking "INSURED.—In this section" and inserting "INSURED.—

"(1) IN GENERAL.—In this section";

(D) by striking the flush language; and

(E) by adding at the end the following new paragraph:

"(2) SPECIAL RULES.—

"(A) INDIVIDUALS LAWFULLY PRESENT.—In the case of an individual described in section 36B(c)(1)(B) of the Internal Revenue Code of 1986, the individual shall be treated as having household income equal to 100 percent of the poverty line for a family of the size involved for purposes of applying this section.

"(B) MEDICARE TRANSITION BUY-IN ENROLLEES IN MEDICAID NON-EXPANSION STATES.—In the case of an individual residing in a State which (as of the date of the enactment of the Medicare for All Act of 2019) does not provide for eligibility under clause (i)(VIII) or (ii)(XX) of section 1902(a)(10)(A) of the Social Security Act for medical assistance under title XIX of such Act (or a waiver of the State plan approved under section 1115) who enrolls in such Medicare Transition buy-in, the preceding sentence, paragraph (1)(B), and paragraphs (1)(A)(i) and (2)(A) of subsection (c) shall each be applied by substituting '0 percent' for '100 percent' each place it appears.".

(h) CONFORMING AMENDMENTS.—

(1) TREATMENT AS A QUALIFIED HEALTH PLAN.—Section 1301(a)(2) of the Patient Protection and Affordable Care Act (42 U.S.C. 18021(a)(2)) is amended—

(A) in the paragraph heading, by inserting "THE MEDICARE TRANSITION BUY-IN," before "AND"; and

(B) by inserting "The Medicare Transition buy-in," before "and a multi-State plan".

(2) LEVEL PLAYING FIELD.—Section 1324(a) of the Patient Protection and Affordable Care Act (42 U.S.C. 18044(a)) is amended by inserting "the Medicare Transition buy-in," before "or a multi-State qualified health plan".

Subtitle B—Transitional Medicare Reforms

SEC. 1011. ELIMINATING THE 24-MONTH WAITING PERIOD FOR MEDICARE COVERAGE FOR INDIVIDUALS WITH DISABILITIES.

(a) IN GENERAL.—Section 226(b) of the Social Security Act (42 U.S.C. 426(b)) is amended—

(1) in paragraph (2)(A), by striking ", and has for 24 calendar months been entitled to,";

(2) in paragraph (2)(B), by striking ", and has been for not less than 24 months,";

(3) in paragraph (2)(C)(ii), by striking ", including the requirement that he has been entitled to the specified benefits for 24 months,";

(4) in the first sentence, by striking "for each month beginning with the later of (I) July 1973 or (II) the twenty-fifth month of his entitlement or status as a qualified railroad retirement beneficiary described in paragraph (2), and" and inserting "for each month for which the individual meets the requirements of paragraph (2), beginning with the month following the month in which the individual meets the requirements of such paragraph, and"; and

(5) in the second sentence, by striking "the 'twenty-fifth month of his entitlement' " and all that follows through "paragraph (2)(C) and".

(b) CONFORMING AMENDMENTS.—

(1) SECTION 226.—Section 226 of the Social Security Act (42 U.S.C. 426) is amended by—

(A) striking subsections (e)(1)(B), (f), and (h); and

(B) redesignating subsections (g) and (i) as subsections (f) and (g), respectively.

(2) MEDICARE DESCRIPTION.—Section 1811(2) of the Social Security Act (42 U.S.C. 1395c(2)) is

amended by striking ''have been entitled for not less than 24 months'' and inserting ''are entitled''.

(3) MEDICARE COVERAGE.—Section 1837(g)(1) of the Social Security Act (42 U.S.C. 1395p(g)(1)) is amended by striking ''25th month of'' and inserting ''month following the first month of''.

(4) RAILROAD RETIREMENT SYSTEM.—Section 7(d)(2)(ii) of the Railroad Retirement Act of 1974 (45 U.S.C. 231f(d)(2)(ii)) is amended—

(A) by striking ''has been entitled to an annuity'' and inserting ''is entitled to an annuity'';

(B) by striking '', for not less than 24 months''; and

(C) by striking ''could have been entitled for 24 calendar months, and''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to insurance benefits under title XVIII of the Social Security Act with respect to items and services furnished in months beginning after December 1 following the date of enactment of this Act, and before the date that is 2 years after the date of the enactment of such Act.

SEC. 1012. ENSURING CONTINUITY OF CARE.

(a) IN GENERAL.—The Secretary shall ensure that all persons enrolled or who seeks to enroll in a health plan during the transition period of the Medicare for All Program are protected from disruptions in their care during the transition period, including continuity of care with such persons current health care provider teams.

(b) CONTINUITY OF COVERAGE AND CARE IN GENERAL.—During the transition period of the Medicare for All Act, group health plans and health insurance issuers offering group or individual health insurance coverage shall not end coverage for an enrollee during the transition period described in the Act until all ages are eligible to enroll in the Medicare for All Program except as expressly agreed upon under the terms of the plan.

(c) CONTINUITY OF COVERAGE AND CARE FOR PERSONS WITH COMPLEX MEDICAL NEEDS.—

(1) The Secretary shall ensure that persons with disabilities, complex medical needs, or chronic conditions are protected from disruptions in their care during the transition period, including continuity of care with such persons current health care provider teams.

(2) During the transition period of the Medicare for All Act group health plans and health insur-

ance issuers offering group or individual health insurance coverage shall not—

(A) end coverage for an enrollee who has a disability, complex medical need, or chronic condition during the transition period described in the Act until all ages are eligible to enroll in the Medicare for All Program; or

(B) impose any exclusion with respect to such plan or coverage on the basis of a person's disability, complex medical need, or chronic condition during the transition period described under this Act until all ages are eligible to enroll in the Medicare for All Program.

(d) PUBLIC CONSULTATION DURING TRANSITION.—The Secretary shall consult with communities and advocacy organizations of persons living with disabilities as well as other patient advocacy organizations to ensure that the transition buy-in takes into account the continuity of care for persons with disabilities, complex medical needs, or chronic conditions.

TITLE XI—MISCELLANEOUS

SEC. 1101. DEFINITIONS.

In this Act—

(1) the term ''group practice'' has the meaning given such term in section 1877(h)(4) of the Social Security Act (42 U.S.C. 1395nn(h)(4));

(2) the term ''individual provider'' means a supplier (as defined for purposes of paragraph (4));

(3) the term ''institutional provider'' means—

(A) providers of services described in section 1861(u) of such Act (42 U.S.C. 1395x(u));

(B) hospitals as defined in section 1861(e) of the Social Security Act (42 U.S.C. 1395x(e)), and any outpatient settings or clinics operating within a hospital license or any setting or clinic that provides outpatient hospital services;

(C) psychiatric hospitals (as defined in section 1861(e) of the Social Security Act (42 U.S.C. 1395x(f)));

(D) rehabilitation hospitals (as defined by the Secretary of Health and Human Services under section 1886(d)(1)(B)(ii) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)(ii)));

(E) long-term care hospitals as defined in section 1861 of the Social Security Act (42 U.S.C. 1395x(ccc)); and

(F) independent dialysis facilities and independent end-stage renal disease facilities as described in 42 CFR 413.174(b);

(4) the term ''medically necessary or appropriate'' means the health care items and services or supplies are needed or appropriate to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms for an individual and are determined to be necessary or appropriate for such individual by the physician or other health care professional treating such individual, after such professional performs an assessment of such individual's condition, in a manner that meets—

(A) the scope of practice, licensing, and other law of the State in which such items and services are to be furnished; and

(B) appropriate standards established by the Secretary for purposes of carrying out this Act;

(5) the term ''provider'' means an institutional provider or a supplier (as defined in section 1861(d) of such Act (42 U.S.C. 1395x(d)) if the reference to ''this title'' were a reference to the Medicare for All Program);

(6) the term ''Secretary'' means the Secretary of Health and Human Services;

(7) the term ''State'' means a State, the District of Columbia, or a territory of the United States; and

(8) the term ''United States'' shall include the States, the District of Columbia, and the territories of the United States.

SEC. 1102. RULES OF CONSTRUCTION.

(a) IN GENERAL.—A State or local government may set additional standards or apply other State or local laws with respect to eligibility, benefits, and minimum provider standards, only if such State or local standards—

(1) provide equal or greater eligibility than is available under this Act;

(2) provide equal or greater in-person access to benefits under this Act;

(3) do not reduce access to benefits under this Act;

(4) allow for the effective exercise of the professional judgment of physicians or other health care professionals; and

(5) are otherwise consistent with this Act.

(b) RELATION TO STATE LICENSING LAW.—Nothing in this Act shall be construed to preempt State licensing,

practice, or educational laws or regulations with respect to health care professionals and health care providers, for such professionals and providers who practice in that State.

(c) APPLICATION TO STATE AND FEDERAL LAW ON WORKPLACE RIGHTS.—Nothing in this Act shall be construed to diminish or alter the rights, privileges, remedies, or obligations of any employee or employer under any Federal or State law or regulation or under any collective bargaining agreement.

(d) RESTRICTIONS ON PROVIDERS.—With respect to any individuals or entities certified to provide items and services covered under section 201(a)(7), a State may not prohibit an individual or entity from participating in the program under this Act for reasons other than the ability of the individual or entity to provide such services.

○

116TH CONGRESS
1ST SESSION

S. 1129

To establish a Medicare-for-all national health insurance program.

IN THE SENATE OF THE UNITED STATES

APRIL 10, 2019

Mr. SANDERS (for himself, Ms. BALDWIN, Mr. BLUMENTHAL, Mr. BOOKER, Mrs. GILLIBRAND, Ms. HARRIS, Mr. LEAHY, Mr. MARKEY, Mr. MERKLEY, Mr. SCHATZ, Mr. UDALL, Ms. WARREN, Mr. WHITEHOUSE, Ms. HIRONO, and Mr. HEINRICH) introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To establish a Medicare-for-all national health insurance program.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Medicare for All Act of 2019''.

(b) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—ESTABLISHMENT OF THE UNIVERSAL MEDICARE PROGRAM; UNIVERSAL ENTITLEMENT; ENROLLMENT

Sec. 101. Establishment of the Universal Medicare Program.
Sec. 102. Universal entitlement.
Sec. 103. Freedom of choice.
Sec. 104. Non-discrimination.
Sec. 105. Enrollment.
Sec. 106. Effective date of benefits.
Sec. 107. Prohibition against duplicating coverage.

TITLE II—COMPREHENSIVE BENEFITS, INCLUDING PREVENTIVE BENEFITS AND BENEFITS FOR LONG-TERM CARE

Sec. 201. Comprehensive benefits.
Sec. 202. No cost-sharing.
Sec. 203. Exclusions and limitations.
Sec. 204. Coverage of institutional long-term care services under Medicaid.
Sec. 205. Prohibiting recovery of correctly paid Medicaid benefits.
Sec. 206. State standards.

TITLE III—PROVIDER PARTICIPATION

Sec. 301. Provider participation and standards.
Sec. 302. Qualifications for providers.
Sec. 303. Use of private contracts.

TITLE IV—ADMINISTRATION

Subtitle A—General Administration Provisions

Sec. 401. Administration.
Sec. 402. Consultation.
Sec. 403. Regional administration.
Sec. 404. Beneficiary ombudsman.
Sec. 405. Complementary conduct of related health programs.

Subtitle B—Control Over Fraud and Abuse

Sec. 411. Application of Federal sanctions to all fraud and abuse under Universal Medicare Program.

TITLE V—QUALITY ASSESSMENT

Sec. 501. Quality standards.
Sec. 502. Addressing health care disparities.

TITLE VI—HEALTH BUDGET; PAYMENTS; COST CONTAINMENT MEASURES

Subtitle A—Budgeting

Sec. 601. National health budget.

Subtitle B—Payments to Providers

Sec. 611. Payments to institutional and individual providers.
Sec. 612. Ensuring accurate valuation of services under the Medicare physician fee schedule.
Sec. 613. Office of primary health care.
Sec. 614. Payments for prescription drugs and approved devices and equipment.

TITLE VII—UNIVERSAL MEDICARE TRUST FUND

Sec. 701. Universal Medicare Trust Fund.

TITLE VIII—CONFORMING AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

Sec. 801. Prohibition of employee benefits duplicative of benefits under the Universal Medicare Program; coordination in case of workers' compensation.
Sec. 802. Repeal of continuation coverage requirements under ERISA and certain other requirements relating to group health plans.
Sec. 803. Effective date of title.

TITLE IX—ADDITIONAL CONFORMING AMENDMENTS

Sec. 901. Relationship to existing Federal health programs.
Sec. 902. Sunset of provisions related to the State Exchanges.

TITLE X—TRANSITION

Subtitle A—Transitional Medicare Buy-In Option and Transitional Public Option

Sec. 1001. Lowering the Medicare age.
Sec. 1002. Establishment of the Medicare transition plan.

Subtitle B—Transitional Medicare Reforms

Sec. 1011. Medicare protection against high out-of-pocket expenditures for fee-for-service benefits and elimination of parts A and B deductibles.
Sec. 1012. Reduction in Medicare part D annual out-of-pocket threshold and elimination of cost-sharing above that threshold.
Sec. 1013. Coverage of dental and vision services and hearing aids and examinations under Medicare part B.
Sec. 1014. Eliminating the 24-month waiting period for Medicare coverage for individuals with disabilities.
Sec. 1015. Guaranteed issue of Medigap policies.

Subtitle C—Private Health Insurance Availability During Transitional Period

Sec. 1021. Continuity of care.

TITLE XI—MISCELLANEOUS

Sec. 1101. Updating resource limits for Supplemental Security Income eligibility (SSI).
Sec. 1102. Definitions.

TITLE I—ESTABLISHMENT OF THE UNIVERSAL MEDICARE PROGRAM; UNIVERSAL ENTITLEMENT; ENROLLMENT

SEC. 101. ESTABLISHMENT OF THE UNIVERSAL MEDICARE PROGRAM.

There is hereby established a national health insurance program to provide comprehensive protection against the costs of health care and health-related services, in accordance with the standards specified in, or established under, this Act.

SEC. 102. UNIVERSAL ENTITLEMENT.

(a) IN GENERAL.—Every individual who is a resident of the United States is entitled to benefits for health care services under this Act. The Secretary shall promulgate a rule that provides criteria for determining residency for eligibility purposes under this Act.

(b) TREATMENT OF OTHER INDIVIDUALS.—The Secretary—

(1) may make eligible for benefits for health care services under this Act other individuals not described in subsection (a) and regulate their eligibility to ensure that every person in the United States has access to health care; and

(2) shall promulgate a rule, consistent with Federal immigration laws, to prevent an individual from traveling to the United States for the sole purpose of obtaining health care services provided under this Act.

SEC. 103. FREEDOM OF CHOICE.

Any individual entitled to benefits under this Act may obtain health services from any institution, agency, or individual qualified to participate under this Act.

SEC. 104. NON-DISCRIMINATION.

(a) IN GENERAL.—No person shall, on the basis of race, color, national origin, age, disability, or sex, including sex stereotyping, gender identity, sexual orientation, and pregnancy and related medical conditions (including termination of pregnancy), be excluded from participation in, be denied the benefits of, or be subjected to discrimination by any participating provider as defined in section 301, or any entity conducting, administering, or funding a health program or activity, including contracts of insurance, pursuant to this Act.

(b) CLAIMS OF DISCRIMINATION.—

(1) IN GENERAL.—The Secretary shall establish a procedure for adjudication of administrative complaints alleging a violation of subsection (a).

(2) JURISDICTION.—Any person aggrieved by a violation of subsection (a) by a covered entity may file suit in any district court of the United States having jurisdiction of the parties.

(3) DAMAGES.—If the court finds a violation of subsection (a), the court may grant compensatory and punitive damages, declaratory relief, injunctive relief, attorneys' fees and costs, or other relief as appropriate.

SEC. 105. ENROLLMENT.

(a) IN GENERAL.—The Secretary shall provide a mechanism for the enrollment of individuals eligible for benefits under this Act. The mechanism shall—

(1) include a process for the automatic enrollment of individuals at the time of birth in the United States or upon the establishment of residency in the United States;

(2) provide for the enrollment, as of the date described in section 106, of all individuals who are eligible to be enrolled as of such date; and

(3) include a process for the enrollment of individuals made eligible for health care services under section 102(b).

(b) ISSUANCE OF UNIVERSAL MEDICARE CARDS.—In conjunction with an individual's enrollment for benefits

under this Act, the Secretary shall provide for the issuance of a Universal Medicare card that shall be used for purposes of identification and processing of claims for benefits under this program. The card shall not include an individual's Social Security number.

SEC. 106. EFFECTIVE DATE OF BENEFITS.

(a) IN GENERAL.—Except as provided in subsection (b), benefits shall first be available under this Act for items and services furnished on January 1 of the fourth calendar year that begins after the date of enactment of this Act.

(b) COVERAGE FOR CHILDREN.—

(1) IN GENERAL.—For any eligible individual who has not yet attained the age of 19, benefits shall first be available under this Act for items and services furnished on January 1 of the first calendar year that begins after the date of enactment of this Act.

(2) OPTION TO CONTINUE IN OTHER COVERAGE DURING TRANSITION PERIOD.—Any person who is eligible to receive benefits as described in paragraph (1) may opt to maintain any coverage described in section 901, private health insurance coverage, or coverage offered pursuant to subtitle A of title X

(including the amendments made by such subtitle) until the effective date described in subsection (a).

SEC. 107. PROHIBITION AGAINST DUPLICATING COVERAGE.

(a) IN GENERAL.—Beginning on the effective date described in section 106(a), it shall be unlawful for—

(1) a private health insurer to sell health insurance coverage that duplicates the benefits provided under this Act; or

(2) an employer to provide benefits for an employee, former employee, or the dependents of an employee or former employee that duplicate the benefits provided under this Act.

(b) CONSTRUCTION.—Nothing in this Act shall be construed as prohibiting the sale of health insurance coverage for any additional benefits not covered by this Act, including additional benefits that an employer may provide to employees or their dependents, or to former employees or their dependents.

TITLE II—COMPREHENSIVE BENEFITS, INCLUDING PREVENTIVE BENEFITS AND BENEFITS FOR LONG-TERM CARE

SEC. 201. COMPREHENSIVE BENEFITS.

(a) IN GENERAL.—Subject to the other provisions of this title and titles IV through IX, individuals enrolled for

benefits under this Act are entitled to have payment made by the Secretary to an eligible provider for the following items and services if medically necessary or appropriate for the maintenance of health or for the diagnosis, treatment, or rehabilitation of a health condition:

(1) Hospital services, including inpatient and outpatient hospital care, including 24-hour-a-day emergency services and inpatient prescription drugs.

(2) Ambulatory patient services.

(3) Primary and preventive services, including chronic disease management.

(4) Prescription drugs, medical devices, biological products, including outpatient prescription drugs, medical devices, and biological products.

(5) Mental health and substance abuse treatment services, including inpatient care.

(6) Laboratory and diagnostic services.

(7) Comprehensive reproductive, maternity, and newborn care.

(8) Pediatrics, including early and periodic screening, diagnostic, and treatment services (as defined in section 1905(r) of the Social Security Act (42 U.S.C. 1396d(r))).

(9) Oral health, audiology, and vision services.

(10) Short-term rehabilitative and habilitative services and devices.

(11) Emergency services and transportation.

(12) Necessary transportation to receive health care services for individuals with disabilities and low-income individuals.

(13) Home and community-based long-term services and supports (to be provided in accordance with the requirements for home and community-based settings under sections 441.530 and 441.710 of title 42, Code of Federal Regulations), including—

(A) services described in paragraphs (7), (8), (13), (19), and (24) of section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a));

(B) home and community-based services described in subsection (c)(4)(B) of section 1915 of the Social Security Act (including habilitation services defined in subsection (c)(5) of such section);

(C) self-directed home and community-based services described in subsection (i) of section 1915 of the Social Security Act;

(D) self-directed personal assistance services (as defined in subsection (j)(4)(A) of section 1915 of the Social Security Act); and

(E) home and community-based attendant services and supports described in subsection (k) of section 1915 of the Social Security Act.

(b) REVISION AND ADJUSTMENT.—The Secretary shall, on a regular basis, evaluate whether the benefits package should be improved or adjusted to promote the health of beneficiaries, account for changes in medical practice or new information from medical research, or respond to other relevant developments in health science, and shall make recommendations to Congress regarding any such improvements or adjustments.

(c) COMPLEMENTARY AND INTEGRATIVE MEDICINE.—

(1) IN GENERAL.—In carrying out subsection (b), the Secretary shall consult with the persons described in paragraph (1) with respect to—

(A) identifying specific complementary and integrative medicine practices that, on the basis of research findings or promising clinical interventions, are appropriate to include in the benefits package; and

(B) identifying barriers to the effective provision and integration of such practices into the delivery of health care, and identifying mechanisms for overcoming such barriers.

(2) CONSULTATION.—In accordance with paragraph (1), the Secretary shall consult with—

(A) the Director of the National Center for Complementary and Integrative Health;

(B) the Commissioner of Food and Drugs;

(C) institutions of higher education, private research institutes, and individual researchers with extensive experience in complementary and integrative medicine and the integration of such practices into the delivery of health care;

(D) nationally recognized providers of complementary and integrative medicine; and

(E) such other officials, entities, and individuals with expertise on complementary and integrative medicine as the Secretary determines appropriate.

(d) STATES MAY PROVIDE ADDITIONAL BENEFITS.—Individual States may provide additional benefits for the residents of such States at the expense of the State.

SEC. 202. NO COST-SHARING.

(a) IN GENERAL.—The Secretary shall ensure that no cost-sharing, including deductibles, coinsurance, copayments, or similar charges, be imposed on an individual for any benefits provided under this Act, except as described in subsection (b).

(b) EXCEPTIONS.—The Secretary may set a cost-sharing schedule for prescription drugs and biological products—

(1) provided that—

(A) such schedule is evidence-based and encourages the use of generic drugs;

(B) such cost-sharing does not apply to preventive drugs;

(C) such cost-sharing does not exceed $200 annually per individual, adjusted annually for inflation; and

(D) such cost-sharing is not imposed on individuals with a household income equal to or below 200 percent of the poverty line for a family of the size involved; and

(2) under which the Secretary may exempt brand-name drugs from consideration in determining whether an individual has reached any out-of-pocket limit if a generic version of such drug is available.

(c) NO BALANCE BILLING.—Notwithstanding contracts in accordance with section 303, no provider may impose a charge to an enrolled individual for covered services for which benefits are provided under this Act.

SEC. 203. EXCLUSIONS AND LIMITATIONS.

(a) IN GENERAL.—Benefits for services are not available under this Act unless the services meet the standards specified in section 201(a), as defined by the Secretary.

(b) TREATMENT OF EXPERIMENTAL SERVICES AND DRUGS.—

(1) IN GENERAL.—In applying subsection (a), the Secretary shall make national coverage determinations with respect to services that are experimental in nature. Such determinations shall be consistent with the national coverage determination process as defined in section 1869(f)(1)(B) of the Social Security Act (42 U.S.C. 1395ff(f)(1)(B)).

(2) APPEALS PROCESS.—The Secretary shall establish a process by which individuals can appeal coverage decisions. The process shall, as much as is feasible, follow process for appeals under the Medicare program described in section 1869 of the Social Security Act (42 U.S.C. 1395ff).

(c) APPLICATION OF PRACTICE GUIDELINES.—In the case of services for which the Department of Health and

Human Services has recognized a national practice guideline, the services are considered to meet the standards specified in section 201(a) if they have been provided in accordance with such guideline. For purposes of this subsection, a service shall be considered to have been provided in accordance with a practice guideline if the health care provider providing the service exercised appropriate professional discretion to deviate from the guideline in a manner authorized or anticipated by the guideline.

SEC. 204. COVERAGE OF INSTITUTIONAL LONG-TERM CARE SERVICES UNDER MEDICAID.

Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended by inserting the following section after section 1946:

"STATE PLAN FOR PROVIDING INSTITUTIONAL LONG-TERM CARE SERVICES

"SEC. 1947. (a) IN GENERAL.—For quarters beginning on or after date on which benefits are first available under section 106(a) of the Medicare for All Act of 2019, notwithstanding any other provision of this title—

"(1) a State plan for medical assistance shall provide for making medical assistance available for services that are institutional long-term care services in a manner consistent with this section; and

"(2) no payment to a State shall be made under this title with respect to expenditures incurred

by the State in providing medical assistance on or after such date for services that are not—

"(A) institutional long-term care services; or

"(B) other services for which benefits are not available under the Medicare for All Act of 2019 and which are furnished under a State plan for medical assistance which provided for medical assistance for such services on September 1, 2018.

"(b) INSTITUTIONAL LONG-TERM CARE SERVICES DEFINED.—In this section, the term 'institutional long-term care services' means the following:

"(1) Nursing facility services for individuals 21 years of age or over described in subparagraph (A) of section 1905(a)(4).

"(2) Inpatient services for individuals 65 years of age or over provided in an institution for mental disease described in section 1905(a)(14).

"(3) Intermediate care facility services described in section 1905(a)(15).

"(4) Inpatient psychiatric hospital services for individuals under age 21 described in section 1905(a)(16).

"(5) Nursing facility services described in section 1905(a)(29).

"(c) MAINTENANCE OF EFFORT.—

"(1) ELIGIBILITY STANDARDS.—

"(A) IN GENERAL.—Beginning on the date described in subsection (a), no payment may be made under section 1903 with respect to medical assistance provided under a State plan for medical assistance if the State adopts income, resource, or other standards and methodologies for purposes of determining an individual's eligibility for medical assistance under the State plan that are more restrictive than those applied as of January 1, 2019.

"(B) INDEXING OF AMOUNTS OF INCOME AND RESOURCE STANDARDS.—In determining whether a State has adopted income or resource standards that are more restrictive than the standards which applied as of January 1, 2019, the Secretary shall deem the amount of any such standard that was applied as of such date to be increased by the percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) from September of 2018 to September

of the fiscal year for which the Secretary is making such determination.

"(2) EXPENDITURES.—

"(A) IN GENERAL.—For each fiscal year or portion of a fiscal year that occurs during the period that begins on the first day of the first fiscal quarter that begins on or after the date on which benefits are first available under section 106(a) of the Medicare for All Act of 2019, as a condition of receiving payments under section 1903(a), a State shall make expenditures for medical assistance for services that are institutional long-term care services in an amount that is not less than the expenditure floor determined for the State and fiscal year (or portion of a fiscal year) under subparagraph (B).

"(B) EXPENDITURE FLOOR.—

"(i) IN GENERAL.—For each fiscal year or portion of a fiscal year described in subparagraph (A), the Secretary shall determine for each State an expenditure floor that shall be equal to—

"(I) the amount of the State's expenditures for fiscal year 2018 on

medical assistance for institutional long-term care services; increased by

"(II) the growth factor determined under subclause (ii).

"(ii) GROWTH FACTOR.—For each fiscal year or portion of a fiscal year described in subparagraph (A), the Secretary shall, not later than September 1 of the fiscal year preceding such fiscal year or portion of a fiscal year, determine a growth factor for each State that takes into account—

"(I) the percentage increase in health care costs in the State;

"(II) the total amount expended by the State for the previous fiscal year on medical assistance for institutional long-term care services;

"(III) the increase, if any, in the total population of the State from July of 2018 to July of the fiscal year preceding the fiscal year involved;

"(IV) the increase, if any, in the population of individuals aged 65 and older of the State from July of 2018

to July of the fiscal year preceding the fiscal year involved; and

"(V) the decrease, if any, in the population of the State that requires medical assistance for institutional long-term care services that is attributable to the availability of coverage for the services described in section 201(a)(13) of the Medicare for All Act of 2019.

"(iii) PRORATION RULE.—Any amount determined under this subparagraph for a portion of a fiscal year shall be prorated based on the length of such portion of a fiscal year relative to a complete fiscal year.

"(d) NONAPPLICATION OF CERTAIN REQUIREMENTS.—Beginning on the date described in subsection (a), any provision of this title requiring a State plan for medical assistance to make available medical assistance for services that are not institutional long-term care services or services described in section 901(a)(3)(A)(ii) of the Medicare for All Act of 2019 shall have no effect.".

SEC. 205. PROHIBITING RECOVERY OF CORRECTLY PAID MEDICAID BENEFITS.

Section 1917 of the Social Security Act (42 U.S.C. 1396p) is amended—

(1) by amending subsection (a) to read as follows:

''(a) No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan, except pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual.''; and

(2) by amending subsection (b) to read as follows:

''(b) No adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan may be made.''.

SEC. 206. STATE STANDARDS.

(a) IN GENERAL.—Nothing in this Act shall prohibit individual States from setting additional standards, with respect to eligibility, benefits, and minimum provider standards, consistent with the purposes of this Act, provided that such standards do not restrict eligibility or reduce access to benefits or services.

(b) RESTRICTIONS ON PROVIDERS.—With respect to any individuals or entities certified to provide services cov-

ered under section 201(a)(7), a State may not prohibit an individual or entity from participating in the program under this Act, for reasons other than the ability of the individual or entity to provide such services.

TITLE III—PROVIDER PARTICIPATION

SEC. 301. PROVIDER PARTICIPATION AND STANDARDS.

(a) IN GENERAL.—An individual or other entity furnishing any covered service under this Act is not a qualified provider unless the individual or entity—

(1) is a qualified provider of the services under section 302;

(2) has filed with the Secretary a participation agreement described in subsection (b); and

(3) meets, as applicable, such other qualifications and conditions with respect to a provider of services under title XVIII of the Social Security Act as described in section 1866 of the Social Security Act (42 U.S.C. 1395cc).

(b) REQUIREMENTS IN PARTICIPATION AGREEMENT.—

(1) IN GENERAL.—A participation agreement described in this subsection between the Secretary and a provider shall provide at least for the following:

(A) Services to eligible persons will be furnished by the provider without discrimination, in accordance with section 104(a). Nothing in this subparagraph shall be construed as requiring the provision of a type or class of services that are outside the scope of the provider's normal practice.

(B) No charge will be made to any enrolled individual for any covered services other than for payment authorized by this Act.

(C) The provider agrees to furnish such information as may be reasonably required by the Secretary, in accordance with uniform reporting standards established under section 401(b)(1), for—

(i) quality review by designated entities;

(ii) making payments under this Act, including the examination of records as may be necessary for the verification of information on which such payments are based;

(iii) statistical or other studies required for the implementation of this Act; and

(iv) such other purposes as the Secretary may specify.

(D) In the case of a provider that is not an individual, the provider agrees not to employ or use for the provision of health services any individual or other provider that has had a participation agreement under this subsection terminated for cause.

(E) In the case of a provider paid under a fee-for-service basis, the provider agrees to submit bills and any required supporting documentation relating to the provision of covered services within 30 days after the date of providing such services.

(2) TERMINATION OF PARTICIPATION AGREEMENT.—

(A) IN GENERAL.—Participation agreements may be terminated, with appropriate notice—

(i) by the Secretary for failure to meet the requirements of this Act; or

(ii) by a provider.

(B) TERMINATION PROCESS.—Providers shall be provided notice and a reasonable opportunity to correct deficiencies before the Sec-

retary terminates an agreement unless a more immediate termination is required for public safety or similar reasons.

(C) PROVIDER PROTECTIONS.—

(i) PROHIBITION.—The Secretary may not terminate a participation agreement or in any other way discriminate against, or cause to be discriminated against, any covered provider or authorized representative of the provider, on account of such provider or representative—

(I) providing, causing to be provided, or being about to provide or cause to be provided to the provider, the Federal Government, or the attorney general of a State information relating to any violation of, or any act or omission the provider or representative reasonably believes to be a violation of, any provision of this title (or an amendment made by this title);

(II) testifying or being about to testify in a proceeding concerning such violation;

(III) assisting or participating, or being about to assist or participate, in such a proceeding; or

(IV) objecting to, or refusing to participate in, any activity, policy, practice, or assigned task that the provider or representative reasonably believes to be in violation of any provision of this Act (including any amendment made by this Act), or any order, rule, regulation, standard, or ban under this Act (including any amendment made by this Act).

(ii) COMPLAINT PROCEDURE.—A provider or representative who believes that he or she has been discriminated against in violation of this section may seek relief in accordance with the procedures, notifications, burdens of proof, remedies, and statutes of limitation set forth in section 2087(b) of title 15, United States Code.

SEC. 302. QUALIFICATIONS FOR PROVIDERS.

(a) IN GENERAL.—A health care provider is considered to be qualified to provide covered services if the provider is licensed or certified and meets—

(1) all the requirements of State law to provide such services; and

(2) applicable requirements of Federal law to provide such services.

(b) MINIMUM PROVIDER STANDARDS.—

(1) IN GENERAL.—The Secretary shall establish, evaluate, and update national minimum standards to ensure the quality of services provided under this Act and to monitor efforts by States to ensure the quality of such services. A State may also establish additional minimum standards which providers shall meet with respect to services provided in such State.

(2) NATIONAL MINIMUM STANDARDS.—The national minimum standards under paragraph (1) shall be established for institutional providers of services and individual health care practitioners. Except as the Secretary may specify in order to carry out this Act, a hospital, skilled nursing facility, or other institutional provider of services shall meet standards for such a provider under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.). Such standards also may include, where appropriate, elements relating to—

(A) adequacy and quality of facilities;

(B) training and competence of personnel (including continuing education requirements);

(C) comprehensiveness of service;

(D) continuity of service;

(E) patient satisfaction, including waiting time and access to services; and

(F) performance standards, including organization, facilities, structure of services, efficiency of operation, and outcome in palliation, improvement of health, stabilization, cure, or rehabilitation.

(3) TRANSITION IN APPLICATION.—If the Secretary provides for additional requirements for providers under this subsection, any such additional requirement shall be implemented in a manner that provides for a reasonable period during which a previously qualified provider is permitted to meet such an additional requirement.

(4) ABILITY TO PROVIDE SERVICES.—With respect to any entity or provider certified to provide services described in section 201(a)(7), the Secretary may not prohibit such entity or provider from participating for reasons other than its ability to provide such services.

(c) FEDERAL PROVIDERS.—Any provider qualified to provide health care services through the Department of Veterans Affairs or Indian Health Service is a qualifying provider under this section with respect to any individual who qualifies for such services under applicable Federal law.

SEC. 303. USE OF PRIVATE CONTRACTS.

(a) IN GENERAL.—Subject to the provisions of this subsection, nothing in this Act shall prohibit an institutional or individual provider from entering into a private contract with an enrolled individual for any item or service—

(1) for which no claim for payment is to be submitted under this Act; and

(2) for which the provider receives—

(A) no reimbursement under this Act directly or on a capitated basis; and

(B) receives no amount for such item or service from an organization which receives reimbursement for such items or service under this Act directly or on a capitated basis.

(b) BENEFICIARY PROTECTIONS.—

(1) IN GENERAL.—Subsection (a) shall not apply to any contract unless—

(A) the contract is in writing and is signed by the beneficiary before any item or service is provided pursuant to the contract;

(B) the contract contains the items described in paragraph (2); and

(C) the contract is not entered into at a time when the beneficiary is facing an emergency health care situation.

(2) ITEMS REQUIRED TO BE INCLUDED IN CONTRACT.—Any contract to provide items and services to which subsection (a) applies shall clearly indicate to the beneficiary that by signing such contract the beneficiary—

(A) agrees not to submit a claim (or to request that the provider submit a claim) under this Act for such items or services even if such items or services are otherwise covered by this Act;

(B) agrees to be responsible, whether through insurance offered under section 107(b) or otherwise, for payment of such items or services and understands that no reimbursement will be provided under this Act for such items or services;

(C) acknowledges that no limits under this Act apply to amounts that may be charged for such items or services;

(D) if the provider is a non-participating provider, acknowledges that the beneficiary has the right to have such items or services provided by other providers for whom payment would be made under this Act; and

(E) acknowledges that the provider is providing services outside the scope of the program under this Act.

(c) PROVIDER REQUIREMENTS.—

(1) IN GENERAL.—Subsection (a) shall not apply to any contract unless an affidavit described in paragraph (2) is in effect during the period any item or service is to be provided pursuant to the contract.

(2) AFFIDAVIT.—An affidavit is described in this subparagraph shall—

(A) identify the practitioner, and be signed by such practitioner;

(B) provide that the practitioner will not submit any claim under this title for any item or service provided to any beneficiary (and will not receive any reimbursement or amount de-

scribed in paragraph (1)(B) for any such item or service) during the 1-year period beginning on the date the affidavit is signed; and

(C) be filed with the Secretary no later than 10 days after the first contract to which such affidavit applies is entered into.

(3) ENFORCEMENT.—If a physician or practitioner signing an affidavit described in paragraph (2) knowingly and willfully submits a claim under this title for any item or service provided during the 1-year period described in paragraph (2)(B) (or receives any reimbursement or amount described in subsection (a)(2) for any such item or service) with respect to such affidavit—

(A) this subsection shall not apply with respect to any items and services provided by the physician or practitioner pursuant to any contract on and after the date of such submission and before the end of such period; and

(B) no payment shall be made under this title for any item or service furnished by the physician or practitioner during the period described in clause (i) (and no reimbursement or payment of any amount described in subsection

(a)(2) shall be made for any such item or service).

TITLE IV—ADMINISTRATION

Subtitle A—General Administration Provisions

SEC. 401. ADMINISTRATION.

(a) GENERAL DUTIES OF THE SECRETARY.—

(1) IN GENERAL.—The Secretary shall develop policies, procedures, guidelines, and requirements to carry out this Act, including related to—

(A) eligibility for benefits;

(B) enrollment;

(C) benefits provided;

(D) provider participation standards and qualifications, as described in title III;

(E) levels of funding;

(F) methods for determining amounts of payments to providers of covered services, consistent with subtitle B;

(G) the determination of medical necessity and appropriateness with respect to coverage of certain services;

(H) planning for capital expenditures and service delivery;

(I) planning for health professional education funding;

(J) encouraging States to develop regional planning mechanisms; and

(K) any other regulations necessary to carry out the purpose of this Act.

(2) REGULATIONS.—Regulations authorized by this Act shall be issued by the Secretary in accordance with section 553 of title 5, United States Code.

(b) UNIFORM REPORTING STANDARDS; ANNUAL REPORT; STUDIES.—

(1) UNIFORM REPORTING STANDARDS.—

(A) IN GENERAL.—The Secretary shall establish uniform State reporting requirements and national standards to ensure an adequate national database containing information pertaining to health services practitioners, approved providers, the costs of facilities and practitioners providing such services, the quality of such services, the outcomes of such services, and the equity of health among population groups. Such standards shall include, to the maximum extent feasible without compromising patient privacy, health outcome measures, and to the maximum extent feasible without exces-

sively burdening providers, the measures described in subparagraphs (D) through (F) of subsection (a)(1).

(B) REPORTS.—The Secretary shall regularly analyze information reported to it and shall define rules and procedures to allow researchers, scholars, health care providers, and others to access and analyze data for purposes consistent with quality and outcomes research, without compromising patient privacy.

(2) ANNUAL REPORT.—Beginning January 1 of the second year beginning after the effective date of this Act, the Secretary shall annually report to Congress on the following:

(A) The status of implementation of the Act.

(B) Enrollment under this Act.

(C) Benefits under this Act.

(D) Expenditures and financing under this Act.

(E) Cost-containment measures and achievements under this Act.

(F) Quality assurance.

(G) Health care utilization patterns, including any changes attributable to the program.

(H) Changes in the per-capita costs of health care.

(I) Differences in the health status of the populations of the different States, including income and racial characteristics, and other population health inequities.

(J) Progress on quality and outcome measures, and long-range plans and goals for achievements in such areas.

(K) Necessary changes in the education of health personnel.

(L) Plans for improving service to medically underserved populations.

(M) Transition problems as a result of implementation of this Act.

(N) Opportunities for improvements under this Act.

(3) STATISTICAL ANALYSES AND OTHER STUDIES.—The Secretary may, either directly or by contract—

(A) make statistical and other studies, on a nationwide, regional, State, or local basis, of any aspect of the operation of this Act;

(B) develop and test methods of payment or delivery as it may consider necessary or promising for the evaluation, or for the improvement, of the operation of this Act; and

(C) develop methodological standards for evidence-based policymaking.

(c) AUDITS.—

(1) IN GENERAL.—The Comptroller General of the United States shall conduct an audit of the Board every fifth fiscal year following the effective date of this Act to determine the effectiveness of the program in carrying out the duties under subsection (a).

(2) REPORTS.—The Comptroller General of the United States shall submit a report to Congress concerning the results of each audit conducted under this subsection.

SEC. 402. CONSULTATION.

The Secretary shall consult with Federal agencies, Indian tribes and urban Indian health organizations, and private entities, such as professional societies, national associations, nationally recognized associations of experts,

medical schools and academic health centers, consumer and patient groups, and labor and business organizations in the formulation of guidelines, regulations, policy initiatives, and information gathering to ensure the broadest and most informed input in the administration of this Act. Nothing in this Act shall prevent the Secretary from adopting guidelines developed by such a private entity if, in the Secretary's judgment, such guidelines are generally accepted as reasonable and prudent and consistent with this Act.

SEC. 403. REGIONAL ADMINISTRATION.

(a) COORDINATION WITH REGIONAL OFFICES.—The Secretary shall establish and maintain regional offices to promote adequate access to, and efficient use of, tertiary care facilities, equipment, and services. Wherever possible, the Secretary shall incorporate regional offices of the Centers for Medicare & Medicaid Services for this purpose.

(b) APPOINTMENT OF REGIONAL AND STATE DIRECTORS.—In each such regional office there shall be—

(1) one regional director appointed by the Secretary;

(2) for each State in the region, a deputy director; and

(3) one deputy director to represent the Native American and Alaska Native tribes in the region.

(c) REGIONAL OFFICE DUTIES.—Regional offices shall be responsible for—

(1) providing an annual State health care needs assessment report to the Secretary, after a thorough examination of health needs, in consultation with public health officials, clinicians, patients, and patient advocates;

(2) recommending changes in provider reimbursement or payment for delivery of health services in the States within the region; and

(3) establishing a quality assurance mechanism in the State in order to minimize both under-utilization and over-utilization and to ensure that all providers meet high-quality standards.

SEC. 404. BENEFICIARY OMBUDSMAN.

(a) IN GENERAL.—The Secretary shall appoint a Beneficiary Ombudsman who shall have expertise and experience in the fields of health care and education of, and assistance to, individuals entitled to benefits under this Act.

(b) DUTIES.—The Beneficiary Ombudsman shall—

(1) receive complaints, grievances, and requests for information submitted by individuals entitled to benefits under this Act with respect to any aspect of the Universal Medicare Program;

(2) provide assistance with respect to complaints, grievances, and requests referred to in subparagraph (a), including—

(A) assistance in collecting relevant information for such individuals, to seek an appeal of a decision or determination made by a regional office or the Secretary; and

(B) assistance to such individuals in presenting information under relating to cost-sharing; and

(3) submit annual reports to Congress and the Secretary that describe the activities of the Office and that include such recommendations for improvement in the administration of this Act as the Ombudsman determines appropriate. The Ombudsman shall not serve as an advocate for any increases in payments or new coverage of services, but may identify issues and problems in payment or coverage policies.

SEC. 405. COMPLEMENTARY CONDUCT OF RELATED HEALTH PROGRAMS.

In performing functions with respect to health personnel education and training, health research, environmental health, disability insurance, vocational rehabilitation, the regulation of food and drugs, and all other mat-

ters pertaining to health, the Secretary shall direct the activities of the Department of Health and Human Services toward contributions to the health of the people complementary to this Act.

Subtitle B—Control Over Fraud and Abuse

SEC. 411. APPLICATION OF FEDERAL SANCTIONS TO ALL FRAUD AND ABUSE UNDER UNIVERSAL MEDICARE PROGRAM.

The following sections of the Social Security Act shall apply to this Act in the same manner as they apply to State medical assistance plans under title XIX of such Act:

(1) Section 1128 (relating to exclusion of individuals and entities).

(2) Section 1128A (civil monetary penalties).

(3) Section 1128B (criminal penalties).

(4) Section 1124 (relating to disclosure of ownership and related information).

(5) Section 1126 (relating to disclosure of certain owners).

TITLE V—QUALITY ASSESSMENT

SEC. 501. QUALITY STANDARDS.

(a) IN GENERAL.—All standards and quality measures under this Act shall be performed by the Center for

Clinical Standards and Quality of the Centers for Medicare & Medicaid Services (referred to in this title as the ''Center''), in coordination with the Agency for Healthcare Research and Quality and other offices of the Department of Health and Human Services.

(b) DUTIES OF THE CENTER.—The Center shall perform the following duties:

(1) PRACTICE GUIDELINES.—The Center shall review and evaluate each practice guideline developed under part B of title IX of the Public Health Service Act. The Center shall determine whether the guideline should be recognized as a national practice guideline.

(2) STANDARDS OF QUALITY, PERFORMANCE MEASURES, AND MEDICAL REVIEW CRITERIA.—The Center shall review and evaluate each standard of quality, performance measure, and medical review criterion developed under part B of title IX of the Public Health Service Act (42 U.S.C. 299 et seq.). The Center shall determine whether the standard, measure, or criterion is appropriate for use in assessing or reviewing the quality of services provided by health care institutions or health care professionals. In evaluating such standards, the Center shall consider the evidentiary basis for the standard,

and the validity, reliability, and feasibility of measuring the standard.

(3) PROFILING OF PATTERNS OF PRACTICE; IDENTIFICATION OF OUTLIERS.—The Center shall adopt methodologies for profiling the patterns of practice of health care professionals and for identifying and notifying outliers.

(4) CRITERIA FOR ENTITIES CONDUCTING QUALITY REVIEWS.—The Center shall develop minimum criteria for competence for entities that can qualify to conduct ongoing and continuous external quality reviews in the administrative regions. Such criteria shall require such an entity to be administratively independent of the individual or board that administers the region and shall ensure that such entities do not provide financial incentives to reviewers to favor one pattern of practice over another. The Center shall ensure coordination and reporting by such entities to ensure national consistency in quality standards.

(5) REPORTING.—The Center shall report to the Secretary annually specifically on findings from outcomes research and development of practice guidelines that may affect the Secretary's deter-

mination of coverage of services under section 401(a)(1)(G).

SEC. 502. ADDRESSING HEALTH CARE DISPARITIES.

(a) EVALUATING DATA COLLECTION APPROACHES.—The Center shall evaluate approaches for the collection of data under this Act, to be performed in conjunction with existing quality reporting requirements and programs under this Act, that allow for the ongoing, accurate, and timely collection of data on disparities in health care services and performance on the basis of race, ethnicity, gender, geography, or socioeconomic status. In conducting such evaluation, the Secretary shall consider the following objectives:

(1) Protecting patient privacy.

(2) Minimizing the administrative burdens of data collection and reporting on providers under this Act.

(3) Improving Universal Medicare Program data on race, ethnicity, gender, geography, and socioeconomic status.

(b) REPORTS TO CONGRESS.—

(1) REPORT ON EVALUATION.—Not later than 18 months after the date on which benefits first become available as described in section 106(a), the Center shall submit to Congress and the Secretary

a report on the evaluation conducted under subsection (a). Such report shall, taking into consideration the results of such evaluation—

(A) identify approaches (including defining methodologies) for identifying and collecting and evaluating data on health care disparities on the basis of race, ethnicity, gender, geography, or socioeconomic status under the Universal Medicare Program; and

(B) include recommendations on the most effective strategies and approaches to reporting quality measures, as appropriate, on the basis of race, ethnicity, gender, geography, or socioeconomic status.

(2) REPORT ON DATA ANALYSES.—Not later than 4 years after the submission of the report under subsection (b)(1), and 4 years thereafter, the Center shall submit to Congress and the Secretary a report that includes recommendations for improving the identification of health care disparities based on the analyses of data collected under subsection (c).

(c) IMPLEMENTING EFFECTIVE APPROACHES.—Not later than 2 years after the date on which benefits first become available as described in section 106(a), the Sec-

retary shall implement the approaches identified in the report submitted under subsection (b)(1) for the ongoing, accurate, and timely collection and evaluation of data on health care disparities on the basis of race, ethnicity, gender, geography, or socioeconomic status.

TITLE VI—HEALTH BUDGET; PAYMENTS; COST CONTAINMENT MEASURES

Subtitle A—Budgeting

SEC. 601. NATIONAL HEALTH BUDGET.

(a) NATIONAL HEALTH BUDGET.—

(1) IN GENERAL.—By not later than September 1 of each year, beginning with the year prior to the date on which benefits first become available as described in section 106(a), the Secretary shall establish a national health budget, which specifies the total expenditures to be made for covered health care services under this Act.

(2) DIVISION OF BUDGET INTO COMPONENTS.—In addition to the cost of covered health services, the national health budget shall consist of at least the following components:

(A) Quality assessment activities under title V.

(B) Health professional education expenditures.

(C) Administrative costs.

(D) Innovation, including in accordance with section 1115A of the Social Security Act (42 U.S.C. 1315a).

(E) Operating and other expenditures not described in subparagraphs (A) through (D) (referred to in this Act as the ''operating component''), consisting of amounts not included in the other components.

(F) Capital expenditures.

(G) Prevention and public health activities.

(3) ALLOCATION AMONG COMPONENTS.—The Secretary shall allocate the budget among the components in a manner that—

(A) ensures a fair allocation for quality assessment activities; and

(B) ensures that the health professional education expenditure component is sufficient to provide for the amount of health professional education expenditures sufficient to meet the need for covered health care services.

(4) TEMPORARY WORKER ASSISTANCE.—For up to 5 years following the date on which benefits first

become available as described in section 106(a), up to 1 percent of the budget may be allocated to programs providing assistance to workers who perform functions in the administration of the health insurance system and who may experience economic dislocation as a result of the implementation of this Act.

(5) RESERVE FUND.—The Secretary shall establish and maintain a reserve fund to respond to the costs of treating an epidemic, pandemic, natural disaster, or other such health emergency.

(b) DEFINITIONS.—In this section:

(1) CAPITAL EXPENDITURES.—The term ''capital expenditures'' means expenses for the purchase, lease, construction, or renovation of capital facilities and for equipment and includes return on equity capital.

(2) HEALTH PROFESSIONAL EDUCATION EXPENDITURES.—The term ''health professional education expenditures'' means expenditures in hospitals and other health care facilities to cover costs associated with teaching and related research activities.

Subtitle B—Payments to Providers

SEC. 611. PAYMENTS TO INSTITUTIONAL AND INDIVIDUAL PROVIDERS.

(a) APPLICATION OF PAYMENT PROCESSES UNDER TITLE XVIII.—Except as otherwise provided in this section, the Secretary shall establish, by regulation, fee schedules that establish payment amounts for benefits under this Act in a manner that is consistent with processes for determining payments for items and services under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), including the application of the provisions of, and amendments made by, section 612.

(b) APPLICATION OF CURRENT AND PLANNED PAYMENT REFORMS.—Any payment reform activities or demonstrations planned or implemented with respect to such title XVIII as of the date of the enactment of this Act shall apply to benefits under this Act, including any reform activities or demonstrations planned or implemented under the provisions of, or amendments made by, the Medicare Access and CHIP Reauthorization Act of 2015 (Public Law 114–10) and the Patient Protection and Affordable Care Act (Public Law 111–148).

SEC. 612. ENSURING ACCURATE VALUATION OF SERVICES UNDER THE MEDICARE PHYSICIAN FEE SCHEDULE.

(a) STANDARDIZED AND DOCUMENTED REVIEW PROCESS.—Section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)) is amended by adding at the end the following new subparagraph:

"(P) STANDARDIZED AND DOCUMENTED REVIEW PROCESS.—

"(i) IN GENERAL.—Not later than one year after the date of enactment of this subparagraph, the Secretary shall establish, document, and make publicly available a standardized process for reviewing the relative values of physicians' services under this paragraph.

"(ii) MINIMUM REQUIREMENTS.—The standardized process shall include, at a minimum, methods and criteria for identifying services for review, prioritizing the review of services, reviewing stakeholder recommendations, and identifying additional resources to be considered during the review process.".

(b) PLANNED AND DOCUMENTED USE OF FUNDS.—Section 1848(c)(2)(M) of the Social Security Act (42

U.S.C. 1305w–4(c)(2)(M)) is amended by adding at the end the following new clause:

"(x) PLANNED AND DOCUMENTED USE OF FUNDS.—For each fiscal year (beginning with the first fiscal year beginning on or after the date of enactment of this clause), the Secretary shall provide to Congress a written plan for using the funds provided under clause (ix) to collect and use information on physicians' services in the determination of relative values under this subparagraph.".

(c) INTERNAL TRACKING OF REVIEWS.—

(1) IN GENERAL.—Not later than one year after the date of enactment of this Act, the Secretary shall submit to Congress a proposed plan for systematically and internally tracking its review of the relative values of physicians' services, such as by establishing an internal database, under section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)), as amended by this section.

(2) MINIMUM REQUIREMENTS.—The proposal shall include, at a minimum, plans and a timeline for achieving the ability to systematically and internally track the following:

(A) When, how, and by whom services are identified for review.

(B) When services are reviewed or when new services are added.

(C) The resources, evidence, data, and recommendations used in reviews.

(D) When relative values are adjusted.

(E) The rationale for final relative value decisions.

(d) FREQUENCY OF REVIEW.—Section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)) is amended—

(1) in subparagraph (B)(i), by striking ''5'' and inserting ''4''; and

(2) in subparagraph (K)(i)(I), by striking ''periodically'' and inserting ''annually''.

(e) CONSULTATION WITH MEDICARE PAYMENT ADVISORY COMMISSION.—

(1) IN GENERAL.—Section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)) is amended—

(A) in subparagraph (B)(i), by inserting ''in consultation with the Medicare Payment Advisory Commission,'' after ''The Secretary,''; and

(B) in subparagraph (K)(i)(I), as amended by subsection (d)(2), by inserting ", in coordination with the Medicare Payment Advisory Commission," after "annually".

(2) CONFORMING AMENDMENTS.—Section 1805 of the Social Security Act (42 U.S.C. 1395b–6) is amended—

(A) in subsection (b)(1)(A), by inserting the following before the semicolon at the end: "and including coordinating with the Secretary in accordance with section 1848(c)(2) to systematically review the relative values established for physicians' services, identify potentially misvalued services, and propose adjustments to the relative values for physicians' services"; and

(B) in subsection (e)(1), in the second sentence, by inserting "or the Ranking Minority Member" after "the Chairman".

(f) PERIODIC AUDIT BY THE COMPTROLLER GENERAL.—Section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)), as amended by subsection (a), is amended by adding at the end the following new subparagraph:

"(Q) PERIODIC AUDIT BY THE COMPTROLLER GENERAL.—

"(i) IN GENERAL.—The Comptroller General of the United States (in this subparagraph referred to as the 'Comptroller General') shall periodically audit the review by the Secretary of relative values established under this paragraph for physicians' services.

"(ii) ACCESS TO INFORMATION.—The Comptroller General shall have unrestricted access to all deliberations, records, and nonproprietary data related to the activities carried out under this paragraph, in a timely manner, upon request.".

SEC. 613. OFFICE OF PRIMARY HEALTH CARE.

(a) IN GENERAL.—There is established within the Agency for Healthcare Research and Quality an Office of Primary Health Care, responsible for coordinating with the Secretary, the Health Resources and Services Administration, and other offices in the Department as necessary, in order to—

(1) coordinate health professional education policies and goals, in consultation with the Secretary to achieve the national goals specified in subsection (b);

(2) develop and maintain a system to monitor the number and specialties of individuals through their health professional education, any postgraduate training, and professional practice;

(3) develop, coordinate, and promote policies that expand the number of primary care practitioners, registered nurses, midlevel practitioners, and dentists; and

(4) recommend the appropriate training, education, technical assistance, and patient advocacy enhancements of primary care health professionals, including registered nurses, to achieve uniform high-quality and patient safety.

(b) NATIONAL GOALS.—Not later than 1 year after the date of enactment of this Act, the Office of Primary Health Care shall set forth national goals to increase access to high-quality primary health care, particularly in underserved areas and for underserved populations.

SEC. 614. PAYMENTS FOR PRESCRIPTION DRUGS AND APPROVED DEVICES AND EQUIPMENT.

(a) NEGOTIATED PRICES.—The prices to be paid for covered pharmaceuticals, medical supplies, and medically necessary assistive equipment shall be negotiated annually by the Secretary.

(b) PRESCRIPTION DRUG FORMULARY.—

(1) IN GENERAL.—The Secretary shall establish a prescription drug formulary system, which shall encourage best-practices in prescribing and discourage the use of ineffective, dangerous, or excessively costly medications when better alternatives are available.

(2) PROMOTION OF USE OF GENERICS.—The formulary under this subsection shall promote the use of generic medications to the greatest extent possible.

(3) FORMULARY UPDATES AND PETITION RIGHTS.—The formulary under this subsection shall be updated frequently and clinicians and patients may petition the Secretary to add new pharmaceuticals or to remove ineffective or dangerous medications from the formulary.

(4) USE OF OFF-FORMULARY MEDICATIONS.—The Secretary shall promulgate rules regarding the use of off-formulary medications which allow for patient access but do not compromise the formulary.

TITLE VII—UNIVERSAL MEDICARE TRUST FUND

SEC. 701. UNIVERSAL MEDICARE TRUST FUND.

(a) IN GENERAL.—There is hereby created on the books of the Treasury of the United States a trust fund

to be known as the Universal Medicare Trust Fund (in this section referred to as the ''Trust Fund''). The Trust Fund shall consist of such gifts and bequests as may be made and such amounts as may be deposited in, or appropriated to, such Trust Fund as provided in this Act.

(b) APPROPRIATIONS INTO TRUST FUND.—

(1) TAXES.—There are hereby appropriated to the Trust Fund for each fiscal year beginning with the fiscal year which includes the date on which benefits first become available as described in section 106, out of any moneys in the Treasury not otherwise appropriated, amounts equivalent to 100 percent of the net increase in revenues to the Treasury which is attributable to the amendments made by sections 801 and 902. The amounts appropriated by the preceding sentence shall be transferred from time to time (but not less frequently than monthly) from the general fund in the Treasury to the Trust Fund, such amounts to be determined on the basis of estimates by the Secretary of the Treasury of the taxes paid to or deposited into the Treasury; and proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than the amounts that should have been so transferred.

(2) CURRENT PROGRAM RECEIPTS.—Notwithstanding any other provision of law, there are hereby appropriated to the Trust Fund for each fiscal year, beginning with the first fiscal year beginning on or after the effective date of benefits under section 106, the amounts that would otherwise have been appropriated to carry out the following programs:

(A) The Medicare program under title XVIII of the Social Security Act (other than amounts attributable to any premiums under such title).

(B) The Medicaid program, under State plans approved under title XIX of such Act.

(C) The Federal employees health benefit program, under chapter 89 of title 5, United States Code.

(D) The TRICARE program, under chapter 55 of title 10, United States Code.

(E) The maternal and child health program (under title V of the Social Security Act), vocational rehabilitation programs, programs for drug abuse and mental health services under the Public Health Service Act, programs providing general hospital or medical assistance, and any other Federal program identified by

the Secretary, in consultation with the Secretary of the Treasury, to the extent the programs provide for payment for health services the payment of which may be made under this Act.

(3) RESTRICTIONS SHALL NOT APPLY.—Any other provision of law in effect on the date of enactment of this Act restricting the use of Federal funds for any reproductive health service shall not apply to monies in the Trust Fund.

(c) INCORPORATION OF PROVISIONS.—The provisions of subsections (b) through (i) of section 1817 of the Social Security Act (42 U.S.C. 1395i) shall apply to the Trust Fund under this section in the same manner as such provisions applied to the Federal Hospital Insurance Trust Fund under such section 1817, except that, for purposes of applying such subsections to this section, the ''Board of Trustees of the Trust Fund'' shall mean the ''Secretary''.

(d) TRANSFER OF FUNDS.—Any amounts remaining in the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) or the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t) after the payment of claims for items and services fur-

nished under title XVIII of such Act have been completed, shall be transferred into the Universal Medicare Trust Fund under this section.

TITLE VIII—CONFORMING AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

SEC. 801. PROHIBITION OF EMPLOYEE BENEFITS DUPLICATIVE OF BENEFITS UNDER THE UNIVERSAL MEDICARE PROGRAM; COORDINATION IN CASE OF WORKERS' COMPENSATION.

(a) IN GENERAL.—Part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131 et seq.) is amended by adding at the end the following new section:

"SEC. 522. PROHIBITION OF EMPLOYEE BENEFITS DUPLICATIVE OF UNIVERSAL MEDICARE PROGRAM BENEFITS; COORDINATION IN CASE OF WORKERS' COMPENSATION.

"(a) IN GENERAL.—Subject to subsection (b), no employee benefit plan may provide benefits that duplicate payment for any items or services for which payment may be made under the Medicare for All Act of 2019.

"(b) REIMBURSEMENT.—Each workers compensation carrier that is liable for payment for workers compensa-

tion services furnished in a State shall reimburse the Universal Medicare Program for the cost of such services.

''(c) DEFINITIONS.—In this subsection—

''(1) the term 'workers compensation carrier' means an insurance company that underwrite workers compensation medical benefits with respect to one or more employers and includes an employer or fund that is financially at risk for the provision of workers compensation medical benefits;

''(2) the term 'workers compensation medical benefits' means, with respect to an enrollee who is an employee subject to the workers compensation laws of a State, the comprehensive medical benefits for work-related injuries and illnesses provided for under such laws with respect to such an employee; and

''(3) the term 'workers compensation services' means items and services included in workers compensation medical benefits and includes items and services (including rehabilitation services and long-term-care services) commonly used for treatment of work-related injuries and illnesses.''.

(b) CONFORMING AMENDMENT.—Section 4(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1003(b)) is amended by adding at the end the fol-

lowing: ''Paragraph (3) shall apply subject to section 522(b) (relating to reimbursement of the Universal Medicare Program by workers compensation carriers).''.

(c) CLERICAL AMENDMENT.—The table of contents in section 1 of such Act is amended by inserting after the item relating to section 521 the following new item:

''Sec 522. Prohibition of employee benefits duplicative of Universal Medicare Program benefits; coordination in case of workers' compensation.''.

SEC. 802. REPEAL OF CONTINUATION COVERAGE REQUIREMENTS UNDER ERISA AND CERTAIN OTHER REQUIREMENTS RELATING TO GROUP HEALTH PLANS.

(a) IN GENERAL.—Part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1161 et seq.) is repealed.

(b) CONFORMING AMENDMENTS.—

(1) Section 502(a) of such Act (29 U.S.C. 1132(a)) is amended—

(A) by striking paragraph (7); and

(B) by redesignating paragraphs (8), (9), and (10) as paragraphs (7), (8), and (9), respectively.

(2) Section 502(c)(1) of such Act (29 U.S.C. 1132(c)(1)) is amended by striking ''paragraph (1) or (4) of section 606,''.

(3) Section 514(b) of such Act (29 U.S.C. 1144(b)) is amended—

(A) in paragraph (7), by striking ''section 206(d)(3)(B)(i)).''; and

(B) by striking paragraph (8).

(4) The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by striking the items relating to part 6 of subtitle B of title I of such Act.

SEC. 803. EFFECTIVE DATE OF TITLE.

The amendments made by this title shall take effect on effective date of benefits under section 106(a).

TITLE IX—ADDITIONAL CONFORMING AMENDMENTS

SEC. 901. RELATIONSHIP TO EXISTING FEDERAL HEALTH PROGRAMS.

(a) MEDICARE, MEDICAID, AND STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP).—

(1) IN GENERAL.—Notwithstanding any other provision of law, subject to paragraphs (2) and (3)—

(A) no benefits shall be available under title XVIII of the Social Security Act for any item or service furnished beginning on or after

the effective date of benefits under section 106(a);

(B) no individual is entitled to medical assistance under a State plan approved under title XIX of such Act for any item or service furnished on or after such date;

(C) no individual is entitled to medical assistance under a State child health plan under title XXI of such Act for any item or service furnished on or after such date; and

(D) no payment shall be made to a State under section 1903(a) or 2105(a) of such Act with respect to medical assistance or child health assistance for any item or service furnished on or after such date.

(2) TRANSITION.—In the case of inpatient hospital services and extended care services during a continuous period of stay which began before the effective date of benefits under section 106, and which had not ended as of such date, for which benefits are provided under title XVIII of the Social Security Act, under a State plan under title XIX of such Act, or under a State child health plan under title XXI such Act, the Secretary of Health and Human Serv-

ices shall provide for continuation of benefits under such title or plan until the end of the period of stay.

(3) SERVICES UNDER MEDICAID.—

(A) IN GENERAL.—This subsection shall not apply to entitlement to medical assistance provided under title XIX of the Social Security Act for—

(i) institutional long-term care services (as defined in section 1947(b) of such Act); or

(ii) any other service for which benefits are not available under this Act and which is furnished under a State plan under title XIX of the Social Security Act which provided for medical assistance for such service on January 1, 2019.

(B) COORDINATION BETWEEN SECRETARY AND STATES.—The Secretary shall coordinate with the directors of State agencies responsible for administering State plans under title XIX of the Social Security Act to—

(i) identify services described in subparagraph (A)(ii) with respect to each State plan; and

(ii) ensure that such services continue to be made available under such plan.

(C) MAINTENANCE OF EFFORT REQUIREMENT.—With respect to any service described in subparagraph (A)(ii) that is made available under a State plan under title XIX of the Social Security Act, the maintenance of effort requirements described in section 1947(c) of such Act (related to eligibility standards and required expenditures) shall apply to such service in the same manner that such requirements apply to institutional long-term care services (as defined in section 1947(b) of such Act).

(b) FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM.—No benefits shall be made available under chapter 89 of title 5, United States Code, for any part of a coverage period occurring on or after the effective date.

(c) TRICARE.—No benefits shall be made available under sections 1079 and 1086 of title 10, United States Code, for items or services furnished on or after the effective date.

(d) TREATMENT OF BENEFITS FOR VETERANS AND NATIVE AMERICANS.—

(1) IN GENERAL.—Nothing in this Act shall affect the eligibility of veterans for the medical bene-

fits and services provided under title 38, United States Code, or of Indians for the medical benefits and services provided by or through the Indian Health Service.

(2) REEVALUATION.—No reevaluation of the Indian Health Service shall be undertaken without consultation with tribal leaders and stakeholders.

SEC. 902. SUNSET OF PROVISIONS RELATED TO THE STATE EXCHANGES.

Effective on the date described in section 106, the Federal and State Exchanges established pursuant to title I of the Patient Protection and Affordable Care Act (Public Law 111–148) shall terminate, and any other provision of law that relies upon participation in or enrollment through such an Exchange, including such provisions of the Internal Revenue Code of 1986, shall cease to have force or effect.

TITLE X—TRANSITION

Subtitle A—Transitional Medicare Buy-In Option and Transitional Public Option

SEC. 1001. LOWERING THE MEDICARE AGE.

(a) IN GENERAL.—Title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.) is amended by adding at the end the following new section:

"TRANSITIONAL MEDICARE BUY-IN OPTION FOR CERTAIN INDIVIDUALS

"SEC. 1899C. (a) OPTION.—

"(1) IN GENERAL.—Every individual who meets the requirements described in paragraph (3) shall be eligible to enroll under this section.

"(2) PART A, B, AND D BENEFITS.—An individual enrolled under this section is entitled to the same benefits (and shall receive the same protections) under this title as an individual who is entitled to benefits under part A and enrolled under parts B and D, including the ability to enroll in a Medicare Advantage plan that provides qualified prescription drug coverage (an MA–PD plan).

"(3) REQUIREMENTS FOR ELIGIBILITY.—The requirements described in this paragraph are the following:

"(A) The individual is a resident of the United States.

"(B) The individual is—

"(i) a citizen or national of the United States; or

"(ii) an alien lawfully admitted for permanent residence.

"(C) The individual is not otherwise entitled to benefits under part A or eligible to enroll under part A or part B.

"(D) The individual has attained the applicable years of age but has not attained 65 years of age.

"(4) APPLICABLE YEARS OF AGE DEFINED.—For purposes of this section, the term 'applicable years of age' means—

"(A) effective January 1 of the first year following the date of enactment of the Medicare for All Act of 2019, the age of 55;

"(B) effective January 1 of the second year following such date of enactment, the age of 45; and

"(C) effective January 1 of the third year following such date of enactment, the age of 35.

"(b) ENROLLMENT; COVERAGE.—The Secretary shall establish enrollment periods and coverage under this section consistent with the principles for establishment of enrollment periods and coverage for individuals under other provisions of this title. The Secretary shall establish such periods so that coverage under this section shall first begin on January 1 of the year on which an individual first becomes eligible to enroll under this section.

"(c) PREMIUM.—

"(1) AMOUNT OF MONTHLY PREMIUMS.—The Secretary shall, during September of each year (beginning with the first September following the date of enactment of the Medicare for All Act of 2019), determine a monthly premium for all individuals enrolled under this section. Such monthly premium shall be equal to 1/12 of the annual premium computed under paragraph (2)(B), which shall apply with respect to coverage provided under this section for any month in the succeeding year.

"(2) ANNUAL PREMIUM.—

"(A) COMBINED PER CAPITA AVERAGE FOR ALL MEDICARE BENEFITS.—The Secretary shall estimate the average, annual per capita amount for benefits and administrative expenses that will be payable under parts A, B, and D (including, as applicable, under part C) in the year for all individuals enrolled under this section.

"(B) ANNUAL PREMIUM.—The annual premium under this subsection for months in a year is equal to the average, annual per capita amount estimated under subparagraph (A) for the year.

"(3) INCREASED PREMIUM FOR CERTAIN PART C AND D PLANS.—Nothing in this section shall preclude an individual from choosing a Medicare Advantage plan or a prescription drug plan which requires the individual to pay an additional amount (because of supplemental benefits or because it is a more expensive plan). In such case the individual would be responsible for the increased monthly premium.

"(d) PAYMENT OF PREMIUMS.—

"(1) IN GENERAL.—Premiums for enrollment under this section shall be paid to the Secretary at such times, and in such manner, as the Secretary determines appropriate.

"(2) DEPOSIT.—Amounts collected by the Secretary under this section shall be deposited in the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund (including the Medicare Prescription Drug Account within such Trust Fund) in such proportion as the Secretary determines appropriate.

"(e) NOT ELIGIBLE FOR MEDICARE COST-SHARING ASSISTANCE.—An individual enrolled under this section shall not be treated as enrolled under any part of this title for purposes of obtaining medical assistance for Medicare cost-sharing or otherwise under title XIX.

"(f) TREATMENT IN RELATION TO THE AFFORDABLE CARE ACT.—

"(1) SATISFACTION OF INDIVIDUAL MANDATE.—For purposes of applying section 5000A of the Internal Revenue Code of 1986, the coverage provided under this section constitutes minimum essential coverage under subsection (f)(1)(A)(i) of such section 5000A.

"(2) ELIGIBILITY FOR PREMIUM ASSISTANCE.—Coverage provided under this section—

"(A) shall be treated as coverage under a qualified health plan in the individual market enrolled in through the Exchange where the individual resides for all purposes of section 36B of the Internal Revenue Code of 1986 other than subsection (c)(2)(B) thereof; and

"(B) shall not be treated as eligibility for other minimum essential coverage for purposes of subsection (c)(2)(B) of such section 36B.

The Secretary shall determine the applicable second lowest cost silver plan which shall apply to coverage under this section for purposes of section 36B of such Code.

"(3) ELIGIBILITY FOR COST-SHARING SUBSIDIES.—For purposes of applying section 1402 of

the Patient Protection and Affordable Care Act (42 U.S.C. 18071)—

"(A) coverage provided under this section shall be treated as coverage under a qualified health plan in the silver level of coverage in the individual market offered through an Exchange; and

"(B) the Secretary shall be treated as the issuer of such plan.

"(g) NO EFFECT ON BENEFITS FOR INDIVIDUALS OTHERWISE ELIGIBLE OR ON TRUST FUNDS.—The Secretary shall implement the provisions of this section in such a manner to ensure that such provisions—

"(1) have no effect on the benefits under this title for individuals who are entitled to, or enrolled for, such benefits other than through this section; and

"(2) have no negative impact on the Federal Hospital Insurance Trust Fund or the Federal Supplementary Medical Insurance Trust Fund (including the Medicare Prescription Drug Account within such Trust Fund).

"(h) CONSULTATION.—In promulgating regulations to implement this section, the Secretary shall consult with interested parties, including groups representing bene-

ficiaries, health care providers, employers, and insurance companies.''.

SEC. 1002. ESTABLISHMENT OF THE MEDICARE TRANSITION PLAN.

(a) IN GENERAL.—To carry out the purpose of this section, for plan years beginning with the first plan year that begins after the date of enactment of this Act and ending with the effective date described in section 106, the Secretary, acting through the Administrator of the Centers for Medicare & Medicaid (referred to in this section as the ''Administrator''), shall establish, and provide for the offering through the Exchanges, of a public health plan (in this Act referred to as the ''Medicare Transition plan'') that provides affordable, high-quality health benefits coverage throughout the United States.

(b) ADMINISTRATING THE MEDICARE TRANSITION.—

(1) ADMINISTRATOR.—The Administrator shall administer the Medicare Transition plan in accordance with this section.

(2) APPLICATION OF ACA REQUIREMENTS.—Consistent with this section, the Medicare Transition plan shall comply with requirements under title I of the Patient Protection and Affordable Care Act (and the amendments made by that title) and title XXVII

of the Public Health Service Act (42 U.S.C. 300gg et seq.) that are applicable to qualified health plans offered through the Exchanges, subject to the limitation under subsection (e)(2).

(3) OFFERING THROUGH EXCHANGES.—The Medicare Transition plan shall be made available only through the Exchanges, and shall be available to individuals wishing to enroll and to qualified employers (as defined in section 1312(f)(2) of the Patient Protection and Affordable Care Act (42 U.S.C. 18032)) who wish to make such plan available to their employees.

(4) ELIGIBILITY TO PURCHASE.—Any United States resident may enroll in the Medicare Transition plan.

(c) BENEFITS; ACTUARIAL VALUE.—In carrying out this section, the Administrator shall ensure that the Medicare Transition plan provides—

(1) coverage for the benefits required to be covered under title II; and

(2) coverage of benefits that are actuarially equivalent to 90 percent of the full actuarial value of the benefits provided under the plan.

(d) PROVIDERS AND REIMBURSEMENT RATES.—

(1) IN GENERAL.—With respect to the reimbursement provided to health care providers for covered benefits, as described in section 201, provided under the Medicare Transition plan, the Administrator shall reimburse such providers at rates determined for equivalent items and services under the original Medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.). For items and services covered under the Medicare Transition plan but not covered under such parts A and B, the Administrator shall reimburse providers at rates set by the Administrator in a manner consistent with the manner in which rates for other items and services were set under the original Medicare fee-for-service program.

(2) PRESCRIPTION DRUGS.—Any payment rate under this subsection for a prescription drug shall be at a rate negotiated by the Administrator with the manufacturer of the drug. If the Administrator is unable to reach a negotiated agreement on such a reimbursement rate, the Administrator shall establish the rate at an amount equal to the lesser of—

(A) the price paid by the Secretary of Veterans Affairs to procure the drug under the

laws administered by the Secretary of Veterans Affairs;

(B) the price paid to procure the drug under section 8126 of title 38, United States Code; or

(C) the best price determined under section 1927(c)(1)(C) of the Social Security Act (42 U.S.C. 1396r–8(c)(1)(C)) for the drug.

(3) PARTICIPATING PROVIDERS.—

(A) IN GENERAL.—A health care provider that is a participating provider of services or supplier under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) or under a State Medicaid plan under title XIX of such Act (42 U.S.C. 1396 et seq.) on the date of enactment of this Act shall be a participating provider in the Medicare Transition plan.

(B) ADDITIONAL PROVIDERS.—The Administrator shall establish a process to allow health care providers not described in subparagraph (A) to become participating providers in the Medicare Transition plan. Such process shall be similar to the process applied to new providers under the Medicare program.

(e) PREMIUMS.—

(1) DETERMINATION.—The Administrator shall determine the premium amount for enrolling in the Medicare Transition plan, which—

(A) may vary according to family or individual coverage, age, and tobacco status (consistent with clauses (i), (iii), and (iv) of section 2701(a)(1)(A) of the Public Health Service Act (42 U.S.C. 300gg(a)(1)(A))); and

(B) shall take into account the cost-sharing reductions and premium tax credits which will be available with respect to the plan under section 1402 of the Patient Protection and Affordable Care Act (42 U.S.C. 18071) and section 36B of the Internal Revenue Code of 1986, as amended by subsection (g).

(2) LIMITATION.—Variation in premium rates of the Medicare Transition plan by rating area, as described in clause (ii) of section 2701(a)(1)(A)(iii) of the Public Health Service Act (42 U.S.C. 300gg(a)(1)(A)) is not permitted.

(f) TERMINATION.—This section shall cease to have force or effect on the effective date described in section 106.

(g) TAX CREDITS AND COST-SHARING SUBSIDIES.—

(1) PREMIUM ASSISTANCE TAX CREDITS.—

(A) CREDITS ALLOWED TO MEDICARE TRANSITION PLAN ENROLLEES AT OR ABOVE 44 PERCENT OF POVERTY IN NON-EXPANSION STATES.—Paragraph (1) of section 36B(c) of the Internal Revenue Code of 1986 is amended by redesignating subparagraphs (C) and (D) as subparagraphs (D) and (E), respectively, and by inserting after subparagraph (B) the following new subparagraph:

"(C) SPECIAL RULES FOR MEDICARE TRANSITION PLAN ENROLLEES.—

"(i) IN GENERAL.—In the case of a taxpayer who is covered, or whose spouse or dependent (as defined in section 152) is covered, by the Medicare Transition plan established under section 1002(a) of the Medicare for All Act of 2019 for all months in the taxable year, subparagraph (A) shall be applied without regard to 'but does not exceed 400 percent'.

"(ii) ENROLLEES IN MEDICAID NON-EXPANSION STATES.—In the case of a taxpayer residing in a State which (as of the date of the enactment of the Medicare for

All Act of 2019) does not provide for eligibility under clause (i)(VIII) or (ii)(XX) of section 1902(a)(10)(A) of the Social Security Act for medical assistance under title XIX of such Act (or a waiver of the State plan approved under section 1115) who is covered, or whose spouse or dependent (as defined in section 152) is covered, by the Medicare Transition plan established under section 1002(a) of the Medicare for All Act of 2019 for all months in the taxable year, subparagraphs (A) and (B) shall be applied by substituting '0 percent' for '100 percent' each place it appears.''.

(B) PREMIUM ASSISTANCE AMOUNTS FOR TAXPAYERS ENROLLED IN MEDICARE TRANSITION PLAN.—

(i) IN GENERAL.—Subparagraph (A) of section 36B(b)(3) of such Code is amended—

(I) by redesignating clause (ii) as clause (iii);

(II) by striking ''clause (ii)'' in clause (i) and inserting ''clauses (ii) and (iii)''; and

(III) by inserting after clause (i) the following new clause:

"(ii) SPECIAL RULES FOR TAXPAYERS ENROLLED IN MEDICARE TRANSITION PLAN.—In the case of a taxpayer who is covered, or whose spouse or dependent (as defined in section 152) is covered, by the Medicare Transition plan established under section 1002(a) of the Medicare for All Act of 2019 for all months in the taxable year, the applicable percentage for any taxable year shall be determined in the same manner as under clause (i), except that the following table shall apply in lieu of the table contained in such clause:

"In the case of household income (expressed as a percent of poverty line) within the following income tier:	The initial premium percentage is—	The final premium percentage is—
Up to 100 percent	2	2
100 percent up to 138 percent	2.04	2.04
138 percent up to 150 percent	3.06	4.08
150 percent and above	4.08	5".

(ii) CONFORMING AMENDMENT.—Subclause (I) of clause (iii) of section 36B(b)(3) of such Code, as redesignated by subparagraph (A)(i), is amended by inserting ", and determined after the appli-

cation of clause (ii)'' after ''after application of this clause''.

(2) COST-SHARING SUBSIDIES.—Subsection (b) of section 1402 of the Patient Protection and Affordable Care Act (42 U.S.C. 18071(b)) is amended—

(A) by inserting '', or in the Medicare Transition plan established under section 1002(a) of the Medicare for All Act of 2019,'' after ''coverage'' in paragraph (1);

(B) by redesignating paragraphs (1) (as so amended) and (2) as subparagraphs (A) and (B), respectively, and by moving such subparagraphs 2 ems to the right;

(C) by striking ''INSURED.—In this section'' and inserting ''INSURED.—

''(1) IN GENERAL.—In this section'';

(D) by striking the flush language; and

(E) by adding at the end the following new paragraph:

''(2) SPECIAL RULES.—

''(A) INDIVIDUALS LAWFULLY PRESENT.—In the case of an individual described in section 36B(c)(1)(B) of the Internal Revenue Code of 1986, the individual shall be treated as having

household income equal to 100 percent of the poverty line for a family of the size involved for purposes of applying this section.

"(B) MEDICARE TRANSITION PLAN ENROLLEES IN MEDICAID NON-EXPANSION STATES.—In the case of an individual residing in a State which (as of the date of the enactment of the Medicare for All Act of 2019) does not provide for eligibility under clause (i)(VIII) or (ii)(XX) of section 1902(a)(10)(A) of the Social Security Act for medical assistance under title XIX of such Act (or a waiver of the State plan approved under section 1115) who enrolls in such Medicare Transition plan, the preceding sentence, paragraph (1)(B), and paragraphs (1)(A)(i) and (2)(A) of subsection (c) shall each be applied by substituting '0 percent' for '100 percent' each place it appears.

"(C) ADJUSTED COST-SHARING FOR MEDICARE TRANSITION PLAN ENROLLEES.—In the case of any individual who enrolls in such Medicare Transition plan, in lieu of the percentages under subsection (c)(1)(B)(i) and (c)(2), the Secretary shall prescribe a method of determining the cost-sharing reduction for any such

individual such that the total of the cost-sharing and the premiums paid by the individual under such Medicare Transition plan does not exceed the percentage of the total allowed costs of benefits provided under the plan equal to the final premium percentage applicable to such individual under section 36B(b)(3)(A)(ii) of the Internal Revenue Code of 1986.''.

(h) CONFORMING AMENDMENTS.—

(1) TREATMENT AS A QUALIFIED HEALTH PLAN.—Section 1301(a)(2) of the Patient Protection and Affordable Care Act (42 U.S.C. 18021(a)(2)) is amended—

(A) in the paragraph heading, by inserting '', THE MEDICARE TRANSITION PLAN,'' before ''AND''; and

(B) by inserting ''The Medicare Transition plan,'' before ''and a multi-State plan''.

(2) LEVEL PLAYING FIELD.—Section 1324(a) of the Patient Protection and Affordable Care Act (42 U.S.C. 18044(a)) is amended by inserting ''the Medicare Transition plan,'' before ''or a multi-State qualified health plan''.

Subtitle B—Transitional Medicare Reforms

SEC. 1011. MEDICARE PROTECTION AGAINST HIGH OUT-OF-POCKET EXPENDITURES FOR FEE-FOR-SERVICE BENEFITS AND ELIMINATION OF PARTS A AND B DEDUCTIBLES.

(a) PROTECTION AGAINST HIGH OUT-OF-POCKET EXPENDITURES.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), as amended by section 1001, is amended by adding at the end the following new section:

"PROTECTION AGAINST HIGH OUT-OF-POCKET EXPENDITURES

"SEC. 1899D. (a) IN GENERAL.—Notwithstanding any other provision of this title, in the case of an individual entitled to, or enrolled for, benefits under part A or enrolled in part B, if the amount of the out-of-pocket cost-sharing of such individual for a year (effective the year beginning January 1 of the year following the date of enactment of the Medicare for All Act of 2019) equals or exceeds $1,500, the individual shall not be responsible for additional out-of-pocket cost-sharing occurred during that year.

"(b) OUT-OF-POCKET COST-SHARING DEFINED.—

"(1) IN GENERAL.—Subject to paragraphs (2) and (3), in this section, the term 'out-of-pocket cost-

sharing' means, with respect to an individual, the amount of the expenses incurred by the individual that are attributable to—

"(A) coinsurance and copayments applicable under part A or B; or

"(B) for items and services that would have otherwise been covered under part A or B but for the exhaustion of those benefits.

"(2) CERTAIN COSTS NOT INCLUDED.—

"(A) NON-COVERED ITEMS AND SERVICES.—Expenses incurred for items and services which are not included (or treated as being included) under part A or B shall not be considered incurred expenses for purposes of determining out-of-pocket cost-sharing under paragraph (1).

"(B) ITEMS AND SERVICES NOT FURNISHED ON AN ASSIGNMENT-RELATED BASIS.—If an item or service is furnished to an individual under this title and is not furnished on an assignment-related basis, any additional expenses the individual incurs above the amount the individual would have incurred if the item or service was furnished on an assignment-related basis shall not be considered incurred ex-

penses for purposes of determining out-of-pocket cost-sharing under paragraph (1).

''(3) SOURCE OF PAYMENT.—For purposes of paragraph (1), the Secretary shall consider expenses to be incurred by the individual without regard to whether the individual or another person, including a State program or other third-party coverage, has paid for such expenses.''.

(b) ELIMINATION OF PARTS A AND B DEDUCTIBLES.—

(1) PART A.—Section 1813(b) of the Social Security Act (42 U.S.C. 1395e(b)) is amended by adding at the end the following new paragraph:

''(4) For each year (beginning January 1 of the year following the date of enactment of the Medicare for All Act of 2019), the inpatient hospital deductible for the year shall be $0.''.

(2) PART B.—Section 1833(b) of the Social Security Act (42 U.S.C. 1395l(b)) is amended, in the first sentence—

(A) by striking ''and for a subsequent year'' and inserting ''for each of 2006 through the year that includes the date of enactment of the Medicare for All Act of 2019''; and

(B) by inserting ", and $0 for each year subsequent year" after "$1)".

SEC. 1012. REDUCTION IN MEDICARE PART D ANNUAL OUT-OF-POCKET THRESHOLD AND ELIMINATION OF COST-SHARING ABOVE THAT THRESHOLD.

(a) REDUCTION.—Section 1860D–2(b)(4)(B) of the Social Security Act (42 U.S.C. 1395w–102(b)(4)(B)) is amended—

(1) in clause (i), by striking "For purposes" and inserting "Subject to clause (iii), for purposes"; and

(2) by adding at the end the following new clause:

"(iii) REDUCTION IN THRESHOLD DURING TRANSITION PERIOD.—

"(I) IN GENERAL.—Subject to subclause (II), for plan years beginning on or after January 1 following the date of enactment of the Medicare for All Act of 2019 and before January 1 of the year that is 4 years following such date of enactment, notwithstanding clauses (i) and (ii), the 'annual out-of-pocket threshold' speci-

fied in this subparagraph is equal to $305.

"(II) AUTHORITY TO EXEMPT BRAND-NAME DRUGS IF GENERIC AVAILABLE.—In applying subclause (I), the Secretary may exempt costs incurred for a covered part D drug that is an applicable drug under section 1860D–14A(g)(2) if the Secretary determines that a generic version of that drug is available.".

(b) ELIMINATION OF COST-SHARING.—Section 1860D–2(b)(4)(A) of the Social Security Act (42 U.S.C. 1395w–102(b)(4)(A)) is amended—

(1) in clause (i)—

(A) by redesignating subclauses (I) and (II) as items (aa) and (bb), respectively;

(B) by striking "subparagraph (B), with cost-sharing" and inserting the following: "subparagraph (B)—

"(I) for plan years 2006 through the plan year ending December 31 following the date of enactment of the Medicare for All Act of 2019, with cost-sharing";

(C) in item (bb), as redesignated by subparagraph (A), by striking the period at the end and inserting ''; and''; and

(D) by adding at the end the following new subclause:

''(II) for the plan year beginning January 1 following the date of enactment of the Medicare for All Act of 2019 and the two subsequent plan years, without any cost-sharing.''; and

(2) in clause (ii)—

(A) by striking ''clause (i)(I)'' and inserting ''clause (i)(I)(aa)''; and

(B) by adding at the end the following new sentence: ''The Secretary shall continue to calculate the dollar amounts specified in clause (i)(I)(aa), including with the adjustment under this clause, after plan year 2018 for purposes of 1860D–14(a)(1)(D)(iii).''.

(c) CONFORMING AMENDMENTS TO LOW-INCOME SUBSIDY.—Section 1860D–14(a) of the Social Security Act (42 U.S.C. 1395w–114(a)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (D)(iii), by striking ''1860D–2(b)(4)(A)(i)(I)'' and inserting ''1860D–2(b)(4)(A)(i)(I)(aa)''; and

(B) in subparagraph (E)—

(i) in the heading, by inserting ''PRIOR TO THE ELIMINATION OF SUCH COST-SHARING FOR ALL INDIVIDUALS'' after ''THRESHOLD''; and

(ii) by striking ''The elimination'' and inserting ''For plan years 2006 through the plan year ending December 31 following the date of enactment of the Medicare for All Act of 2019, the elimination''; and

(2) in paragraph (2)(E)—

(A) in the heading, by inserting ''PRIOR TO THE ELIMINATION OF SUCH COST-SHARING FOR ALL INDIVIDUALS'' after ''THRESHOLD'';

(B) by striking ''Subject to'' and inserting ''For plan years 2006 through the plan year ending December 31 following the date of enactment of the Medicare for All Act of 2019, subject to''; and

(C) by striking ''1860D–2(b)(4)(A)(i)(I)'' and inserting ''1860D–2(b)(4)(A)(i)(I)(aa)''.

SEC. 1013. COVERAGE OF DENTAL AND VISION SERVICES AND HEARING AIDS AND EXAMINATIONS UNDER MEDICARE PART B.

(a) DENTAL SERVICES.—

(1) REMOVAL OF EXCLUSION FROM COVERAGE.—Section 1862(a) of the Social Security Act (42 U.S.C. 1395y(a)) is amended by striking paragraph (12).

(2) COVERAGE.—

(A) IN GENERAL.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended—

(i) in subparagraph (GG), by striking ''and'' at the end;

(ii) in subparagraph (HH), by striking the period at the end and inserting ''; and''; and

(iii) by adding at the end the following new subparagraph:

''(II) dental services;''.

(B) PAYMENT.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)) is amended—

(i) by striking ''and'' before ''(CC)''; and

(ii) by inserting before the semicolon at the end the following: ", and (DD) with respect to dental services described in section 1861(s)(2)(II), the amount paid shall be an amount equal to 80 percent of the lesser of the actual charge for the services or the amount determined under the fee schedule established under section 1848(b).".

(C) EFFECTIVE DATE.—The amendments made by this subsection shall apply to items and services furnished on or after January 1 following the date of the enactment of this Act.

(b) VISION SERVICES.—

(1) IN GENERAL.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)), as amended by subsection (a), is amended—

(A) in subparagraph (HH), by striking "and" at the end;

(B) in subparagraph (II), by inserting "and" at the end; and

(C) by adding at the end the following new subparagraph:

"(JJ) vision services;".

(2) PAYMENT.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)), as amended by subsection (a), is amended—

(A) by striking ''and'' before ''(DD)''; and

(B) by inserting before the semicolon at the end the following: '', and (EE) with respect to vision services described in section 1861(s)(2)(JJ), the amount paid shall be an amount equal to 80 percent of the lesser of the actual charge for the services or the amount determined under the fee schedule established under section 1848(b).''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to items and services furnished on or after January 1 following the date of the enactment of this Act.

(c) HEARING AIDS AND EXAMINATIONS THEREFOR.—

(1) IN GENERAL.—Section 1862(a)(7) of the Social Security Act (42 U.S.C. 1395y(a)(7)) is amended by striking ''hearing aids or examinations therefor,''.

(2) EFFECTIVE DATE.—The amendment made by this subsection shall apply to items and services

furnished on or after January 1 following the date of the enactment of this Act.

SEC. 1014. ELIMINATING THE 24-MONTH WAITING PERIOD FOR MEDICARE COVERAGE FOR INDIVIDUALS WITH DISABILITIES.

(a) IN GENERAL.—Section 226(b) of the Social Security Act (42 U.S.C. 426(b)) is amended—

(1) in paragraph (2)(A), by striking ", and has for 24 calendar months been entitled to,";

(2) in paragraph (2)(B), by striking ", and has been for not less than 24 months,";

(3) in paragraph (2)(C)(ii), by striking ", including the requirement that he has been entitled to the specified benefits for 24 months,";

(4) in the first sentence, by striking "for each month beginning with the later of (I) July 1973 or (II) the twenty-fifth month of his entitlement or status as a qualified railroad retirement beneficiary described in paragraph (2), and" and inserting "for each month for which the individual meets the requirements of paragraph (2), beginning with the month following the month in which the individual meets the requirements of such paragraph, and"; and

(5) in the second sentence, by striking ''the 'twenty-fifth month of his entitlement' '' and all that follows through ''paragraph (2)(C) and''.

(b) CONFORMING AMENDMENTS.—

(1) SECTION 226.—Section 226 of the Social Security Act (42 U.S.C. 426) is amended by—

(A) striking subsections (e)(1)(B), (f), and (h); and

(B) redesignating subsections (g) and (i) as subsections (f) and (g), respectively.

(2) MEDICARE DESCRIPTION.—Section 1811(2) of the Social Security Act (42 U.S.C. 1395c(2)) is amended by striking ''have been entitled for not less than 24 months'' and inserting ''are entitled''.

(3) MEDICARE COVERAGE.—Section 1837(g)(1) of the Social Security Act (42 U.S.C. 1395p(g)(1)) is amended by striking ''25th month of'' and inserting ''month following the first month of''.

(4) RAILROAD RETIREMENT SYSTEM.—Section 7(d)(2)(ii) of the Railroad Retirement Act of 1974 (45 U.S.C. 231f(d)(2)(ii)) is amended—

(A) by striking ''has been entitled to an annuity'' and inserting ''is entitled to an annuity'';

(B) by striking ", for not less than 24 months"; and

(C) by striking "could have been entitled for 24 calendar months, and".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to insurance benefits under title XVIII of the Social Security Act with respect to items and services furnished in months beginning after December 1 following the date of enactment of this Act, and before January 1 of the year that is 4 years after such date of enactment.

SEC. 1015. GUARANTEED ISSUE OF MEDIGAP POLICIES.

Section 1882 of the Social Security Act (42 U.S.C. 1395ss) is amended by adding at the end the following new subsection:

"(aa) GUARANTEED ISSUE FOR ALL MEDIGAP-ELIGIBLE MEDICARE BENEFICIARIES.—Notwithstanding paragraphs (2)(A) and (2)(D) of subsection (s) or any other provision of this section, on or after the date of enactment of this subsection, the issuer of a medicare supplemental policy may not deny or condition the issuance or effectiveness of a medicare supplemental policy, or discriminate in the pricing of the policy, because of health status, claims experience, receipt of health care, or medical condition in the case of any individual entitled to, or en-

rolled for, benefits under part A and enrolled for benefits under part B.''.

Subtitle C—Private Health Insurance Availability During Transitional Period

SEC. 1021. CONTINUITY OF CARE.

(a) IN GENERAL.—The Secretary shall ensure that all individuals enrolled in, or who seek to enroll in, a group health plan, health insurance coverage offered by a health insurance issuer, or the plan established under section 1002 during the transition period of this Act are protected from disruptions in their care during the transition period.

(b) PUBLIC CONSULTATION DURING TRANSITION.—The Secretary shall consult with communities and advocacy organizations of individuals living with disabilities and other patient advocacy organizations to ensure the transition described in this section takes into account the continuity of care for individuals with disabilities, complex medical needs, or chronic conditions.

(c) DEFINITIONS.—In this section, the terms ''health insurance coverage'', ''health insurance issuer'', and ''group health plans'' have the meanings given such terms in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91).

TITLE XI—MISCELLANEOUS

SEC. 1101. UPDATING RESOURCE LIMITS FOR SUPPLEMENTAL SECURITY INCOME ELIGIBILITY (SSI).

Section 1611(a)(3) of the Social Security Act (42 U.S.C. 1382(a)(3)) is amended—

(1) in subparagraph (A)—

(A) by striking ''and'' after ''January 1, 1988,''; and

(B) by inserting '', and to $6,200 on January 1, 2019'' before the period;

(2) in subparagraph (B)—

(A) by striking ''and'' after ''January 1, 1988,''; and

(B) by inserting '', and to $4,100 on January 1, 2019'' before the period; and

(3) by adding at the end the following new subparagraph:

''(C) Beginning with December of 2019, whenever the dollar amounts in effect under paragraphs (1)(A) and (2)(A) of this subsection are increased for a month by a percentage under section 1617(a)(2), each of the dollar amounts in effect under this paragraph shall be increased, effective with such month, by the same percentage (and

rounded, if not a multiple of $10, to the closest multiple of $10). Each increase under this subparagraph shall be based on the unrounded amount for the prior 12-month period.''.

SEC. 1102. DEFINITIONS.

In this Act—

(1) the term ''Secretary'' means the Secretary of Health and Human Services;

(2) the term ''State'' means a State, the District of Columbia, or a territory of the United States; and

(3) the term ''United States'' shall include the States, the District of Columbia, and the territories of the United States.

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State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-FIRST SESSION

H. F. No. 1200

02/14/2019 Authored by Mann, Hausman, Schultz, Koegel, Hassan and others
The bill was read for the first time and referred to the Committee on Health and Human Services Policy

A bill for an act

relating to health; guaranteeing that health care is available and affordable for every Minnesotan; establishing the Minnesota Health Plan, Minnesota Health Board, Minnesota Health Fund, Office of Health Quality and Planning, ombudsman for patient advocacy, and auditor general for the Minnesota Health Plan; requesting a 1332 waiver; authorizing rulemaking; appropriating money; amending Minnesota Statutes 2018, sections 13.3806, by adding a subdivision; 14.03, subdivisions 2, 3; 15A.0815, subdivision 2; proposing coding for new law as Minnesota Statutes, chapter 62W.

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

ARTICLE 1

MINNESOTA HEALTH PLAN

Section 1. **[62W.01] HEALTH PLAN REQUIREMENTS.**

In order to keep Minnesota residents healthy and provide the best quality of health care, the Minnesota Health Plan must:

(1) ensure all Minnesota residents are covered;

(2) cover all necessary care, including dental, vision and hearing, mental health, chemical dependency treatment, prescription drugs, medical equipment and supplies, long-term care, and home care;

(3) allow patients to choose their providers;

(4) reduce costs by negotiating fair prices and by cutting administrative bureaucracy, not by restricting or denying care;

(5) be affordable to all through premiums based on ability to pay and elimination of co-pays;

(6) focus on preventive care and early intervention to improve health;

(7) ensure that there are enough health care providers to guarantee timely access to care;

(8) continue Minnesota's leadership in medical education, research, and technology;

(9) provide adequate and timely payments to providers; and

(10) use a simple funding and payment system.

Sec. 2. **[62W.02] MINNESOTA HEALTH PLAN GENERAL PROVISIONS.**

Subdivision 1. **Short title.** This chapter may be cited as the "Minnesota Health Plan."

Subd. 2. **Purpose.** The Minnesota Health Plan shall provide all medically necessary health care services for all Minnesota residents in a manner that meets the requirements in section 62W.01.

Subd. 3. **Definitions.** As used in this chapter, the following terms have the meanings provided:

(a) "Board" means the Minnesota Health Board.

(b) "Plan" means the Minnesota Health Plan.

(c) "Fund" means the Minnesota Health Fund.

(d) "Medically necessary" means services or supplies needed to promote health and to prevent, diagnose, or treat a particular patient's medical condition that meet accepted standards of medical practice within a provider's professional peer group and geographic region.

(e) "Institutional provider" means an inpatient hospital, nursing facility, rehabilitation facility, and other health care facilities that provide overnight care.

(f) "Noninstitutional provider" means individual providers, group practices, clinics, outpatient surgical centers, imaging centers, and other health facilities that do not provide overnight care.

ARTICLE 2
ELIGIBILITY

Section 1. **[62W.03] ELIGIBILITY.**

Subdivision 1. **Residency.** All Minnesota residents are eligible for the Minnesota Health Plan.

Subd. 2. **Enrollment; identification.** The Minnesota Health Board shall establish a procedure to enroll residents and provide each with identification that may be used by health care providers to confirm eligibility for services. The application for enrollment shall be no more than two pages.

Subd. 3. **Residents temporarily out of state.** (a) The Minnesota Health Plan shall provide health care coverage to Minnesota residents who are temporarily out of the state who intend to return and reside in Minnesota.

(b) Coverage for emergency care obtained out of state shall be at prevailing local rates. Coverage for nonemergency care obtained out of state shall be according to rates and conditions established by the board. The board may require that a resident be transported back to Minnesota when prolonged treatment of an emergency condition is necessary and when that transport will not adversely affect a patient's care or condition.

Subd. 4. **Visitors.** Nonresidents visiting Minnesota shall be billed by the board for all services received under the Minnesota Health Plan. The board may enter into intergovernmental arrangements or contracts with other states and countries to provide reciprocal coverage for temporary visitors.

Subd. 5. **Nonresident employed in Minnesota.** The board shall extend eligibility to nonresidents employed in Minnesota under a premium schedule set by the board.

Subd. 6. **Business outside of Minnesota employing Minnesota residents.** The board shall apply for a federal waiver to collect the employer contribution mandated by federal law.

Subd. 7. **Retiree benefits.** (a) All persons who are eligible for retiree medical benefits under an employer-employee contract shall remain eligible for those benefits provided the contractually mandated payments for those benefits are made to the Minnesota Health Fund, which shall assume financial responsibility for care provided under the terms of the contract along with additional health benefits covered by the Minnesota Health Plan. Retirees who elect to reside outside of Minnesota shall be eligible for benefits under the terms and conditions of the retiree's employer-employee contract.

(b) The board may establish financial arrangements with states and foreign countries in order to facilitate meeting the terms of the contracts described in paragraph (a). Payments for care provided by non-Minnesota providers to Minnesota retirees shall be reimbursed at rates established by the Minnesota Health Board. Providers who accept any payment from the Minnesota Health Plan for a covered service shall not bill the patient for the covered service.

Subd. 8. **Presumptive eligibility.** (a) An individual is presumed eligible for coverage under the Minnesota Health Plan if the individual arrives at a health facility unconscious, comatose, or otherwise unable, because of the individual's physical or mental condition, to document eligibility or to act on the individual's own behalf. If the patient is a minor, the patient is presumed eligible, and the health facility shall provide care as if the patient were eligible.

(b) Any individual is presumed eligible when brought to a health facility according to any provision of section 253B.05.

(c) Any individual involuntarily committed to an acute psychiatric facility or to a hospital with psychiatric beds according to any provision of section 253B.05, providing for involuntary commitment, is presumed eligible.

(d) All health facilities subject to state and federal provisions governing emergency medical treatment must comply with those provisions.

Subd. 9. **Data.** Data collected because an individual applies for or is enrolled in the Minnesota Health Plan are private data on individuals as defined in section 13.02, subdivision 12, but may be released to:

(1) providers for purposes of confirming enrollment and processing payments for benefits;

(2) the ombudsman for patient advocacy for purposes of performing duties under section 62W.12 or 62W.13; or

(3) the auditor general for purposes of performing duties under section 62W.14.

Sec. 2. Minnesota Statutes 2018, section 13.3806, is amended by adding a subdivision to read:

Subd. 1d. **Minnesota Health Plan.** Data on enrollees under the Minnesota Health Plan are classified under sections 62W.03, subdivision 9, and 62W.13, subdivision 6.

ARTICLE 3
BENEFITS

Section 1. **[62W.04] BENEFITS.**

Subdivision 1. **General provisions.** Any eligible individual may choose to receive services under the Minnesota Health Plan from any participating provider.

Subd. 2. **Covered benefits.** Covered health care benefits in this chapter include all medically necessary care subject to the limitations specified in subdivision 4. Covered health care benefits for Minnesota Health Plan enrollees include:

(1) inpatient and outpatient health facility services;

(2) inpatient and outpatient professional health care provider services;

(3) diagnostic imaging, laboratory services, and other diagnostic and evaluative services;

(4) medical equipment, appliances, and assistive technology, including prosthetics, eyeglasses, and hearing aids, their repair, technical support, and customization needed for individual use;

(5) inpatient and outpatient rehabilitative care;

(6) emergency care services;

(7) emergency transportation;

(8) necessary transportation for health care services for persons with disabilities or who may qualify as low income;

(9) child and adult immunizations and preventive care;

(10) health and wellness education;

(11) hospice care;

(12) care in a skilled nursing facility;

(13) home health care including health care provided in an assisted living facility;

(14) mental health services;

(15) substance abuse treatment;

(16) dental care;

(17) vision care;

(18) hearing care;

(19) prescription drugs;

(20) podiatric care;

(21) chiropractic care;

(22) acupuncture;

(23) therapies which are shown by the National Institutes of Health National Center for Complementary and Integrative Health to be safe and effective;

(24) blood and blood products;

(25) dialysis;

(26) adult day care;

(27) rehabilitative and habilitative services;

(28) ancillary health care or social services previously covered by Minnesota's public health programs;

(29) case management and care coordination;

(30) language interpretation and translation for health care services, including sign language and Braille or other services needed for individuals with communication barriers; and

(31) those health care and long-term supportive services currently covered under Minnesota Statutes 2016, chapter 256B, for persons on medical assistance, including home and community-based waivered services under chapter 256B.

Subd. 3. **Benefit expansion.** The Minnesota Health Board may expand health care benefits beyond the minimum benefits described in this section when expansion meets the intent of this chapter and when there are sufficient funds to cover the expansion.

Subd. 4. **Cost-sharing for the room and board portion of long-term care.** The Minnesota Health Board shall develop income and asset qualifications based on medical assistance standards for covered benefits under subdivision 2, clauses (12) and (13). All health care services for long-term care in a skilled nursing facility or assisted living facility are fully covered but, notwithstanding section 62W.20, subdivision 6, room and board costs may be charged to patients who do not meet income and asset qualifications.

Subd. 5. **Exclusions.** The following health care services shall be excluded from coverage by the Minnesota Health Plan:

(1) health care services determined to have no medical benefit by the board;

(2) treatments and procedures primarily for cosmetic purposes, unless required to correct a congenital defect, restore or correct a part of the body that has been altered as a result of injury, disease, or surgery, or determined to be medically necessary by a qualified, licensed health care provider in the Minnesota Health Plan; and

(3) services of a health care provider or facility that is not licensed or accredited by the state, except for approved services provided to a Minnesota resident who is temporarily out of the state.

Subd. 6. **Prohibition.** The Minnesota Health Plan shall not pay for drugs requiring a prescription if the pharmaceutical companies directly market those drugs to consumers in Minnesota.

Sec. 2. **[62W.041] PATIENT CARE.**

(a) All patients shall have a primary care provider and have access to care coordination.

(b) Referrals are not required for a patient to see a health care specialist. If a patient sees a specialist and does not have a primary care provider, the Minnesota Health Plan may assist with choosing a primary care provider.

(c) The board may establish a computerized registry to assist patients in identifying appropriate providers.

ARTICLE 4
FUNDING

Section 1. **[62W.19] MINNESOTA HEALTH FUND.**

Subdivision 1. **General provisions.** (a) The Minnesota Health Fund, a revolving fund, is established under the jurisdiction and control of the Minnesota Health Board to implement the Minnesota Health Plan and to receive premiums and other sources of revenue. The fund shall be administered by a director appointed by the Minnesota Health Board.

(b) All money collected, received, and transferred according to this chapter shall be deposited in the Minnesota Health Fund.

(c) Money deposited in the Minnesota Health Fund shall be used exclusively to finance the Minnesota Health Plan.

(d) All claims for health care services rendered shall be made to the Minnesota Health Fund.

(e) All payments made for health care services shall be disbursed from the Minnesota Health Fund.

(f) Premiums and other revenues collected each year must be sufficient to cover that year's projected costs.

Subd. 2. **Accounts.** The Minnesota Health Fund shall have operating, capital, and reserve accounts.

Subd. 3. **Operating account.** The operating account in the Minnesota Health Fund shall be comprised of the accounts specified in paragraphs (a) to (e).

(a) **Medical services account.** The medical services account must be used to provide for all medical services and benefits covered under the Minnesota Health Plan.

(b) **Prevention account.** The prevention account must be used to establish and maintain primary community prevention programs, including preventive screening tests.

(c) **Program administration, evaluation, planning, and assessment account.** The program administration, evaluation, planning, and assessment account must be used to monitor and improve the plan's effectiveness and operations. The board may establish grant programs including demonstration projects for this purpose.

(d) **Training and development account.** The training and development account must be used to incentivize the training and development of health care providers and the health care workforce needed to meet the health care needs of the population.

(e) **Health service research account.** The health service research account must be used to support research and innovation as determined by the Minnesota Health Board, and recommended by the Office of Health Quality and Planning and the Ombudsman for Patient Advocacy.

Subd. 4. **Capital account.** The capital account must be used to pay for capital expenditures for institutional providers.

Subd. 5. **Reserve account.** (a) The Minnesota Health Plan must at all times hold in reserve an amount estimated in the aggregate to provide for the payment of all losses and claims for which the Minnesota Health Plan may be liable and to provide for the expense of adjustment or settlement of losses and claims.

(b) Money currently held in reserve by state, city, and county health programs must be transferred to the Minnesota Health Fund when the Minnesota Health Plan replaces those programs.

(c) The board shall have provisions in place to insure the Minnesota Health Plan against unforeseen expenditures or revenue shortfalls not covered by the reserve account. The board may borrow money to cover temporary shortfalls.

Subd. 6. **Assets of the Minnesota Health Plan; functions of the commissioner of Minnesota Management and Budget.** All money received by the Minnesota Health Fund shall be paid to the commissioner of Minnesota Management and Budget as agent of the board who shall not commingle these funds with any other money. The money in these accounts shall be paid out on warrants drawn by the commissioner on requisition by the board.

Subd. 7. **Management.** The Minnesota Health Fund shall be separate from the state treasury. Management of the fund shall be conducted by the Minnesota Health Board, which has exclusive authority over the fund.

Sec. 2. **[62W.20] REVENUE SOURCES.**

Subdivision 1. **Minnesota Health Plan premium.** (a) The Minnesota Health Board shall:

(1) determine the aggregate cost of providing health care according to this chapter;

(2) develop an equitable and affordable premium structure based on income, including unearned income, and a business health tax;

(3) in consultation with the Department of Revenue, develop an efficient means of collecting premiums and the business health tax; and

(4) coordinate with existing, ongoing funding sources from federal and state programs.

(b) The premium structure must be based on ability to pay.

(c) On or before January 15, 2017, the board shall submit to the governor and the legislature a report on the premium and business health tax structure established to finance the Minnesota Health Plan.

Subd. 2. **Federal receipts.** All federal funding received by Minnesota including the premium subsidies under the Affordable Care Act, Public Law 111-148, as amended by Public Law 111-152, is appropriated to the Minnesota Health Plan Board to be used to administer the Minnesota Health Plan under chapter 62W. Federal funding that is received for implementing and administering the Minnesota Health Plan must be used to provide health care for Minnesota residents.

Subd. 3. **Funds from outside sources.** Institutional providers operating under Minnesota Health Plan operating budgets may raise and expend funds from sources other than the Minnesota Health Plan including private or foundation donors. Contributions to providers in excess of $500,000 must be reported to the board.

Subd. 4. **Governmental payments.** The chief executive officer and, if required under federal law, the commissioners of health, human services, and commerce shall seek all necessary waivers, exemptions, agreements, or legislation so that all current federal payments to the state, including the premium tax credits under the Affordable Care Act, are paid directly to the Minnesota Health Plan. When any required waivers, exemptions, agreements, or legislation are obtained, the Minnesota Health Plan shall assume responsibility for all health care benefits and health care services previously paid for with federal funds. In obtaining the waivers, exemptions, agreements, or legislation, the chief executive officer and, if required, commissioners shall seek from the federal government a contribution for health care services in Minnesota that reflects: medical inflation, the state gross domestic product, the size and age of the population, the number of residents living below the poverty level, and the number of Medicare and VA eligible individuals, and that does not decrease in relation to the federal contribution to other states as a result of the waivers, exemptions, agreements, or savings from implementation of the Minnesota Health Plan.

Subd. 5. **Federal preemption.** (a) The board shall secure a repeal or a waiver of any provision of federal law that preempts any provision of this chapter. The commissioners of health, human services, and commerce shall provide all necessary assistance.

(b) In the section 1332 waiver application, the board shall request to waive any of the following provisions of the Patient Protection and Affordable Care Act, to the extent necessary to implement this act:

(1) United States Code, title 42, sections 18021 to 18024;

(2) United States Code, title 42, sections 18031 to 18033;

(3) United States Code, title 42, section 18071; and

(4) sections 36B and 5000A of the Internal Revenue Code of 1986, as amended.

(c) In the event that a repeal or a waiver of law or regulations cannot be secured, the board shall adopt rules, or seek conforming state legislation, consistent with federal law, in an effort to best fulfill the purposes of this chapter.

(d) The Minnesota Health Plan's responsibility for providing care shall be secondary to existing federal government programs for health care services to the extent that funding for these programs is not transferred to the Minnesota Health Fund or that the transfer is delayed beyond the date on which initial benefits are provided under the Minnesota Health Plan.

Subd. 6. **No cost-sharing.** No deductible, co-payment, coinsurance, or other cost-sharing shall be imposed with respect to covered benefits.

Sec. 3. **[62W.21] SUBROGATION.**

Subdivision 1. **Collateral source.** (a) When other payers for health care have been terminated, health care costs shall be collected from collateral sources whenever medical services provided to an individual are, or may be, covered services under a policy of insurance, or other collateral source available to that individual, or when the individual has a right of action for compensation permitted under law.

(b) As used in this section, collateral source includes:

(1) health insurance policies and the medical components of automobile, homeowners, and other forms of insurance;

(2) medical components of worker's compensation;

(3) pension plans;

(4) employer plans;

(5) employee benefit contracts;

(6) government benefit programs;

(7) a judgment for damages for personal injury;

(8) the state of last domicile for individuals moving to Minnesota for medical care who have extraordinary medical needs; and

(9) any third party who is or may be liable to an individual for health care services or costs.

(c) Collateral source does not include:

(1) a contract or plan that is subject to federal preemption; or

(2) any governmental unit, agency, or service, to the extent that subrogation is prohibited by law. An entity described in paragraph (b) is not excluded from the obligations imposed by this section by virtue of a contract or relationship with a government unit, agency, or service.

(d) The board shall negotiate waivers, seek federal legislation, or make other arrangements to incorporate collateral sources into the Minnesota Health Plan.

Subd. 2. **Notification.** When an individual who receives health care services under the Minnesota Health Plan is entitled to coverage, reimbursement, indemnity, or other compensation from a collateral source, the individual shall notify the health care provider and provide information identifying the collateral source, the nature and extent of coverage

or entitlement, and other relevant information. The health care provider shall forward this information to the board. The individual entitled to coverage, reimbursement, indemnity, or other compensation from a collateral source shall provide additional information as requested by the board.

Subd. 3. **Reimbursement.** (a) The Minnesota Health Plan shall seek reimbursement from the collateral source for services provided to the individual and may institute appropriate action, including legal proceedings, to recover the reimbursement. Upon demand, the collateral source shall pay to the Minnesota Health Fund the sums it would have paid or expended on behalf of the individual for the health care services provided by the Minnesota Health Plan.

(b) In addition to any other right to recovery provided in this section, the board shall have the same right to recover the reasonable value of health care benefits from a collateral source as provided to the commissioner of human services under section 256B.37.

(c) If a collateral source is exempt from subrogation or the obligation to reimburse the Minnesota Health Plan, the board may require that an individual who is entitled to medical services from the source first seek those services from that source before seeking those services from the Minnesota Health Plan.

(d) To the extent permitted by federal law, the board shall have the same right of subrogation over contractual retiree health care benefits provided by employers as other contracts, allowing the Minnesota Health Plan to recover the cost of health care services provided to individuals covered by the retiree benefits, unless arrangements are made to transfer the revenues of the health care benefits directly to the Minnesota Health Plan.

Subd. 4. **Defaults, underpayments, and late payments.** (a) Default, underpayment, or late payment of any tax or other obligation imposed by this chapter shall result in the remedies and penalties provided by law, except as provided in this section.

(b) Eligibility for health care benefits under section 62W.04 shall not be impaired by any default, underpayment, or late payment of any premium or other obligation imposed by this chapter.

ARTICLE 5
PAYMENTS

Section 1. **[62W.05] PROVIDER PAYMENTS.**

Subdivision 1. **General provisions.** (a) All health care providers licensed to practice in Minnesota may participate in the Minnesota Health Plan and other providers as determined by the board.

(b) A participating health care provider shall comply with all federal laws and regulations governing referral fees and fee splitting including, but not limited to, United States Code, title 42, sections 1320a-7b and 1395nn, whether reimbursed by federal funds or not.

(c) A fee schedule or financial incentive may not adversely affect the care a patient receives or the care a health provider recommends.

Subd. 2. **Payments to noninstitutional providers.** (a) The Minnesota Health Board shall establish and oversee a fair and efficient payment system for noninstitutional providers.

(b) The board shall pay noninstitutional providers based on rates negotiated with providers. Rates shall take into account the need to address provider shortages.

(c) The board shall establish payment criteria and methods of payment for care coordination for patients especially those with chronic illness and complex medical needs.

(d) Providers who accept any payment from the Minnesota Health Plan for a covered health care service shall not bill the patient for the covered health care service.

(e) Providers shall be paid within 30 business days for claims filed following procedures established by the board.

Subd. 3. **Payments to institutional providers.** (a) The board shall set annual budgets for institutional providers. These budgets shall consist of an operating and a capital budget. An institution's annual budget shall be set to cover its anticipated health care services for the next year based on past performance and projected changes in prices and health care service levels. The annual budget for each individual institutional provider must be set separately. The board shall not set a joint budget for a group of more than one institutional provider nor for a parent corporation that owns or operates one or more institutional provider.

(b) Providers who accept any payment from the Minnesota Health Plan for a covered health care service shall not bill the patient for the covered health care service.

Subd. 4. **Capital management plan.** (a) The board shall periodically develop a capital investment plan that will serve as a guide in determining the annual budgets of institutional

providers and in deciding whether to approve applications for approval of capital expenditures by noninstitutional providers.

(b) Providers who propose to make capital purchases in excess of $500,000 must obtain board approval. The board may alter the threshold expenditure level that triggers the requirement to submit information on capital expenditures. Institutional providers shall propose these expenditures and submit the required information as part of the annual budget they submit to the board. Noninstitutional providers shall submit applications for approval of these expenditures to the board. The board must respond to capital expenditure applications in a timely manner.

ARTICLE 6
GOVERNANCE

Section 1. Minnesota Statutes 2018, section 14.03, subdivision 2, is amended to read:

Subd. 2. **Contested case procedures.** The contested case procedures of the Administrative Procedure Act provided in sections 14.57 to 14.69 do not apply to (a) proceedings under chapter 414, except as specified in that chapter, (b) the commissioner of corrections, (c) the unemployment insurance program and the Social Security disability determination program in the Department of Employment and Economic Development, (d) the commissioner of mediation services, (e) the Workers' Compensation Division in the Department of Labor and Industry, (f) the Workers' Compensation Court of Appeals, ~~or~~ (g) the Board of Pardons, or (h) the Minnesota Health Plan.

Sec. 2. Minnesota Statutes 2018, section 15A.0815, subdivision 2, is amended to read:

Subd. 2. **Group I salary limits.** The salary for a position listed in this subdivision shall not exceed 133 percent of the salary of the governor. This limit must be adjusted annually on January 1. The new limit must equal the limit for the prior year increased by the percentage increase, if any, in the Consumer Price Index for all urban consumers from October of the second prior year to October of the immediately prior year. The commissioner of management and budget must publish the limit on the department's website. This subdivision applies to the following positions:

Commissioner of administration;

Commissioner of agriculture;

Commissioner of education;

Commissioner of commerce;

Commissioner of corrections;

Commissioner of health;

Chief executive officer of the Minnesota Health Plan;

Commissioner, Minnesota Office of Higher Education;

Commissioner, Housing Finance Agency;

Commissioner of human rights;

Commissioner of human services;

Commissioner of labor and industry;

Commissioner of management and budget;

Commissioner of natural resources;

Commissioner, Pollution Control Agency;

Commissioner of public safety;

Commissioner of revenue;

Commissioner of employment and economic development;

Commissioner of transportation; and

Commissioner of veterans affairs.

Sec. 3. **[62W.06] MINNESOTA HEALTH BOARD.**

Subdivision 1. **Establishment.** The Minnesota Health Board is established to promote the delivery of high quality, coordinated health care services that enhance health; prevent illness, disease, and disability; slow the progression of chronic diseases; and improve personal health management. The board shall administer the Minnesota Health Plan. The board shall oversee:

(1) the Office of Health Quality and Planning under section 62W.09; and

(2) the Minnesota Health Fund under section 62W.19.

Subd. 2. **Board composition.** (a) The board shall consist of 15 members, including a representative selected by each of the five rural regional health planning boards under section 62W.08 and three representatives selected by the metropolitan regional health planning board under section 62W.08. These members shall appoint the following additional members to serve on the board:

(1) one patient member and one employer member; and

(2) five providers that include one physician, one registered nurse, one mental health provider, one dentist, and one facility director.

(b) Each member shall qualify by taking the oath of office to uphold the Minnesota and United States Constitution and to operate the Minnesota Health Plan in the public interest by upholding the underlying principles of this chapter.

Subd. 3. **Term and compensation; selection of chair.** Board members shall serve four years. Board members shall set the board's compensation not to exceed the compensation of Public Utilities Commission members. The board shall select the chair from its membership.

Subd. 4. **Removal of board member.** A board member may be removed by a two-thirds vote of the members voting on removal. After receiving notice and hearing, a member may be removed for malfeasance or nonfeasance in performance of the member's duties. Conviction of any criminal behavior regardless of how much time has lapsed is grounds for immediate removal.

Subd. 5. **General duties.** The board shall:

(1) ensure that all of the requirements of section 62W.01 are met;

(2) hire a chief executive officer for the Minnesota Health Plan who shall be qualified after taking the oath of office specified in subdivision 2 and who shall administer all aspects of the plan as directed by the board;

(3) hire a director for the Office of Health Quality and Planning who shall be qualified after taking the oath of office specified in subdivision 2;

(4) hire a director of the Minnesota Health Fund who shall be qualified after taking the oath of office specified in subdivision 2;

(5) provide technical assistance to the regional boards established under section 62W.08;

(6) conduct necessary investigations and inquiries and require the submission of information, documents, and records the board considers necessary to carry out the purposes of this chapter;

(7) establish a process for the board to receive the concerns, opinions, ideas, and recommendations of the public regarding all aspects of the Minnesota Health Plan and the means of addressing those concerns;

(8) conduct other activities the board considers necessary to carry out the purposes of this chapter;

(9) collaborate with the agencies that license health facilities to ensure that facility performance is monitored and that deficient practices are recognized and corrected in a timely manner;

(10) adopt rules, policies, and procedures as necessary to carry out the duties assigned under this chapter;

(11) establish conflict of interest standards that prohibit providers from receiving any financial benefit from their medical decisions outside of board reimbursement, including any financial benefit for referring a patient for any service, product, or provider, or for prescribing, ordering, or recommending any drug, product, or service;

(12) establish conflict of interest standards related to pharmaceuticals, medical supplies and devices and their marketing to providers so that no provider receives any incentive to prescribe, administer, or use any product or service;

(13) require all electronic health records used by providers be fully interoperable with the open source electronic health records system used by the United States Veterans Administration;

(14) provide financial help and assistance in retraining and job placement to Minnesota workers who may be displaced because of the administrative efficiencies of the Minnesota Health Plan;

(15) ensure that assistance is provided to all workers and communities who may be affected by provisions in this chapter; and

(16) work with the Department of Employment and Economic Development (DEED) to ensure that funding and program services are promptly and efficiently distributed to all affected workers. DEED shall monitor and report on a regular basis on the status of displaced workers.

There is currently a serious shortage of providers in many health care professions, from medical technologists to registered nurses, and many potentially displaced health administrative workers already have training in some medical field. To alleviate these shortages, the dislocated worker support program should emphasize retraining and placement into health care related positions if appropriate. As Minnesota residents, all displaced workers shall be covered under the Minnesota Health Plan.

Subd. 6. **Waiver request duties.** Before submitting a waiver application under section 1332 of the Patient Protection and Affordable Care Act, Public Law Number 111-148, as amended, the board shall do the following, as required by federal law:

(1) conduct or contract for any necessary actuarial analyses and actuarial certifications needed to support the board's estimates that the waiver will comply with the comprehensive coverage, affordability, and scope of coverage requirements in federal law;

(2) conduct or contract for any necessary economic analyses needed to support the board's estimates that the waiver will comply with the comprehensive coverage, affordability, scope of coverage, and federal deficit requirements in federal law. These analyses must include:

(i) a detailed ten-year budget plan; and

(ii) a detailed analysis regarding the estimated impact of the waiver on health insurance coverage in the state;

(3) establish a detailed draft implementation timeline for the waiver plan; and

(4) establish quarterly, annual, and cumulative targets for the comprehensive coverage, affordability, scope of coverage, and federal deficit requirements in federal law.

Subd. 7. **Financial duties.** The board shall:

(1) establish and collect premiums and the business health tax according to section 62W.20, subdivision 1;

(2) approve statewide and regional budgets that include budgets for the accounts in section 62W.19;

(3) negotiate and establish payment rates for providers;

(4) monitor compliance with all budgets and payment rates and take action to achieve compliance to the extent authorized by law;

(5) pay claims for medical products or services as negotiated, and may issue requests for proposals from Minnesota nonprofit business corporations for a contract to process claims;

(6) seek federal approval to bill other states for health care coverage provided to residents from out-of-state who come to Minnesota for long-term care or other costly treatment when the resident's home state fails to provide such coverage, unless a reciprocal agreement with those states to provide similar coverage to Minnesota residents relocating to those states can be negotiated;

(7) administer the Minnesota Health Fund created under section 62W.19;

(8) annually determine the appropriate level for the Minnesota Health Plan reserve account and implement policies needed to establish the appropriate reserve;

(9) implement fraud prevention measures necessary to protect the operation of the Minnesota Health Plan; and

(10) work to ensure appropriate cost control by:

(i) instituting aggressive public health measures, early intervention and preventive care, health and wellness education, and promotion of personal health improvement;

(ii) making changes in the delivery of health care services and administration that improve efficiency and care quality;

(iii) minimizing administrative costs;

(iv) ensuring that the delivery system does not contain excess capacity; and

(v) negotiating the lowest possible prices for prescription drugs, medical equipment, and medical services.

If the board determines that there will be a revenue shortfall despite the cost control measures mentioned in clause (10), the board shall implement measures to correct the shortfall, including an increase in premiums and other revenues. The board shall report to the legislature on the causes of the shortfall, reasons for the inadequacy of cost controls, and measures taken to correct the shortfall.

Subd. 8. **Minnesota Health Board management duties.** The board shall:

(1) develop and implement enrollment procedures for the Minnesota Health Plan;

(2) implement eligibility standards for the Minnesota Health Plan;

(3) arrange for health care to be provided at convenient locations, including ensuring the availability of school nurses so that all students have access to health care, immunizations, and preventive care at public schools and encouraging providers to open small health clinics at larger workplaces and retail centers;

(4) make recommendations, when needed, to the legislature about changes in the geographic boundaries of the health planning regions;

(5) establish an electronic claims and payments system for the Minnesota Health Plan;

(6) monitor the operation of the Minnesota Health Plan through consumer surveys and regular data collection and evaluation activities, including evaluations of the adequacy and

quality of services furnished under the program, the need for changes in the benefit package, the cost of each type of service, and the effectiveness of cost control measures under the program;

(7) disseminate information and establish a health care website to provide information to the public about the Minnesota Health Plan including providers and facilities, and state and regional health planning board meetings and activities;

(8) collaborate with public health agencies, schools, and community clinics;

(9) ensure that Minnesota Health Plan policies and providers, including public health providers, support all Minnesota residents in achieving and maintaining maximum physical and mental health; and

(10) annually report to the chairs and ranking minority members of the senate and house of representatives committees with jurisdiction over health care issues on the performance of the Minnesota Health Plan, fiscal condition and need for payment adjustments, any needed changes in geographic boundaries of the health planning regions, recommendations for statutory changes, receipt of revenue from all sources, whether current year goals and priorities are met, future goals and priorities, major new technology or prescription drugs, and other circumstances that may affect the cost or quality of health care.

Subd. 9. **Policy duties.** The board shall:

(1) develop and implement cost control and quality assurance procedures;

(2) ensure strong public health services including education and community prevention and clinical services;

(3) ensure a continuum of coordinated high-quality primary to tertiary care to all Minnesota residents; and

(4) implement policies to ensure that all Minnesota residents receive culturally and linguistically competent care.

Subd. 10. **Self-insurance.** The board shall determine the feasibility of self-insuring providers for malpractice and shall establish a self-insurance system and create a special fund for payment of losses incurred if the board determines self-insuring providers would reduce costs.

Sec. 4. **[62W.07] HEALTH PLANNING REGIONS.**

A metropolitan health planning region consisting of the seven-county metropolitan area is established. By October 1, 2018, the commissioner of health shall designate five rural

health planning regions from the greater Minnesota area composed of geographically contiguous counties grouped on the basis of the following considerations:

(1) patterns of utilization of health care services;

(2) health care resources, including workforce resources;

(3) health needs of the population, including public health needs;

(4) geography;

(5) population and demographic characteristics; and

(6) other considerations as appropriate.

The commissioner of health shall designate the health planning regions.

Sec. 5. **[62W.08] REGIONAL HEALTH PLANNING BOARD.**

Subdivision 1. **Regional planning board composition.** (a) Each regional board shall consist of one county commissioner per county selected by the county board and two county commissioners per county selected by the county board in the seven-county metropolitan area. A county commissioner may designate a representative to act as a member of the board in the member's absence. Each board shall select the chair from among its membership.

(b) Board members shall serve for four-year terms and may receive per diems for meetings as provided in section 15.059, subdivision 3.

Subd. 2. **Regional health board duties.** Regional health planning boards shall:

(1) recommend health standards, goals, priorities, and guidelines for the region;

(2) prepare an operating and capital budget for the region to recommend to the Minnesota Health Board;

(3) collaborate with local public health care agencies to educate consumers and providers on public health programs, goals, and the means of reaching those goals;

(4) hire a regional health planning director;

(5) collaborate with public health care agencies to implement public health and wellness initiatives; and

(6) ensure that all parts of the region have access to a 24-hour nurse hotline and 24-hour urgent care clinics.

Sec. 6. **[62W.09] OFFICE OF HEALTH QUALITY AND PLANNING.**

Subdivision 1. **Establishment.** The Minnesota Health Board shall establish an Office of Health Quality and Planning to assess the quality, access, and funding adequacy of the Minnesota Health Plan.

Subd. 2. **General duties.** (a) The Office of Health Quality and Planning shall make annual recommendations to the board on the overall direction on subjects including:

(1) the overall effectiveness of the Minnesota Health Plan in addressing public health and wellness;

(2) access to health care;

(3) quality improvement;

(4) efficiency of administration;

(5) adequacy of budget and funding;

(6) appropriateness of payments for providers;

(7) capital expenditure needs;

(8) long-term health care;

(9) mental health and substance abuse services;

(10) staffing levels and working conditions in health care facilities;

(11) identification of number and mix of health care facilities and providers required to best meet the needs of the Minnesota Health Plan;

(12) care for chronically ill patients;

(13) educating providers on promoting the use of advance directives with patients to enable patients to obtain the health care of their choice;

(14) research needs; and

(15) integration of disease management programs into health care delivery.

(b) Analyze shortages in health care workforce required to meet the needs of the population and develop plans to meet those needs in collaboration with regional planners and educational institutions.

(c) Analyze methods of paying providers and make recommendations to improve quality and control costs.

(d) Assist in coordination of the Minnesota Health Plan and public health programs.

Subd. 3. **Assessment and evaluation of benefits.** (a) The Office of Health Quality and Planning shall:

(1) consider health care benefit additions to the Minnesota Health Plan and evaluate them based on evidence of clinical efficacy;

(2) establish a process and criteria by which providers may request authorization to provide health care services and treatments that are not included in the Minnesota Health Plan benefit set, including experimental health care treatments;

(3) evaluate proposals to increase the efficiency and effectiveness of the health care delivery system, and make recommendations to the board based on the cost-effectiveness of the proposals; and

(4) identify complementary and alternative health care modalities that have been shown to be safe and effective.

(b) The board may convene advisory panels as needed.

Sec. 7. **[62W.10] ETHICS AND CONFLICT OF INTEREST.**

(a) All provisions of section 43A.38 apply to employees and the chief executive officer of the Minnesota Health Plan, the members and directors of the Minnesota Health Board, the regional health boards, the director of the Office of Health Quality and Planning, the director of the Minnesota Health Fund, and the ombudsman for patient advocacy. Failure to comply with section 43A.38 shall be grounds for disciplinary action which may include termination of employment or removal from the board.

(b) In order to avoid the appearance of political bias or impropriety, the Minnesota Health Plan chief executive officer shall not:

(1) engage in leadership of, or employment by, a political party or a political organization;

(2) publicly endorse a political candidate;

(3) contribute to any political candidates or political parties and political organizations; or

(4) attempt to avoid compliance with this subdivision by making contributions through a spouse or other family member.

(c) In order to avoid a conflict of interest, individuals specified in paragraph (a) shall not be currently employed by a medical provider or a pharmaceutical, medical insurance,

or medical supply company. This paragraph does not apply to the five provider members of the board.

Sec. 8. **[62W.11] CONFLICT OF INTEREST COMMITTEE.**

(a) The board shall establish a conflict of interest committee to develop standards of practice for individuals or entities doing business with the Minnesota Health Plan, including but not limited to, board members, providers, and medical suppliers. The committee shall establish guidelines on the duty to disclose the existence of a financial interest and all material facts related to that financial interest to the committee.

(b) In considering the transaction or arrangement, if the committee determines a conflict of interest exists, the committee shall investigate alternatives to the proposed transaction or arrangement. After exercising due diligence, the committee shall determine whether the Minnesota Health Plan can obtain with reasonable efforts a more advantageous transaction or arrangement with a person or entity that would not give rise to a conflict of interest. If this is not reasonably possible under the circumstances, the committee shall make a recommendation to the board on whether the transaction or arrangement is in the best interest of the Minnesota Health Plan, and whether the transaction is fair and reasonable. The committee shall provide the board with all material information used to make the recommendation. After reviewing all relevant information, the board shall decide whether to approve the transaction or arrangement.

Sec. 9. **[62W.12] OMBUDSMAN OFFICE FOR PATIENT ADVOCACY.**

Subdivision 1. **Creation of office.** (a) The Ombudsman Office for Patient Advocacy is created to represent the interests of the consumers of health care. The ombudsman shall help residents of the state secure the health care services and health care benefits they are entitled to under the laws administered by the Minnesota Health Board and advocate on behalf of and represent the interests of enrollees in entities created by this chapter and in other forums.

(b) The ombudsman shall be a patient advocate appointed by the governor, who serves in the unclassified service and may be removed only for just cause. The ombudsman must be selected without regard to political affiliation and must be knowledgeable about and have experience in health care services and administration.

(c) The ombudsman may gather information about decisions, acts, and other matters of the Minnesota Health Board, health care organization, or a health care program. A person may not serve as ombudsman while holding another public office.

(d) The budget for the ombudsman's office shall be determined by the legislature and is independent from the Minnesota Health Board. The ombudsman shall establish offices to provide convenient access to residents.

(e) The Minnesota Health Board has no oversight or authority over the ombudsman for patient advocacy.

Subd. 2. **Ombudsman's duties.** The ombudsman shall:

(1) ensure that patient advocacy services are available to all Minnesota residents;

(2) establish and maintain the grievance process according to section 62W.13;

(3) receive, evaluate, and respond to consumer complaints about the Minnesota Health Plan;

(4) establish a process to receive recommendations from the public about ways to improve the Minnesota Health Plan;

(5) develop educational and informational guides according to communication services under section 15.441, describing consumer rights and responsibilities;

(6) ensure the guides in clause (5) are widely available to consumers and specifically available in provider offices and health care facilities; and

(7) prepare an annual report about the consumer perspective on the performance of the Minnesota Health Plan, including recommendations for needed improvements.

Sec. 10. **[62W.13] GRIEVANCE SYSTEM.**

Subdivision 1. **Grievance system established.** The ombudsman shall establish a grievance system for complaints. The system shall provide a process that ensures adequate consideration of Minnesota Health Plan enrollee grievances and appropriate remedies.

Subd. 2. **Referral of grievances.** The ombudsman may refer any grievance that does not pertain to compliance with this chapter to the federal Centers for Medicare and Medicaid Services or any other appropriate local, state, and federal government entity for investigation and resolution.

Subd. 3. **Submittal by designated agents and providers.** A provider may join with, or otherwise assist, a complainant to submit the grievance to the ombudsman. A provider or an employee of a provider who, in good faith, joins with or assists a complainant in submitting a grievance is subject to the protections and remedies under sections 181.931 to 181.935.

Subd. 4. **Review of documents.** The ombudsman may require additional information from health care providers or the board.

Subd. 5. **Written notice of disposition.** The ombudsman shall send a written notice of the final disposition of the grievance, and the reasons for the decision, to the complainant, to any provider who is assisting the complainant, and to the board, within 30 calendar days of receipt of the request for review unless the ombudsman determines that additional time is reasonably necessary to fully and fairly evaluate the relevant grievance. The ombudsman's order of corrective action shall be binding on the Minnesota Health Plan. A decision of the ombudsman is subject to de novo review by the district court.

Subd. 6. **Data.** Data on enrollees collected because an enrollee submits a complaint to the ombudsman are private data on individuals as defined in section 13.02, subdivision 12, but may be released to a provider who is the subject of the complaint or to the board for purposes of this section.

Sec. 11. **[62W.14] AUDITOR GENERAL FOR THE MINNESOTA HEALTH PLAN.**

Subdivision 1. **Establishment.** There is within the Office of the Legislative Auditor an auditor general for health care fraud and abuse for the Minnesota Health Plan who is appointed by the legislative auditor.

Subd. 2. **Duties.** The auditor general shall:

(1) investigate, audit, and review the financial and business records of the Minnesota Health Plan and the Minnesota Health Fund;

(2) investigate, audit, and review the financial and business records of individuals, public and private agencies and institutions, and private corporations that provide services or products to the Minnesota Health Plan, the costs of which are reimbursed by the Minnesota Health Plan;

(3) investigate allegations of misconduct on the part of an employee or appointee of the Minnesota Health Board and on the part of any provider of health care services that is reimbursed by the Minnesota Health Plan, and report any findings of misconduct to the attorney general;

(4) investigate fraud and abuse;

(5) arrange for the collection and analysis of data needed to investigate the inappropriate utilization of these products and services; and

(6) annually report recommendations for improvements to the Minnesota Health Plan to the board.

Sec. 12. **[62W.15] MINNESOTA HEALTH PLAN POLICIES AND PROCEDURES; RULEMAKING.**

Subdivision 1. **Exempt rules.** The Minnesota Health Plan policies and procedures are exempt from the Administrative Procedure Act but, to the extent authorized by law to adopt rules, the board may use the provisions of section 14.386, paragraph (a), clauses (1) and (3). Section 14.386, paragraph (b), does not apply to these rules.

Subd. 2. **Rulemaking procedures.** (a) Whenever the board determines that a rule should be adopted under this section establishing, modifying, or revoking a policy or procedure, the board shall publish in the State Register the proposed policy or procedure and shall afford interested persons a period of 30 days after publication to submit written data or comments.

(b) On or before the last day of the period provided for the submission of written data or comments, any interested person may file with the board written objections to the proposed rule, stating the grounds for objection and requesting a public hearing on those objections. Within 30 days after the last day for filing objections, the board shall publish in the State Register a notice specifying the policy or procedure to which objections have been filed and a hearing requested and specifying a time and place for the hearing.

Subd. 3. **Rule adoption.** Within 60 days after the expiration of the period provided for the submission of written data or comments, or within 60 days after the completion of any hearing, the board shall issue a rule adopting, modifying, or revoking a policy or procedure, or make a determination that a rule should not be adopted. The rule may contain a provision delaying its effective date for such period as the board determines is necessary.

Sec. 13. **[62W.151] EXEMPTION FROM RULEMAKING.**

The board and its operation of the Minnesota Health Plan and the Minnesota Health Fund is exempt from rulemaking under chapter 14.

Sec. 14. Minnesota Statutes 2018, section 14.03, subdivision 3, is amended to read:

Subd. 3. **Rulemaking procedures.** (a) The definition of a rule in section 14.02, subdivision 4, does not include:

(1) rules concerning only the internal management of the agency or other agencies that do not directly affect the rights of or procedures available to the public;

(2) an application deadline on a form; and the remainder of a form and instructions for use of the form to the extent that they do not impose substantive requirements other than requirements contained in statute or rule;

(3) the curriculum adopted by an agency to implement a statute or rule permitting or mandating minimum educational requirements for persons regulated by an agency, provided the topic areas to be covered by the minimum educational requirements are specified in statute or rule;

(4) procedures for sharing data among government agencies, provided these procedures are consistent with chapter 13 and other law governing data practices.

(b) The definition of a rule in section 14.02, subdivision 4, does not include:

(1) rules of the commissioner of corrections relating to the release, placement, term, and supervision of inmates serving a supervised release or conditional release term, the internal management of institutions under the commissioner's control, and rules adopted under section 609.105 governing the inmates of those institutions;

(2) rules relating to weight limitations on the use of highways when the substance of the rules is indicated to the public by means of signs;

(3) opinions of the attorney general;

(4) the data element dictionary and the annual data acquisition calendar of the Department of Education to the extent provided by section 125B.07;

(5) the occupational safety and health standards provided in section 182.655;

(6) revenue notices and tax information bulletins of the commissioner of revenue;

(7) uniform conveyancing forms adopted by the commissioner of commerce under section 507.09;

(8) standards adopted by the Electronic Real Estate Recording Commission established under section 507.0945; ~~or~~

(9) the interpretive guidelines developed by the commissioner of human services to the extent provided in chapter 245A.~~;~~ ; or

(10) rules, policies, and procedures adopted by the Minnesota Health Board under chapter 62W.

ARTICLE 7
IMPLEMENTATION

Section 1. **APPROPRIATION.**

$..... in fiscal year 2020 is appropriated from the general fund to the Minnesota Health Fund under the Minnesota Health Plan to provide start-up funding for the provisions of chapter 62W.

Sec. 2. **EFFECTIVE DATE AND TRANSITION.**

Subdivision 1. **Effective date.** This act is effective the day following final enactment. The commissioner of management and budget and the chief executive officer of the Minnesota Health Plan shall regularly update the legislature on the status of planning, implementation, and financing of this act.

Subd. 2. **Timing to implement.** The Minnesota Health Plan must be operational within two years from the date of final enactment of this act.

Subd. 3. **Prohibition.** On and after the day the Minnesota Health Plan becomes operational, a health plan, as defined in Minnesota Statutes, section 62Q.01, subdivision 3, may not be sold in Minnesota for services provided by the Minnesota Health Plan.

Subd. 4. **Transition.** (a) The commissioners of health, human services, and commerce shall prepare an analysis of the state's capital expenditure needs for the purpose of assisting the board in adopting the statewide capital budget for the year following implementation. The commissioners shall submit this analysis to the board.

(b) The following timelines shall be implemented:

(1) the commissioner of health shall designate the health planning regions utilizing the criteria specified in Minnesota Statutes, section 62W.07, 30 days after the date of enactment of this act;

(2) the regional boards shall be established three months after the date of enactment of this act; and

(3) the Minnesota Health Board shall be established five months after the date of enactment of this act; and

(4) the commissioner of health, or the commissioner's designee, shall convene the first meeting of each of the regional boards and the Minnesota Health Board within 30 days after each of the boards has been established.

Subd. 5. **Report.** Within one year of the effective date of chapter 62W, DEED shall provide to the Minnesota Health Board, the governor, and the chairs and ranking members of the legislative committees with jurisdiction over health, human services, and commerce a report spelling out the appropriations and legislation necessary to assist all affected individuals and communities through the transition.

SENATE
STATE OF MINNESOTA
NINETY-FIRST SESSION

S.F. No. 1125

(SENATE AUTHORS: MARTY, Bakk, Eaton, Kent and Rest)

DATE	D-PG	OFFICIAL STATUS
02/11/2019	336	Introduction and first reading Referred to Health and Human Services Finance and Policy

A bill for an act

relating to health; guaranteeing that health care is available and affordable for every Minnesotan; establishing the Minnesota Health Plan, Minnesota Health Board, Minnesota Health Fund, Office of Health Quality and Planning, ombudsman for patient advocacy, and auditor general for the Minnesota Health Plan; requesting a 1332 waiver; authorizing rulemaking; appropriating money; amending Minnesota Statutes 2018, sections 13.3806, by adding a subdivision; 14.03, subdivisions 2, 3; 15A.0815, subdivision 2; proposing coding for new law as Minnesota Statutes, chapter 62W.

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

ARTICLE 1
MINNESOTA HEALTH PLAN

Section 1. **[62W.01] HEALTH PLAN REQUIREMENTS.**

In order to keep Minnesota residents healthy and provide the best quality of health care, the Minnesota Health Plan must:

(1) ensure all Minnesota residents are covered;

(2) cover all necessary care, including dental, vision and hearing, mental health, chemical dependency treatment, prescription drugs, medical equipment and supplies, long-term care, and home care;

(3) allow patients to choose their providers;

(4) reduce costs by negotiating fair prices and by cutting administrative bureaucracy, not by restricting or denying care;

(5) be affordable to all through premiums based on ability to pay and elimination of co-pays;

(6) focus on preventive care and early intervention to improve health;

(7) ensure that there are enough health care providers to guarantee timely access to care;

(8) continue Minnesota's leadership in medical education, research, and technology;

(9) provide adequate and timely payments to providers; and

(10) use a simple funding and payment system.

Sec. 2. **[62W.02] MINNESOTA HEALTH PLAN GENERAL PROVISIONS.**

Subdivision 1. **Short title.** This chapter may be cited as the "Minnesota Health Plan."

Subd. 2. **Purpose.** The Minnesota Health Plan shall provide all medically necessary health care services for all Minnesota residents in a manner that meets the requirements in section 62W.01.

Subd. 3. **Definitions.** As used in this chapter, the following terms have the meanings provided:

(a) "Board" means the Minnesota Health Board.

(b) "Plan" means the Minnesota Health Plan.

(c) "Fund" means the Minnesota Health Fund.

(d) "Medically necessary" means services or supplies needed to promote health and to prevent, diagnose, or treat a particular patient's medical condition that meet accepted standards of medical practice within a provider's professional peer group and geographic region.

(e) "Institutional provider" means an inpatient hospital, nursing facility, rehabilitation facility, and other health care facilities that provide overnight care.

(f) "Noninstitutional provider" means individual providers, group practices, clinics, outpatient surgical centers, imaging centers, and other health facilities that do not provide overnight care.

ARTICLE 2
ELIGIBILITY

Section 1. **[62W.03] ELIGIBILITY.**

Subdivision 1. **Residency.** All Minnesota residents are eligible for the Minnesota Health Plan.

Subd. 2. **Enrollment; identification.** The Minnesota Health Board shall establish a procedure to enroll residents and provide each with identification that may be used by health care providers to confirm eligibility for services. The application for enrollment shall be no more than two pages.

Subd. 3. **Residents temporarily out of state.** (a) The Minnesota Health Plan shall provide health care coverage to Minnesota residents who are temporarily out of the state who intend to return and reside in Minnesota.

(b) Coverage for emergency care obtained out of state shall be at prevailing local rates. Coverage for nonemergency care obtained out of state shall be according to rates and conditions established by the board. The board may require that a resident be transported back to Minnesota when prolonged treatment of an emergency condition is necessary and when that transport will not adversely affect a patient's care or condition.

Subd. 4. **Visitors.** Nonresidents visiting Minnesota shall be billed by the board for all services received under the Minnesota Health Plan. The board may enter into intergovernmental arrangements or contracts with other states and countries to provide reciprocal coverage for temporary visitors.

Subd. 5. **Nonresident employed in Minnesota.** The board shall extend eligibility to nonresidents employed in Minnesota under a premium schedule set by the board.

Subd. 6. **Business outside of Minnesota employing Minnesota residents.** The board shall apply for a federal waiver to collect the employer contribution mandated by federal law.

Subd. 7. **Retiree benefits.** (a) All persons who are eligible for retiree medical benefits under an employer-employee contract shall remain eligible for those benefits provided the contractually mandated payments for those benefits are made to the Minnesota Health Fund, which shall assume financial responsibility for care provided under the terms of the contract along with additional health benefits covered by the Minnesota Health Plan. Retirees who elect to reside outside of Minnesota shall be eligible for benefits under the terms and conditions of the retiree's employer-employee contract.

(b) The board may establish financial arrangements with states and foreign countries in order to facilitate meeting the terms of the contracts described in paragraph (a). Payments for care provided by non-Minnesota providers to Minnesota retirees shall be reimbursed at rates established by the Minnesota Health Board. Providers who accept any payment from the Minnesota Health Plan for a covered service shall not bill the patient for the covered service.

Subd. 8. **Presumptive eligibility.** (a) An individual is presumed eligible for coverage under the Minnesota Health Plan if the individual arrives at a health facility unconscious, comatose, or otherwise unable, because of the individual's physical or mental condition, to document eligibility or to act on the individual's own behalf. If the patient is a minor, the patient is presumed eligible, and the health facility shall provide care as if the patient were eligible.

(b) Any individual is presumed eligible when brought to a health facility according to any provision of section 253B.05.

(c) Any individual involuntarily committed to an acute psychiatric facility or to a hospital with psychiatric beds according to any provision of section 253B.05, providing for involuntary commitment, is presumed eligible.

(d) All health facilities subject to state and federal provisions governing emergency medical treatment must comply with those provisions.

Subd. 9. **Data.** Data collected because an individual applies for or is enrolled in the Minnesota Health Plan are private data on individuals as defined in section 13.02, subdivision 12, but may be released to:

(1) providers for purposes of confirming enrollment and processing payments for benefits;

(2) the ombudsman for patient advocacy for purposes of performing duties under section 62W.12 or 62W.13; or

(3) the auditor general for purposes of performing duties under section 62W.14.

Sec. 2. Minnesota Statutes 2018, section 13.3806, is amended by adding a subdivision to read:

Subd. 1d. **Minnesota Health Plan.** Data on enrollees under the Minnesota Health Plan are classified under sections 62W.03, subdivision 9, and 62W.13, subdivision 6.

ARTICLE 3
BENEFITS

Section 1. **[62W.04] BENEFITS.**

Subdivision 1. **General provisions.** Any eligible individual may choose to receive services under the Minnesota Health Plan from any participating provider.

Subd. 2. **Covered benefits.** Covered health care benefits in this chapter include all medically necessary care subject to the limitations specified in subdivision 4. Covered health care benefits for Minnesota Health Plan enrollees include:

(1) inpatient and outpatient health facility services;

(2) inpatient and outpatient professional health care provider services;

(3) diagnostic imaging, laboratory services, and other diagnostic and evaluative services;

(4) medical equipment, appliances, and assistive technology, including prosthetics, eyeglasses, and hearing aids, their repair, technical support, and customization needed for individual use;

(5) inpatient and outpatient rehabilitative care;

(6) emergency care services;

(7) emergency transportation;

(8) necessary transportation for health care services for persons with disabilities or who may qualify as low income;

(9) child and adult immunizations and preventive care;

(10) health and wellness education;

(11) hospice care;

(12) care in a skilled nursing facility;

(13) home health care including health care provided in an assisted living facility;

(14) mental health services;

(15) substance abuse treatment;

(16) dental care;

(17) vision care;

(18) hearing care;

(19) prescription drugs;

(20) podiatric care;

(21) chiropractic care;

(22) acupuncture;

(23) therapies which are shown by the National Institutes of Health National Center for Complementary and Integrative Health to be safe and effective;

(24) blood and blood products;

(25) dialysis;

(26) adult day care;

(27) rehabilitative and habilitative services;

(28) ancillary health care or social services previously covered by Minnesota's public health programs;

(29) case management and care coordination;

(30) language interpretation and translation for health care services, including sign language and Braille or other services needed for individuals with communication barriers; and

(31) those health care and long-term supportive services currently covered under Minnesota Statutes 2016, chapter 256B, for persons on medical assistance, including home and community-based waivered services under chapter 256B.

Subd. 3. **Benefit expansion.** The Minnesota Health Board may expand health care benefits beyond the minimum benefits described in this section when expansion meets the intent of this chapter and when there are sufficient funds to cover the expansion.

Subd. 4. **Cost-sharing for the room and board portion of long-term care.** The Minnesota Health Board shall develop income and asset qualifications based on medical assistance standards for covered benefits under subdivision 2, clauses (12) and (13). All health care services for long-term care in a skilled nursing facility or assisted living facility are fully covered but, notwithstanding section 62W.20, subdivision 6, room and board costs may be charged to patients who do not meet income and asset qualifications.

Subd. 5. **Exclusions.** The following health care services shall be excluded from coverage by the Minnesota Health Plan:

(1) health care services determined to have no medical benefit by the board;

(2) treatments and procedures primarily for cosmetic purposes, unless required to correct a congenital defect, restore or correct a part of the body that has been altered as a result of injury, disease, or surgery, or determined to be medically necessary by a qualified, licensed health care provider in the Minnesota Health Plan; and

(3) services of a health care provider or facility that is not licensed or accredited by the state, except for approved services provided to a Minnesota resident who is temporarily out of the state.

Subd. 6. **Prohibition.** The Minnesota Health Plan shall not pay for drugs requiring a prescription if the pharmaceutical companies directly market those drugs to consumers in Minnesota.

Sec. 2. **[62W.041] PATIENT CARE.**

(a) All patients shall have a primary care provider and have access to care coordination.

(b) Referrals are not required for a patient to see a health care specialist. If a patient sees a specialist and does not have a primary care provider, the Minnesota Health Plan may assist with choosing a primary care provider.

(c) The board may establish a computerized registry to assist patients in identifying appropriate providers.

ARTICLE 4
FUNDING

Section 1. **[62W.19] MINNESOTA HEALTH FUND.**

Subdivision 1. **General provisions.** (a) The Minnesota Health Fund, a revolving fund, is established under the jurisdiction and control of the Minnesota Health Board to implement the Minnesota Health Plan and to receive premiums and other sources of revenue. The fund shall be administered by a director appointed by the Minnesota Health Board.

(b) All money collected, received, and transferred according to this chapter shall be deposited in the Minnesota Health Fund.

(c) Money deposited in the Minnesota Health Fund shall be used exclusively to finance the Minnesota Health Plan.

(d) All claims for health care services rendered shall be made to the Minnesota Health Fund.

(e) All payments made for health care services shall be disbursed from the Minnesota Health Fund.

(f) Premiums and other revenues collected each year must be sufficient to cover that year's projected costs.

Subd. 2. **Accounts.** The Minnesota Health Fund shall have operating, capital, and reserve accounts.

Subd. 3. **Operating account.** The operating account in the Minnesota Health Fund shall be comprised of the accounts specified in paragraphs (a) to (e).

(a) **Medical services account.** The medical services account must be used to provide for all medical services and benefits covered under the Minnesota Health Plan.

(b) **Prevention account.** The prevention account must be used to establish and maintain primary community prevention programs, including preventive screening tests.

(c) **Program administration, evaluation, planning, and assessment account.** The program administration, evaluation, planning, and assessment account must be used to monitor and improve the plan's effectiveness and operations. The board may establish grant programs including demonstration projects for this purpose.

(d) **Training and development account.** The training and development account must be used to incentivize the training and development of health care providers and the health care workforce needed to meet the health care needs of the population.

(e) **Health service research account.** The health service research account must be used to support research and innovation as determined by the Minnesota Health Board, and recommended by the Office of Health Quality and Planning and the Ombudsman for Patient Advocacy.

Subd. 4. **Capital account.** The capital account must be used to pay for capital expenditures for institutional providers.

Subd. 5. **Reserve account.** (a) The Minnesota Health Plan must at all times hold in reserve an amount estimated in the aggregate to provide for the payment of all losses and claims for which the Minnesota Health Plan may be liable and to provide for the expense of adjustment or settlement of losses and claims.

(b) Money currently held in reserve by state, city, and county health programs must be transferred to the Minnesota Health Fund when the Minnesota Health Plan replaces those programs.

(c) The board shall have provisions in place to insure the Minnesota Health Plan against unforeseen expenditures or revenue shortfalls not covered by the reserve account. The board may borrow money to cover temporary shortfalls.

Subd. 6. **Assets of the Minnesota Health Plan; functions of the commissioner of Minnesota Management and Budget.** All money received by the Minnesota Health Fund shall be paid to the commissioner of Minnesota Management and Budget as agent of the board who shall not commingle these funds with any other money. The money in these accounts shall be paid out on warrants drawn by the commissioner on requisition by the board.

Subd. 7. **Management.** The Minnesota Health Fund shall be separate from the state treasury. Management of the fund shall be conducted by the Minnesota Health Board, which has exclusive authority over the fund.

Sec. 2. **[62W.20] REVENUE SOURCES.**

Subdivision 1. **Minnesota Health Plan premium.** (a) The Minnesota Health Board shall:

(1) determine the aggregate cost of providing health care according to this chapter;

(2) develop an equitable and affordable premium structure based on income, including unearned income, and a business health tax;

(3) in consultation with the Department of Revenue, develop an efficient means of collecting premiums and the business health tax; and

(4) coordinate with existing, ongoing funding sources from federal and state programs.

(b) The premium structure must be based on ability to pay.

(c) On or before January 15, 2017, the board shall submit to the governor and the legislature a report on the premium and business health tax structure established to finance the Minnesota Health Plan.

Subd. 2. **Federal receipts.** All federal funding received by Minnesota including the premium subsidies under the Affordable Care Act, Public Law 111-148, as amended by Public Law 111-152, is appropriated to the Minnesota Health Plan Board to be used to administer the Minnesota Health Plan under chapter 62W. Federal funding that is received for implementing and administering the Minnesota Health Plan must be used to provide health care for Minnesota residents.

Subd. 3. **Funds from outside sources.** Institutional providers operating under Minnesota Health Plan operating budgets may raise and expend funds from sources other than the Minnesota Health Plan including private or foundation donors. Contributions to providers in excess of $500,000 must be reported to the board.

Subd. 4. **Governmental payments.** The chief executive officer and, if required under federal law, the commissioners of health, human services, and commerce shall seek all necessary waivers, exemptions, agreements, or legislation so that all current federal payments to the state, including the premium tax credits under the Affordable Care Act, are paid directly to the Minnesota Health Plan. When any required waivers, exemptions, agreements, or legislation are obtained, the Minnesota Health Plan shall assume responsibility for all health care benefits and health care services previously paid for with federal funds. In obtaining the waivers, exemptions, agreements, or legislation, the chief executive officer and, if required, commissioners shall seek from the federal government a contribution for health care services in Minnesota that reflects: medical inflation, the state gross domestic product, the size and age of the population, the number of residents living below the poverty level, and the number of Medicare and VA eligible individuals, and that does not decrease in relation to the federal contribution to other states as a result of the waivers, exemptions, agreements, or savings from implementation of the Minnesota Health Plan.

Subd. 5. **Federal preemption.** (a) The board shall secure a repeal or a waiver of any provision of federal law that preempts any provision of this chapter. The commissioners of health, human services, and commerce shall provide all necessary assistance.

(b) In the section 1332 waiver application, the board shall request to waive any of the following provisions of the Patient Protection and Affordable Care Act, to the extent necessary to implement this act:

(1) United States Code, title 42, sections 18021 to 18024;

(2) United States Code, title 42, sections 18031 to 18033;

(3) United States Code, title 42, section 18071; and

(4) sections 36B and 5000A of the Internal Revenue Code of 1986, as amended.

(c) In the event that a repeal or a waiver of law or regulations cannot be secured, the board shall adopt rules, or seek conforming state legislation, consistent with federal law, in an effort to best fulfill the purposes of this chapter.

(d) The Minnesota Health Plan's responsibility for providing care shall be secondary to existing federal government programs for health care services to the extent that funding for these programs is not transferred to the Minnesota Health Fund or that the transfer is delayed beyond the date on which initial benefits are provided under the Minnesota Health Plan.

Subd. 6. **No cost-sharing.** No deductible, co-payment, coinsurance, or other cost-sharing shall be imposed with respect to covered benefits.

Sec. 3. **[62W.21] SUBROGATION.**

Subdivision 1. **Collateral source.** (a) When other payers for health care have been terminated, health care costs shall be collected from collateral sources whenever medical services provided to an individual are, or may be, covered services under a policy of insurance, or other collateral source available to that individual, or when the individual has a right of action for compensation permitted under law.

(b) As used in this section, collateral source includes:

(1) health insurance policies and the medical components of automobile, homeowners, and other forms of insurance;

(2) medical components of worker's compensation;

(3) pension plans;

(4) employer plans;

(5) employee benefit contracts;

(6) government benefit programs;

(7) a judgment for damages for personal injury;

(8) the state of last domicile for individuals moving to Minnesota for medical care who have extraordinary medical needs; and

(9) any third party who is or may be liable to an individual for health care services or costs.

(c) Collateral source does not include:

(1) a contract or plan that is subject to federal preemption; or

(2) any governmental unit, agency, or service, to the extent that subrogation is prohibited by law. An entity described in paragraph (b) is not excluded from the obligations imposed by this section by virtue of a contract or relationship with a government unit, agency, or service.

(d) The board shall negotiate waivers, seek federal legislation, or make other arrangements to incorporate collateral sources into the Minnesota Health Plan.

Subd. 2. **Notification.** When an individual who receives health care services under the Minnesota Health Plan is entitled to coverage, reimbursement, indemnity, or other compensation from a collateral source, the individual shall notify the health care provider and provide information identifying the collateral source, the nature and extent of coverage

or entitlement, and other relevant information. The health care provider shall forward this information to the board. The individual entitled to coverage, reimbursement, indemnity, or other compensation from a collateral source shall provide additional information as requested by the board.

Subd. 3. **Reimbursement.** (a) The Minnesota Health Plan shall seek reimbursement from the collateral source for services provided to the individual and may institute appropriate action, including legal proceedings, to recover the reimbursement. Upon demand, the collateral source shall pay to the Minnesota Health Fund the sums it would have paid or expended on behalf of the individual for the health care services provided by the Minnesota Health Plan.

(b) In addition to any other right to recovery provided in this section, the board shall have the same right to recover the reasonable value of health care benefits from a collateral source as provided to the commissioner of human services under section 256B.37.

(c) If a collateral source is exempt from subrogation or the obligation to reimburse the Minnesota Health Plan, the board may require that an individual who is entitled to medical services from the source first seek those services from that source before seeking those services from the Minnesota Health Plan.

(d) To the extent permitted by federal law, the board shall have the same right of subrogation over contractual retiree health care benefits provided by employers as other contracts, allowing the Minnesota Health Plan to recover the cost of health care services provided to individuals covered by the retiree benefits, unless arrangements are made to transfer the revenues of the health care benefits directly to the Minnesota Health Plan.

Subd. 4. **Defaults, underpayments, and late payments.** (a) Default, underpayment, or late payment of any tax or other obligation imposed by this chapter shall result in the remedies and penalties provided by law, except as provided in this section.

(b) Eligibility for health care benefits under section 62W.04 shall not be impaired by any default, underpayment, or late payment of any premium or other obligation imposed by this chapter.

ARTICLE 5
PAYMENTS

Section 1. **[62W.05] PROVIDER PAYMENTS.**

Subdivision 1. **General provisions.** (a) All health care providers licensed to practice in Minnesota may participate in the Minnesota Health Plan and other providers as determined by the board.

(b) A participating health care provider shall comply with all federal laws and regulations governing referral fees and fee splitting including, but not limited to, United States Code, title 42, sections 1320a-7b and 1395nn, whether reimbursed by federal funds or not.

(c) A fee schedule or financial incentive may not adversely affect the care a patient receives or the care a health provider recommends.

Subd. 2. **Payments to noninstitutional providers.** (a) The Minnesota Health Board shall establish and oversee a fair and efficient payment system for noninstitutional providers.

(b) The board shall pay noninstitutional providers based on rates negotiated with providers. Rates shall take into account the need to address provider shortages.

(c) The board shall establish payment criteria and methods of payment for care coordination for patients especially those with chronic illness and complex medical needs.

(d) Providers who accept any payment from the Minnesota Health Plan for a covered health care service shall not bill the patient for the covered health care service.

(e) Providers shall be paid within 30 business days for claims filed following procedures established by the board.

Subd. 3. **Payments to institutional providers.** (a) The board shall set annual budgets for institutional providers. These budgets shall consist of an operating and a capital budget. An institution's annual budget shall be set to cover its anticipated health care services for the next year based on past performance and projected changes in prices and health care service levels. The annual budget for each individual institutional provider must be set separately. The board shall not set a joint budget for a group of more than one institutional provider nor for a parent corporation that owns or operates one or more institutional provider.

(b) Providers who accept any payment from the Minnesota Health Plan for a covered health care service shall not bill the patient for the covered health care service.

Subd. 4. **Capital management plan.** (a) The board shall periodically develop a capital investment plan that will serve as a guide in determining the annual budgets of institutional

providers and in deciding whether to approve applications for approval of capital expenditures by noninstitutional providers.

(b) Providers who propose to make capital purchases in excess of $500,000 must obtain board approval. The board may alter the threshold expenditure level that triggers the requirement to submit information on capital expenditures. Institutional providers shall propose these expenditures and submit the required information as part of the annual budget they submit to the board. Noninstitutional providers shall submit applications for approval of these expenditures to the board. The board must respond to capital expenditure applications in a timely manner.

ARTICLE 6
GOVERNANCE

Section 1. Minnesota Statutes 2018, section 14.03, subdivision 2, is amended to read:

Subd. 2. **Contested case procedures.** The contested case procedures of the Administrative Procedure Act provided in sections 14.57 to 14.69 do not apply to (a) proceedings under chapter 414, except as specified in that chapter, (b) the commissioner of corrections, (c) the unemployment insurance program and the Social Security disability determination program in the Department of Employment and Economic Development, (d) the commissioner of mediation services, (e) the Workers' Compensation Division in the Department of Labor and Industry, (f) the Workers' Compensation Court of Appeals, ~~or~~ (g) the Board of Pardons, or (h) the Minnesota Health Plan.

Sec. 2. Minnesota Statutes 2018, section 15A.0815, subdivision 2, is amended to read:

Subd. 2. **Group I salary limits.** The salary for a position listed in this subdivision shall not exceed 133 percent of the salary of the governor. This limit must be adjusted annually on January 1. The new limit must equal the limit for the prior year increased by the percentage increase, if any, in the Consumer Price Index for all urban consumers from October of the second prior year to October of the immediately prior year. The commissioner of management and budget must publish the limit on the department's website. This subdivision applies to the following positions:

Commissioner of administration;

Commissioner of agriculture;

Commissioner of education;

Commissioner of commerce;

Commissioner of corrections;

Commissioner of health;

Chief executive officer of the Minnesota Health Plan;

Commissioner, Minnesota Office of Higher Education;

Commissioner, Housing Finance Agency;

Commissioner of human rights;

Commissioner of human services;

Commissioner of labor and industry;

Commissioner of management and budget;

Commissioner of natural resources;

Commissioner, Pollution Control Agency;

Commissioner of public safety;

Commissioner of revenue;

Commissioner of employment and economic development;

Commissioner of transportation; and

Commissioner of veterans affairs.

Sec. 3. **[62W.06] MINNESOTA HEALTH BOARD.**

Subdivision 1. **Establishment.** The Minnesota Health Board is established to promote the delivery of high quality, coordinated health care services that enhance health; prevent illness, disease, and disability; slow the progression of chronic diseases; and improve personal health management. The board shall administer the Minnesota Health Plan. The board shall oversee:

(1) the Office of Health Quality and Planning under section 62W.09; and

(2) the Minnesota Health Fund under section 62W.19.

Subd. 2. **Board composition.** (a) The board shall consist of 15 members, including a representative selected by each of the five rural regional health planning boards under section 62W.08 and three representatives selected by the metropolitan regional health planning board under section 62W.08. These members shall appoint the following additional members to serve on the board:

(1) one patient member and one employer member; and

(2) five providers that include one physician, one registered nurse, one mental health provider, one dentist, and one facility director.

(b) Each member shall qualify by taking the oath of office to uphold the Minnesota and United States Constitution and to operate the Minnesota Health Plan in the public interest by upholding the underlying principles of this chapter.

Subd. 3. **Term and compensation; selection of chair.** Board members shall serve four years. Board members shall set the board's compensation not to exceed the compensation of Public Utilities Commission members. The board shall select the chair from its membership.

Subd. 4. **Removal of board member.** A board member may be removed by a two-thirds vote of the members voting on removal. After receiving notice and hearing, a member may be removed for malfeasance or nonfeasance in performance of the member's duties. Conviction of any criminal behavior regardless of how much time has lapsed is grounds for immediate removal.

Subd. 5. **General duties.** The board shall:

(1) ensure that all of the requirements of section 62W.01 are met;

(2) hire a chief executive officer for the Minnesota Health Plan who shall be qualified after taking the oath of office specified in subdivision 2 and who shall administer all aspects of the plan as directed by the board;

(3) hire a director for the Office of Health Quality and Planning who shall be qualified after taking the oath of office specified in subdivision 2;

(4) hire a director of the Minnesota Health Fund who shall be qualified after taking the oath of office specified in subdivision 2;

(5) provide technical assistance to the regional boards established under section 62W.08;

(6) conduct necessary investigations and inquiries and require the submission of information, documents, and records the board considers necessary to carry out the purposes of this chapter;

(7) establish a process for the board to receive the concerns, opinions, ideas, and recommendations of the public regarding all aspects of the Minnesota Health Plan and the means of addressing those concerns;

(8) conduct other activities the board considers necessary to carry out the purposes of this chapter;

(9) collaborate with the agencies that license health facilities to ensure that facility performance is monitored and that deficient practices are recognized and corrected in a timely manner;

(10) adopt rules, policies, and procedures as necessary to carry out the duties assigned under this chapter;

(11) establish conflict of interest standards that prohibit providers from receiving any financial benefit from their medical decisions outside of board reimbursement, including any financial benefit for referring a patient for any service, product, or provider, or for prescribing, ordering, or recommending any drug, product, or service;

(12) establish conflict of interest standards related to pharmaceuticals, medical supplies and devices and their marketing to providers so that no provider receives any incentive to prescribe, administer, or use any product or service;

(13) require all electronic health records used by providers be fully interoperable with the open source electronic health records system used by the United States Veterans Administration;

(14) provide financial help and assistance in retraining and job placement to Minnesota workers who may be displaced because of the administrative efficiencies of the Minnesota Health Plan;

(15) ensure that assistance is provided to all workers and communities who may be affected by provisions in this chapter; and

(16) work with the Department of Employment and Economic Development (DEED) to ensure that funding and program services are promptly and efficiently distributed to all affected workers. DEED shall monitor and report on a regular basis on the status of displaced workers.

There is currently a serious shortage of providers in many health care professions, from medical technologists to registered nurses, and many potentially displaced health administrative workers already have training in some medical field. To alleviate these shortages, the dislocated worker support program should emphasize retraining and placement into health care related positions if appropriate. As Minnesota residents, all displaced workers shall be covered under the Minnesota Health Plan.

Subd. 6. **Waiver request duties.** Before submitting a waiver application under section 1332 of the Patient Protection and Affordable Care Act, Public Law Number 111-148, as amended, the board shall do the following, as required by federal law:

(1) conduct or contract for any necessary actuarial analyses and actuarial certifications needed to support the board's estimates that the waiver will comply with the comprehensive coverage, affordability, and scope of coverage requirements in federal law;

(2) conduct or contract for any necessary economic analyses needed to support the board's estimates that the waiver will comply with the comprehensive coverage, affordability, scope of coverage, and federal deficit requirements in federal law. These analyses must include:

(i) a detailed ten-year budget plan; and

(ii) a detailed analysis regarding the estimated impact of the waiver on health insurance coverage in the state;

(3) establish a detailed draft implementation timeline for the waiver plan; and

(4) establish quarterly, annual, and cumulative targets for the comprehensive coverage, affordability, scope of coverage, and federal deficit requirements in federal law.

Subd. 7. **Financial duties.** The board shall:

(1) establish and collect premiums and the business health tax according to section 62W.20, subdivision 1;

(2) approve statewide and regional budgets that include budgets for the accounts in section 62W.19;

(3) negotiate and establish payment rates for providers;

(4) monitor compliance with all budgets and payment rates and take action to achieve compliance to the extent authorized by law;

(5) pay claims for medical products or services as negotiated, and may issue requests for proposals from Minnesota nonprofit business corporations for a contract to process claims;

(6) seek federal approval to bill other states for health care coverage provided to residents from out-of-state who come to Minnesota for long-term care or other costly treatment when the resident's home state fails to provide such coverage, unless a reciprocal agreement with those states to provide similar coverage to Minnesota residents relocating to those states can be negotiated;

(7) administer the Minnesota Health Fund created under section 62W.19;

(8) annually determine the appropriate level for the Minnesota Health Plan reserve account and implement policies needed to establish the appropriate reserve;

(9) implement fraud prevention measures necessary to protect the operation of the Minnesota Health Plan; and

(10) work to ensure appropriate cost control by:

(i) instituting aggressive public health measures, early intervention and preventive care, health and wellness education, and promotion of personal health improvement;

(ii) making changes in the delivery of health care services and administration that improve efficiency and care quality;

(iii) minimizing administrative costs;

(iv) ensuring that the delivery system does not contain excess capacity; and

(v) negotiating the lowest possible prices for prescription drugs, medical equipment, and medical services.

If the board determines that there will be a revenue shortfall despite the cost control measures mentioned in clause (10), the board shall implement measures to correct the shortfall, including an increase in premiums and other revenues. The board shall report to the legislature on the causes of the shortfall, reasons for the inadequacy of cost controls, and measures taken to correct the shortfall.

Subd. 8. **Minnesota Health Board management duties.** The board shall:

(1) develop and implement enrollment procedures for the Minnesota Health Plan;

(2) implement eligibility standards for the Minnesota Health Plan;

(3) arrange for health care to be provided at convenient locations, including ensuring the availability of school nurses so that all students have access to health care, immunizations, and preventive care at public schools and encouraging providers to open small health clinics at larger workplaces and retail centers;

(4) make recommendations, when needed, to the legislature about changes in the geographic boundaries of the health planning regions;

(5) establish an electronic claims and payments system for the Minnesota Health Plan;

(6) monitor the operation of the Minnesota Health Plan through consumer surveys and regular data collection and evaluation activities, including evaluations of the adequacy and

quality of services furnished under the program, the need for changes in the benefit package, the cost of each type of service, and the effectiveness of cost control measures under the program;

(7) disseminate information and establish a health care website to provide information to the public about the Minnesota Health Plan including providers and facilities, and state and regional health planning board meetings and activities;

(8) collaborate with public health agencies, schools, and community clinics;

(9) ensure that Minnesota Health Plan policies and providers, including public health providers, support all Minnesota residents in achieving and maintaining maximum physical and mental health; and

(10) annually report to the chairs and ranking minority members of the senate and house of representatives committees with jurisdiction over health care issues on the performance of the Minnesota Health Plan, fiscal condition and need for payment adjustments, any needed changes in geographic boundaries of the health planning regions, recommendations for statutory changes, receipt of revenue from all sources, whether current year goals and priorities are met, future goals and priorities, major new technology or prescription drugs, and other circumstances that may affect the cost or quality of health care.

Subd. 9. **Policy duties.** The board shall:

(1) develop and implement cost control and quality assurance procedures;

(2) ensure strong public health services including education and community prevention and clinical services;

(3) ensure a continuum of coordinated high-quality primary to tertiary care to all Minnesota residents; and

(4) implement policies to ensure that all Minnesota residents receive culturally and linguistically competent care.

Subd. 10. **Self-insurance.** The board shall determine the feasibility of self-insuring providers for malpractice and shall establish a self-insurance system and create a special fund for payment of losses incurred if the board determines self-insuring providers would reduce costs.

Sec. 4. **[62W.07] HEALTH PLANNING REGIONS.**

A metropolitan health planning region consisting of the seven-county metropolitan area is established. By October 1, 2018, the commissioner of health shall designate five rural

health planning regions from the greater Minnesota area composed of geographically contiguous counties grouped on the basis of the following considerations:

(1) patterns of utilization of health care services;

(2) health care resources, including workforce resources;

(3) health needs of the population, including public health needs;

(4) geography;

(5) population and demographic characteristics; and

(6) other considerations as appropriate.

The commissioner of health shall designate the health planning regions.

Sec. 5. **[62W.08] REGIONAL HEALTH PLANNING BOARD.**

Subdivision 1. **Regional planning board composition.** (a) Each regional board shall consist of one county commissioner per county selected by the county board and two county commissioners per county selected by the county board in the seven-county metropolitan area. A county commissioner may designate a representative to act as a member of the board in the member's absence. Each board shall select the chair from among its membership.

(b) Board members shall serve for four-year terms and may receive per diems for meetings as provided in section 15.059, subdivision 3.

Subd. 2. **Regional health board duties.** Regional health planning boards shall:

(1) recommend health standards, goals, priorities, and guidelines for the region;

(2) prepare an operating and capital budget for the region to recommend to the Minnesota Health Board;

(3) collaborate with local public health care agencies to educate consumers and providers on public health programs, goals, and the means of reaching those goals;

(4) hire a regional health planning director;

(5) collaborate with public health care agencies to implement public health and wellness initiatives; and

(6) ensure that all parts of the region have access to a 24-hour nurse hotline and 24-hour urgent care clinics.

Sec. 6. **[62W.09] OFFICE OF HEALTH QUALITY AND PLANNING.**

Subdivision 1. **Establishment.** The Minnesota Health Board shall establish an Office of Health Quality and Planning to assess the quality, access, and funding adequacy of the Minnesota Health Plan.

Subd. 2. **General duties.** (a) The Office of Health Quality and Planning shall make annual recommendations to the board on the overall direction on subjects including:

(1) the overall effectiveness of the Minnesota Health Plan in addressing public health and wellness;

(2) access to health care;

(3) quality improvement;

(4) efficiency of administration;

(5) adequacy of budget and funding;

(6) appropriateness of payments for providers;

(7) capital expenditure needs;

(8) long-term health care;

(9) mental health and substance abuse services;

(10) staffing levels and working conditions in health care facilities;

(11) identification of number and mix of health care facilities and providers required to best meet the needs of the Minnesota Health Plan;

(12) care for chronically ill patients;

(13) educating providers on promoting the use of advance directives with patients to enable patients to obtain the health care of their choice;

(14) research needs; and

(15) integration of disease management programs into health care delivery.

(b) Analyze shortages in health care workforce required to meet the needs of the population and develop plans to meet those needs in collaboration with regional planners and educational institutions.

(c) Analyze methods of paying providers and make recommendations to improve quality and control costs.

(d) Assist in coordination of the Minnesota Health Plan and public health programs.

Subd. 3. **Assessment and evaluation of benefits.** (a) The Office of Health Quality and Planning shall:

(1) consider health care benefit additions to the Minnesota Health Plan and evaluate them based on evidence of clinical efficacy;

(2) establish a process and criteria by which providers may request authorization to provide health care services and treatments that are not included in the Minnesota Health Plan benefit set, including experimental health care treatments;

(3) evaluate proposals to increase the efficiency and effectiveness of the health care delivery system, and make recommendations to the board based on the cost-effectiveness of the proposals; and

(4) identify complementary and alternative health care modalities that have been shown to be safe and effective.

(b) The board may convene advisory panels as needed.

Sec. 7. **[62W.10] ETHICS AND CONFLICT OF INTEREST.**

(a) All provisions of section 43A.38 apply to employees and the chief executive officer of the Minnesota Health Plan, the members and directors of the Minnesota Health Board, the regional health boards, the director of the Office of Health Quality and Planning, the director of the Minnesota Health Fund, and the ombudsman for patient advocacy. Failure to comply with section 43A.38 shall be grounds for disciplinary action which may include termination of employment or removal from the board.

(b) In order to avoid the appearance of political bias or impropriety, the Minnesota Health Plan chief executive officer shall not:

(1) engage in leadership of, or employment by, a political party or a political organization;

(2) publicly endorse a political candidate;

(3) contribute to any political candidates or political parties and political organizations; or

(4) attempt to avoid compliance with this subdivision by making contributions through a spouse or other family member.

(c) In order to avoid a conflict of interest, individuals specified in paragraph (a) shall not be currently employed by a medical provider or a pharmaceutical, medical insurance,

or medical supply company. This paragraph does not apply to the five provider members of the board.

Sec. 8. **[62W.11] CONFLICT OF INTEREST COMMITTEE.**

(a) The board shall establish a conflict of interest committee to develop standards of practice for individuals or entities doing business with the Minnesota Health Plan, including but not limited to, board members, providers, and medical suppliers. The committee shall establish guidelines on the duty to disclose the existence of a financial interest and all material facts related to that financial interest to the committee.

(b) In considering the transaction or arrangement, if the committee determines a conflict of interest exists, the committee shall investigate alternatives to the proposed transaction or arrangement. After exercising due diligence, the committee shall determine whether the Minnesota Health Plan can obtain with reasonable efforts a more advantageous transaction or arrangement with a person or entity that would not give rise to a conflict of interest. If this is not reasonably possible under the circumstances, the committee shall make a recommendation to the board on whether the transaction or arrangement is in the best interest of the Minnesota Health Plan, and whether the transaction is fair and reasonable. The committee shall provide the board with all material information used to make the recommendation. After reviewing all relevant information, the board shall decide whether to approve the transaction or arrangement.

Sec. 9. **[62W.12] OMBUDSMAN OFFICE FOR PATIENT ADVOCACY.**

Subdivision 1. **Creation of office.** (a) The Ombudsman Office for Patient Advocacy is created to represent the interests of the consumers of health care. The ombudsman shall help residents of the state secure the health care services and health care benefits they are entitled to under the laws administered by the Minnesota Health Board and advocate on behalf of and represent the interests of enrollees in entities created by this chapter and in other forums.

(b) The ombudsman shall be a patient advocate appointed by the governor, who serves in the unclassified service and may be removed only for just cause. The ombudsman must be selected without regard to political affiliation and must be knowledgeable about and have experience in health care services and administration.

(c) The ombudsman may gather information about decisions, acts, and other matters of the Minnesota Health Board, health care organization, or a health care program. A person may not serve as ombudsman while holding another public office.

(d) The budget for the ombudsman's office shall be determined by the legislature and is independent from the Minnesota Health Board. The ombudsman shall establish offices to provide convenient access to residents.

(e) The Minnesota Health Board has no oversight or authority over the ombudsman for patient advocacy.

Subd. 2. **Ombudsman's duties.** The ombudsman shall:

(1) ensure that patient advocacy services are available to all Minnesota residents;

(2) establish and maintain the grievance process according to section 62W.13;

(3) receive, evaluate, and respond to consumer complaints about the Minnesota Health Plan;

(4) establish a process to receive recommendations from the public about ways to improve the Minnesota Health Plan;

(5) develop educational and informational guides according to communication services under section 15.441, describing consumer rights and responsibilities;

(6) ensure the guides in clause (5) are widely available to consumers and specifically available in provider offices and health care facilities; and

(7) prepare an annual report about the consumer perspective on the performance of the Minnesota Health Plan, including recommendations for needed improvements.

Sec. 10. **[62W.13] GRIEVANCE SYSTEM.**

Subdivision 1. **Grievance system established.** The ombudsman shall establish a grievance system for complaints. The system shall provide a process that ensures adequate consideration of Minnesota Health Plan enrollee grievances and appropriate remedies.

Subd. 2. **Referral of grievances.** The ombudsman may refer any grievance that does not pertain to compliance with this chapter to the federal Centers for Medicare and Medicaid Services or any other appropriate local, state, and federal government entity for investigation and resolution.

Subd. 3. **Submittal by designated agents and providers.** A provider may join with, or otherwise assist, a complainant to submit the grievance to the ombudsman. A provider or an employee of a provider who, in good faith, joins with or assists a complainant in submitting a grievance is subject to the protections and remedies under sections 181.931 to 181.935.

Subd. 4. **Review of documents.** The ombudsman may require additional information from health care providers or the board.

Subd. 5. **Written notice of disposition.** The ombudsman shall send a written notice of the final disposition of the grievance, and the reasons for the decision, to the complainant, to any provider who is assisting the complainant, and to the board, within 30 calendar days of receipt of the request for review unless the ombudsman determines that additional time is reasonably necessary to fully and fairly evaluate the relevant grievance. The ombudsman's order of corrective action shall be binding on the Minnesota Health Plan. A decision of the ombudsman is subject to de novo review by the district court.

Subd. 6. **Data.** Data on enrollees collected because an enrollee submits a complaint to the ombudsman are private data on individuals as defined in section 13.02, subdivision 12, but may be released to a provider who is the subject of the complaint or to the board for purposes of this section.

Sec. 11. **[62W.14] AUDITOR GENERAL FOR THE MINNESOTA HEALTH PLAN.**

Subdivision 1. **Establishment.** There is within the Office of the Legislative Auditor an auditor general for health care fraud and abuse for the Minnesota Health Plan who is appointed by the legislative auditor.

Subd. 2. **Duties.** The auditor general shall:

(1) investigate, audit, and review the financial and business records of the Minnesota Health Plan and the Minnesota Health Fund;

(2) investigate, audit, and review the financial and business records of individuals, public and private agencies and institutions, and private corporations that provide services or products to the Minnesota Health Plan, the costs of which are reimbursed by the Minnesota Health Plan;

(3) investigate allegations of misconduct on the part of an employee or appointee of the Minnesota Health Board and on the part of any provider of health care services that is reimbursed by the Minnesota Health Plan, and report any findings of misconduct to the attorney general;

(4) investigate fraud and abuse;

(5) arrange for the collection and analysis of data needed to investigate the inappropriate utilization of these products and services; and

(6) annually report recommendations for improvements to the Minnesota Health Plan to the board.

Sec. 12. **[62W.15] MINNESOTA HEALTH PLAN POLICIES AND PROCEDURES; RULEMAKING.**

Subdivision 1. **Exempt rules.** The Minnesota Health Plan policies and procedures are exempt from the Administrative Procedure Act but, to the extent authorized by law to adopt rules, the board may use the provisions of section 14.386, paragraph (a), clauses (1) and (3). Section 14.386, paragraph (b), does not apply to these rules.

Subd. 2. **Rulemaking procedures.** (a) Whenever the board determines that a rule should be adopted under this section establishing, modifying, or revoking a policy or procedure, the board shall publish in the State Register the proposed policy or procedure and shall afford interested persons a period of 30 days after publication to submit written data or comments.

(b) On or before the last day of the period provided for the submission of written data or comments, any interested person may file with the board written objections to the proposed rule, stating the grounds for objection and requesting a public hearing on those objections. Within 30 days after the last day for filing objections, the board shall publish in the State Register a notice specifying the policy or procedure to which objections have been filed and a hearing requested and specifying a time and place for the hearing.

Subd. 3. **Rule adoption.** Within 60 days after the expiration of the period provided for the submission of written data or comments, or within 60 days after the completion of any hearing, the board shall issue a rule adopting, modifying, or revoking a policy or procedure, or make a determination that a rule should not be adopted. The rule may contain a provision delaying its effective date for such period as the board determines is necessary.

Sec. 13. **[62W.151] EXEMPTION FROM RULEMAKING.**

The board and its operation of the Minnesota Health Plan and the Minnesota Health Fund is exempt from rulemaking under chapter 14.

Sec. 14. Minnesota Statutes 2018, section 14.03, subdivision 3, is amended to read:

Subd. 3. **Rulemaking procedures.** (a) The definition of a rule in section 14.02, subdivision 4, does not include:

(1) rules concerning only the internal management of the agency or other agencies that do not directly affect the rights of or procedures available to the public;

(2) an application deadline on a form; and the remainder of a form and instructions for use of the form to the extent that they do not impose substantive requirements other than requirements contained in statute or rule;

(3) the curriculum adopted by an agency to implement a statute or rule permitting or mandating minimum educational requirements for persons regulated by an agency, provided the topic areas to be covered by the minimum educational requirements are specified in statute or rule;

(4) procedures for sharing data among government agencies, provided these procedures are consistent with chapter 13 and other law governing data practices.

(b) The definition of a rule in section 14.02, subdivision 4, does not include:

(1) rules of the commissioner of corrections relating to the release, placement, term, and supervision of inmates serving a supervised release or conditional release term, the internal management of institutions under the commissioner's control, and rules adopted under section 609.105 governing the inmates of those institutions;

(2) rules relating to weight limitations on the use of highways when the substance of the rules is indicated to the public by means of signs;

(3) opinions of the attorney general;

(4) the data element dictionary and the annual data acquisition calendar of the Department of Education to the extent provided by section 125B.07;

(5) the occupational safety and health standards provided in section 182.655;

(6) revenue notices and tax information bulletins of the commissioner of revenue;

(7) uniform conveyancing forms adopted by the commissioner of commerce under section 507.09;

(8) standards adopted by the Electronic Real Estate Recording Commission established under section 507.0945; ~~or~~

(9) the interpretive guidelines developed by the commissioner of human services to the extent provided in chapter 245A.~~;~~ or

(10) rules, policies, and procedures adopted by the Minnesota Health Board under chapter 62W.

ARTICLE 7
IMPLEMENTATION

Section 1. **APPROPRIATION.**

$..... in fiscal year 2020 is appropriated from the general fund to the Minnesota Health Fund under the Minnesota Health Plan to provide start-up funding for the provisions of chapter 62W.

Sec. 2. **EFFECTIVE DATE AND TRANSITION.**

Subdivision 1. **Effective date.** This act is effective the day following final enactment. The commissioner of management and budget and the chief executive officer of the Minnesota Health Plan shall regularly update the legislature on the status of planning, implementation, and financing of this act.

Subd. 2. **Timing to implement.** The Minnesota Health Plan must be operational within two years from the date of final enactment of this act.

Subd. 3. **Prohibition.** On and after the day the Minnesota Health Plan becomes operational, a health plan, as defined in Minnesota Statutes, section 62Q.01, subdivision 3, may not be sold in Minnesota for services provided by the Minnesota Health Plan.

Subd. 4. **Transition.** (a) The commissioners of health, human services, and commerce shall prepare an analysis of the state's capital expenditure needs for the purpose of assisting the board in adopting the statewide capital budget for the year following implementation. The commissioners shall submit this analysis to the board.

(b) The following timelines shall be implemented:

(1) the commissioner of health shall designate the health planning regions utilizing the criteria specified in Minnesota Statutes, section 62W.07, 30 days after the date of enactment of this act;

(2) the regional boards shall be established three months after the date of enactment of this act; and

(3) the Minnesota Health Board shall be established five months after the date of enactment of this act; and

(4) the commissioner of health, or the commissioner's designee, shall convene the first meeting of each of the regional boards and the Minnesota Health Board within 30 days after each of the boards has been established.

Subd. 5. **Report.** Within one year of the effective date of chapter 62W, DEED shall provide to the Minnesota Health Board, the governor, and the chairs and ranking members of the legislative committees with jurisdiction over health, human services, and commerce a report spelling out the appropriations and legislation necessary to assist all affected individuals and communities through the transition.

Council Regular Meeting

DATE: 5/11/2020

TO: City Council
FROM: Curt Boganey, City Manager
THROUGH: N/A
BY: Meg Beekman, Community Development Director

SUBJECT: Resolution Authorizing Letter of Support for Legislation to Provide Funding for Small Businesses

Background:

In March the state funded the Small Business Emergency Loan Program with a $30 million appropriation for businesses impacted by Executive Orders 20-04 and 20-08. DEED immediately began administering the program, and to date $17 million has been loaned out, with funds evenly split between metro and greater Minnesota.

The program, as it is currently operated, allows certain eligible small businesses in Minnesota to borrow up to $35,000 with no interest and no payments for six months. After the six month deferment period, loans must be paid back monthly over five years. Up to 50 percent of the loan may be forgiven if the business remains operating for two years following loan disbursement. Applicants are required to provide collateral or a personal guarantee for at least 20 percent of the loan amount.
Criticisms of the program have been that it treats all small businesses, regardless of size, the same and does not take into account the unique challenges the very smallest businesses may face in meeting the application criteria. Further, many immigrant and POCI-owned businesses face additional barriers to accessing financial resources, which were not addressed with how the program was designed and administered which has led to disparate outcomes in the distribution of funds.

Another criticism of the program is related to the timing of the Executive Orders and has led to certain businesses being excluded. The program was created under Executive Order 20-15, which refers to businesses closed under previous orders 20-04 and 20-08 specifically. Those Executive Orders closed restaurants, bars, coffee shops, indoor health clubs, tattoo parlors, beauty salons, nail shops, entertainment venues, and other places of public accommodation. Later, Executive Order 20-20 issued a Stay-at-Home order, closing non-essential businesses such as flower shops, tobacco shops, clothing stores, and other office, service-oriented and retail establishments not considered essential or already closed. Because these businesses are not included in Executive Order 20-15, they are not been eligible for the state's Small Business Emergency Loan Program. This leaves out a large number of Minnesota businesses. The House has proposed a bill (HF1507) to resupply the Small Business Emergency Loan Program with $50 million of additional funds from the state's appropriation of federal CARES act funding. The bill proposes a number of amendments to the program designed to address the concerns which have been raised. The alterations to the program would include:

- Earmarked funds specific to varying sizes of small businesses with loan terms and forgiveness terms tailored to fit the needs and capacity of businesses of that size

- Earmarked funds available only to minority-owned businesses

- Earmarked funds available for operators of retail space with a strong ethnic cultural orientation that is leased primarily to small businesses provided the funds are used to maintain existing vendors as tenants

The Senate has also proposed a bill (SF4481) to resupply the Small Business Emergency Loan Program with an additional $30 million. $20 million from the state's General Fund and $10 million from the states allocation of CARES Act funds. The bill would require that $8 million of the additional funds go towards grants up to $10,000 to businesses with six to ten employees, and $2 million go towards grants for businesses with five or fewer employees. The bill does not propose any other changes to the program.

Both bills are currently moving through committee. Neither bill proposes to broaden the list of businesses eligible for funds to include those businesses affected by Executive Order 20-20.

Budget Issues:

There are no budget issues related to this item.

Strategic Priorities and Values:

Resident Economic Stability

ATTACHMENTS:

Description	Upload Date	Type
Resolution	5/7/2020	Resolution Letter
House Bill	5/7/2020	Backup Material
Senate Bill	5/7/2020	Backup Material

Councilmember _____ introduced the following resolution and moved its adoption:

CITY COUNCIL RESOLUTION NO. _____

RESOLUTION AUTHORIZING A LETTER OF SUPPORT FOR LEGISLATION REGARDING FUNDING FOR SMALL BUSINESSES

WHEREAS, the spread of COVID-19 and the resulting emergency declarations and emergency orders issued by the Governor have created a great deal of uncertainty and has dramatically impacted local businesses, particularly small businesses; and

WHEREAS, the City has many micro businesses, many owned by immigrants and people of color, that are a critical part of the economic vitality of the City are the businesses that have been hit particularly hard by this emergency; and

WHEREAS, On March 23, 2020, Governor Walz issued Executive Order 20-15, creating the Small Business Emergency Loan Program with a $30 million appropriation for businesses impacted by Executive Orders 20-04 and 20-08; and

WHEREAS, The Minnesota Department of Employment and Economic Development has been administering the program, and issued $17 million of loans to date; and

WHEREAS, The state legislature is now considering separate House and Senate bills to appropriate additional funds to the program and make amendments to the program

NOW, THEREFORE, BE IT RESOLVED, by the City Council of the City of Brooklyn Center, Minnesota, that the City Council hereby authorizes the Mayor to provide a letter of support on behalf of the City for legislation that supports and provides funding for small businesses, and further encourages the legislature to ensure the following program elements are included:

1. Established funds for minority-owned businesses

2. Established funds for businesses of varying sizes with separate loan and forgiveness criteria appropriate to the needs and capacity of those businesses

3. Small businesses affected by closures due to all Executive Orders be eligible for funding

May 11, 2020 _____
Date

_____
Mayor

ATTEST: _____
City Clerk

RESOLUTION NO. _____

The motion for the adoption of the foregoing resolution was duly seconded by member _____

and upon vote being taken thereon, the following voted in favor thereof:

and the following voted against the same:

whereupon said resolution was declared duly passed and adopted.

..... moves to amend H.F. No. 1507, the first engrossment, as follows:

Delete everything after the enacting clause and insert:

"Section 1. **SMALL BUSINESS EMERGENCY LOAN PROGRAM; TRANSFER.**

$5,000,000 in fiscal year 2020 is transferred from the loan guarantee trust fund account in the special revenue fund under Minnesota Statutes, section 116J.881, subdivision 4, to the commissioner of employment and economic development for deposit in the small business emergency loan account in the special revenue fund under Minnesota Statutes, section 116M.18, subdivision 9, to make loans as set forth in governor's Executive Order No. 20-15, Providing Immediate Relief to Small Businesses During the COVID-19 Peacetime Emergency.

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

Sec. 2. **SMALL BUSINESS EMERGENCY LOAN PROGRAM; APPROPRIATIONS.**

(a) $50,000,000 in fiscal year 2020 is appropriated from the federal funds received by the state of Minnesota under the Coronavirus Aid, Relief, and Economic Security Act, Public Law 116-136, Title V, to the commissioner of employment and economic development for loans under paragraph (c). The appropriation in this paragraph is reduced by any amount appropriated in paragraph (b). Funds are available until December 31, 2020.

(b) If the appropriation in paragraph (a) is unable to be made before May 15, 2020, then $50,000,000 in fiscal year 2020 is appropriated from the general fund to the commissioner of employment and economic development for loans under paragraph (c). Funds are available until December 31, 2020.

(c) Money appropriated under paragraph (a) or (b) shall be used to make loans as set forth in governor's Executive Order No. 20-15, Providing Immediate Relief to Small Businesses During the COVID-19 Peacetime Emergency. Of the $50,000,000 appropriated:

(1) $11,000,000 is for making loans as specified in paragraph (d);

(2) $8,000,000 is for making loans as specified in paragraph (e); and

(3) $10,000,000 is for making loans as specified in paragraph (f).

(d) Loans under this paragraph are available only to businesses employing no more than the equivalent of six full-time persons in Minnesota. The terms of these loans will be the same as those under Executive Order No. 20-15, except that:

(1) the maximum loan amount is $15,000;

(2) payments on loans are deferred for 12 months instead of six; and

(3) up to 100 percent of the loan may be forgiven if the commissioner approves and the business continues operating in the community at substantially the same levels for two years following loan disbursement.

(e) Loans under this paragraph are available only to businesses employing the equivalent of at least seven but not more than 20 full-time persons in Minnesota. The terms of these loans will be the same as those under Executive Order No. 20-15, except that:

(1) the maximum loan amount is $20,000;

(2) payments on loans are deferred for 12 months instead of six; and

(3) up to an additional 25 percent of the loan may be forgiven if the commissioner approves and the business continues operating in the community at substantially the same levels for a third year following loan disbursement.

(f) Loans under this paragraph are available only to:

(1) minority business enterprises, as defined in Minnesota Statutes, section 116M.14, subdivision 5; or

(2) operators of permanent indoor retail space that has a strong ethnic cultural orientation and is leased primarily to very small businesses.

The terms of these loans will be the same as those under Executive Order No. 20-15, except that for loans under clause (2):

(i) there is no maximum loan amount;

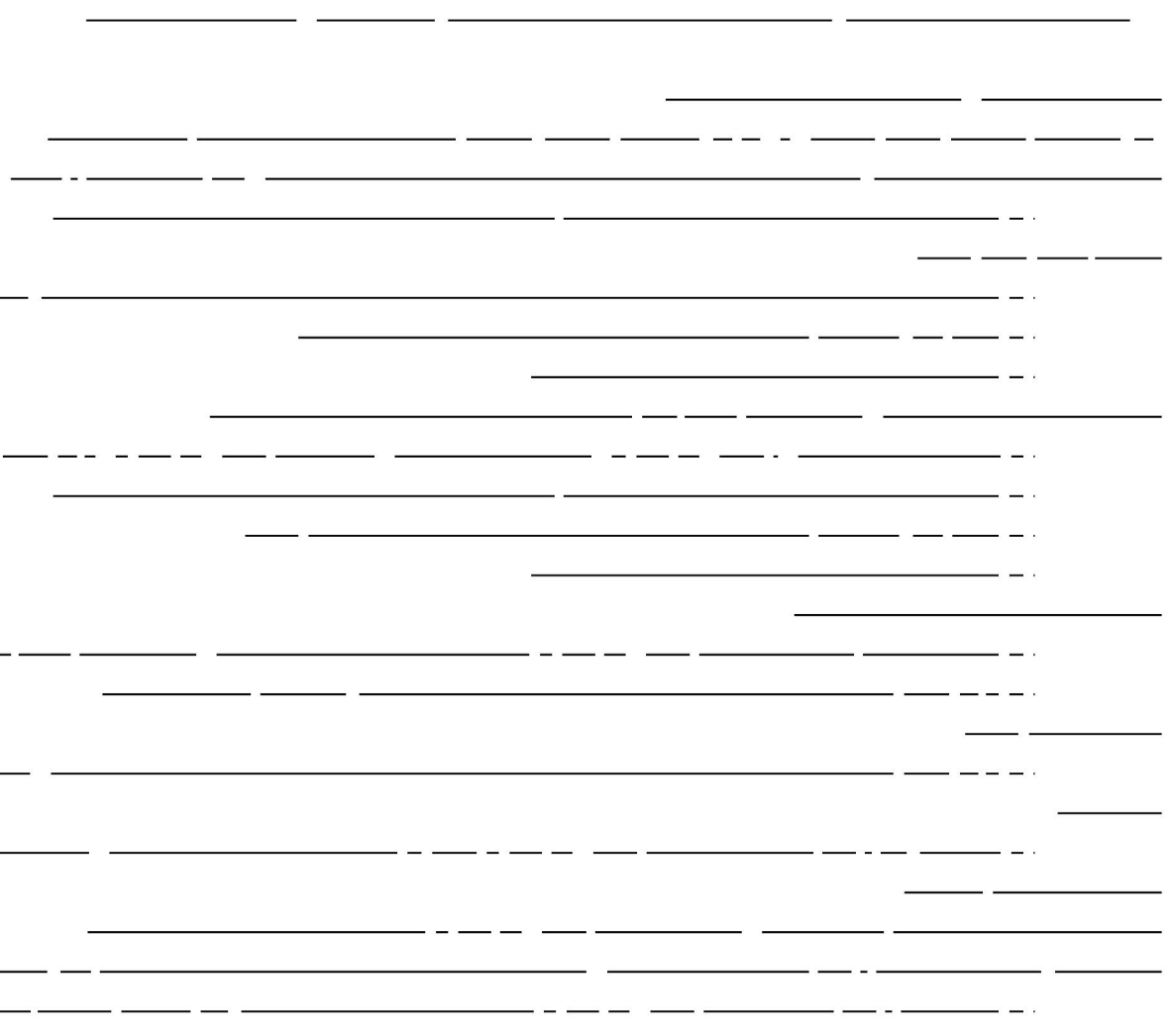
(ii) payments on loans are deferred for 12 months instead of six;

(iii) up to an additional 25 percent of the loan may be forgiven if the commissioner approves and the business continues operating in the community at substantially the same levels for a third year following loan disbursement, however, no part of the loan may be forgiven unless the loan recipient has offered forgiveness of at least 50 percent of rent due from existing vendors during the COVID-19 peacetime emergency; and

(iv) loan funds must be used primarily for maintaining existing vendors as tenants, such as through full or partial forgiveness of rent during the COVID-19 peacetime emergency.

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

Amend the title accordingly



Council Regular Meeting

DATE: 5/11/2020

TO: City Council
FROM: Curt Boganey, City Manager
THROUGH: N/A
BY: Tim Gannon, Police Chief

SUBJECT: Recognition of Police Week and Peace Officer's Memorial Day

Background:

Congress and the President of the United States has designated May 15 as Peace Officers Memorial Day, and the week in which it falls as Police Week. Observance of Police Week and Peace Officers Memorial Day will help recognize our Brooklyn Center Police Department and other law enforcement agencies, as well as officers who died or were disabled in the line of duty

Budget Issues:

No budget issues

Strategic Priorities and Values:

Safe, Secure, Stable Community

ATTACHMENTS:

Description	Upload Date	Type
Resolution Police Week	5/4/2020	Cover Memo

Member introduced the following resolution and moved its adoption:

RESOLUTION NO.

RESOLUTION RECOGNIZING MAY 10 THROUGH MAY 16, 2020 AS POLICE WEEK AND MAY 15, 2020, AS POLICE OFFICERS MEMORIAL DAY

WHEREAS, the Congress and President of the United States has designated May 15 as Peace Officers Memorial Day, and the week in which it falls as Police Week; and

WHEREAS, the members of the law enforcement agency of Brooklyn Center play an essential role in safeguarding the rights and freedoms of the citizens of Brooklyn Center; and

WHEREAS, it is important that all citizens know and understand the problems, duties and responsibilities of their police department, and that members of our police department recognize their duty to serve the people by safeguarding life and property, by protecting them against violence or disorder, and by protecting the innocent against deception and the weak against oppression or intimidation; and

WHEREAS, the police department of Brooklyn Center has grown to be a modern and scientific law enforcement agency which unceasingly provides a vital public service.

NOW, THEREFORE, BE IT RESOLVED by the City Council of the City of Brooklyn Center, Minnesota, that the citizens of Brooklyn Center and all patriotic, civil and educational organizations be called upon to observe the week of May 10 through 16, 2020, as Police Week with appropriate ceremonies in which all of our people may join in commemorating police officers, past and present, who by their faithful and loyal devotion to their responsibilities have rendered a dedicated service to their communities and, in doing so, have established for themselves an enviable and enduring reputation for preserving the rights and security of all citizens.

FURTHER, be it resolved that all citizens of Brooklyn Center be called upon to observe Friday, May 15, 2020 as Peace Officers Memorial Day in honor of those peace officers who, through their courageous deeds, have lost their lives or have become disabled in the performance of duty.

_____ _____

Date Mayor

ATTEST: _____

City Clerk

RESOLUTION NO. _____

The motion for the adoption of the foregoing resolution was duly seconded by member

and upon vote being taken thereon, the following voted in favor thereof:

and the following voted against the same:
whereupon said resolution was declared duly passed and adopted.

Council Regular Meeting

DATE: 5/11/2020

TO: City Council
FROM: Curt Boganey, City Manager
THROUGH: N/A
BY: Tim Gannon, Chief of Police

SUBJECT: The 2020 Biennial Body Worn Camera Audit

Background:

The State of Minnesota requires all police agencies that use body worn cameras (BWC) to conduct an independent audit of policy and practice every two years. The department had an independent auditor review and then complete and audit report.

The City Council and the Legislative Commission on Data Practices and Personal Data Privacy are to be given the results within 60 days. The Commission has received the findings and a PowerPoint presentation has been prepared to give to the City Council.

Budget Issues:

No Council policy issue to consider

Strategic Priorities and Values:

Safe, Secure, Stable Community

ATTACHMENTS:

Description	Upload Date	Type
Audit Results	5/6/2020	Backup Material
Powerpoint	5/6/2020	Presentation

INDEPENDENT AUDIT REPORT

Chief Tim Gannon
Brooklyn Center Police Department
6645 Humboldt Ave. No.
Brooklyn Center, MN 55430

Dear Chief Gannon:

An independent audit of the Brooklyn Center Police Department's Portable Recording System (body-worn cameras (BWCs)) was conducted of August 2, 2019. The objective of the audit was to verify Brooklyn Center Police Department's compliance with Minnesota Statutes §§13.825 and 626.8473.

Data elements the audit includes:

Minnesota Statute §13.825

- Data Classification
- Retention of Data
- Access by Data Subjects
- Inventory of Portable Recording System Technology
- Use of Agency-Issued Portable Recording Systems
- Authorization to Access Data
- Sharing Among Agencies

Minnesota Statute §626.8473

- Public Comment
- Body-worn Camera Policy

The Brooklyn Center Police Department is located in Hennepin County, Minnesota and employs forty-nine (49) peace officers. The Brooklyn Center Police Department utilizes Panasonic Arbitrator body-worn cameras and software and stores the BWC data on a local file server.

Audit Requirement: Data Classification

Determine that the data collected by BWCs are appropriately classified.

Brooklyn Center BWC data is presumptively private. All data collected during the time period August 1, 2017, through July 31, 2019, is classified as private or non-public data. The Brooklyn Center Police Department had no instances of the discharge of a firearm by a peace officer, use of force that resulted in substantial bodily harm, requests from data subjects for the data to be made accessible to the public, or court orders directing the agency to release the BWC data to the public. Public data classifications would be documented in the Notes field of the Arbitrator 360° Back-End Client.

No discrepancies noted.

Audit Requirement: Retention of Data

Determine that the data collected by BWC's are appropriately retained and destroyed in accordance with statutes.

The Brooklyn Center Police Department utilizes the General Records Retention Schedule for Minnesota Cities and agency specified retention periods in the Arbitrator 360° Back-End Client software system. Either during, or at the conclusion of a BWC recording, an Arbitrator classification is assigned. Each Arbitrator classification has an associated retention period. Upon reaching the retention date, data is systematically deleted. All BWC data is maintained for at least 90 days. Retention periods listed in the Brooklyn Center Police Department's BWC policy are inconsistent with classification retention in the Arbitrator 360° software.

Random active videos were selected in the Arbitrator 360° Back-End Client and from a report produced out of the Arbitrator 360° Back-End Client and verified against the system retention rules. Each record selected was appropriately scheduled for deletion based on the classification assigned. Records selected were from the time period August 1, 2017, through July 31, 2019. BWC video, meta data, and audit trails are purged from the Arbitrator 360° Back-End Client upon reaching the specified retention period. A server log report details that BWC data existed and was deleted from the server, but the report does not include a classification in order to determine if deleted data was appropriately destroyed.

The Brooklyn Center Police Department has not received a request from a data subject to retain BWC data beyond the applicable retention period.

Discrepancies noted.

Audit Requirement: Access by Data Subjects

Determine that individuals who are the subject of collected data have access to the data, and if the data subject requests a copy of the data, other individuals who do not consent to its release must be redacted.

BWC data is available and access may be requested by on-line request form, by email, or in person. During the time period August 1, 2017 through July 31, 2019, the Brooklyn Center Police Department had no requests to view BWC data but did fulfill requests for copies of BWC data from data subjects. Data subjects other than the requestor were redacted using third party redaction software. Requests for, or access to, BWC data are documented in the case file meta data in the Laserfiche document imaging system. The assigned Records Manager is responsible for reviewing data prior to its release.

No discrepancies noted.

Audit Requirement: Inventory of Portable Recording System Technology

Determine the total number of recording devices owned and maintained by the agency; a daily record of the total number of recording devices actually deployed and used by officers, the policies and procedures for use of portable recording systems by required by section 626.8473; and the total amount of recorded audio and video collected by the portable recording system and maintained by the agency, the agency's retention schedule for the data, the agency's procedures for destruction of the data, and that the data are available to the public.

Brooklyn Center Police Department's BWC inventory consists of 40 devices. Devices are assigned to individual officers. The Brooklyn Center Police Department BWC policy requires patrol officers to wear BWC's while on duty. Sergeants monitor deployment and use by officers. A review of randomly selected dates from the patrol schedule were verified against active videos in Arbitrator 360° Back-End Client and a server log report and confirmed that BWCs are being worn and activated. The report of active BWC data produced from Arbitrator shows a consistent number of active videos in each quarter of 2018 and 2019.

A copy of the Brooklyn Center Police Department's Policy on BWCs is posted on the City's website.

The Arbitrator 360° Back-End Client, the Arbitrator report of active BWC data, and the server log report of deleted BWC data summarize the total amount of BWC data created, deleted, and stored/maintained.

The Brooklyn Center Police Department utilizes the General Records Retention Schedule for Minnesota Cities and agency specified retention in Arbitrator 360°.

BWC video is fully deleted from the Arbitrator 360° Back-End Client and local file server upon reaching the scheduled deletion date. Meta data and audit trail information associated to the deleted video is not maintained in the Arbitrator 360° Back-End Client.

BWC data is available upon request, and access may be requested by on-line request form, email or in person.

No discrepancies noted.

Audit Requirement: Use of Agency-Issued Portable Recording Systems

Determine if peace officers are only allowed to use portable recording systems issued and maintained by the officer's agency.

The Brooklyn Center Police Department's BWC policy states that officers who are issued mobile video recorders (MVR) as part of their uniform, wear and activate the MVR consistent with policy. The policy does not state that officers are only allowed to use agency issued portable recording systems issued and maintained by the agency.

Discrepancy noted.

Audit Requirement: Authorization to Access Data

Determine if the agency complies with sections 13.05, Subd. 5, and 13.055 in the operation of portable recording systems and in maintaining portable recording system data.

Command staff conducted monthly audits throughout 2018 to assess use of and proper categorization of BWC data. Sergeants and Command staff review all videos relating to resistance. The operation of BWC use by new employees is assessed and reviewed no less than monthly.

User access to BWC data is managed by the assignment of group roles and permissions in Arbitrator. Permissions are based on staff work assignments. The patrol commander is responsible for managing the assignment of user rights.

Agency personnel are prohibited from accessing BWC data for non-business reasons and from sharing the data for non-law-enforcement-related purposes. The agency's BWC policy governs access to, and sharing of, data. Access is to BWC data is captured in the audit trail.

When BWC data is deleted from Arbitrator, its contents cannot be determined.

The Brooklyn Center Police Department has had no security breaches.

No discrepancies noted.

Audit Requirement: Sharing Among Agencies

Determine if non public BWC data is shared with other law enforcement agencies, government entities, or federal agencies.

The Brooklyn Center Police Department's BWC policy allows for the sharing of data with other law enforcement agencies for legitimate law enforcement purposes only and for the sharing of data with prosecutors. Sharing of data is documented in writing at the time of disclosure in Laserfiche case file meta data.

No discrepancies noted.

Audit Requirement: Biennial Audit

Determine if the agency maintains records showing the date and time the portable recording system data were collected, the applicable classification of the data, how the data are used, and whether data are destroyed as required.

The Arbitrator 360° Back-End Client, Arbitrator report, and a database server log report document the date and time portable recording system data was collected. All BWC data for the audit period is classified as private or non-public data. Laserfiche meta data documents how the

data are used and shared. Active BWC data within the Arbitrator 360° Back-End Client includes a classification with an associated retention period and a scheduled deletion data.

No discrepancies noted.

Audit Requirement: Portable Recording System Vendor

Determine if portable recording system data stored in the cloud, is stored in accordance with security requirements of the United States Federal Bureau of Investigation Criminal Justice Information Services Division Security Policy 5.4 or its successor version.

Brooklyn Center Police Department BWC data is stored on a local file server in the Police Department and is backed up on a daily basis. A security audit was in process at the time of this audit.

No discrepancies noted.

Audit Requirement: Public Comment

Determine if the law enforcement agency provided an opportunity for public comment before it purchased or implemented a portable recording system and if the governing body with jurisdiction over the budget of the law enforcement agency provided an opportunity for public comment at a regularly scheduled meeting.

The Brooklyn Center Police Department solicited public comment prior to purchase and implementation of the body worn camera program. Public comment was solicited on the department's Facebook page and at multiple community meetings commencing in 2016. The Brooklyn Center City Council held a public hearing at their regularly scheduled meeting on March 13, 2017. The body worn camera program was implemented August 1, 2017.

No discrepancies noted.

Audit Requirement: Body-worn Camera Policy

Determine if a written policy governing the use of portable recording systems has been established and is enforced.

The Brooklyn Center Police Department's BWC policy is posted on the agency's website. The policy was compared to the requirements of Minn. Stat. § 626.8473. The agency's policy includes all minimum requirements of Minn. Stat. § 626.8473, Subd. 3.

No discrepancies noted.

This report was prepared exclusively for the City of Brooklyn Center and Brooklyn Center Police Department by Lynn Lembcke Consulting. The findings in this report are impartial and based on information and documentation provided and examined.

Dated: March 22, 2020

Lynn Lembcke Consulting



Lynn Lembcke

Portable Recording System Independent Audit

City Council Meeting, **Date**
Tim Gannon, Police Chief

BCPD Body Worn Cameras (BWCs)

- BCPD officially began using BWCs on 08/1/2017. This was following a brief test and evaluation period by a small group of officers.
- MN State Statute 13.825 Subd. 9 requires a biennial audit of portable recording systems, covering a wide variety of aspects of collection, handling, and retention of video.
- On 08/02/2019 an independent audit was conducted.
- On 03/22/2020 the results of the audit were received by BCPD.

Biennial Audit

MN State Statute 13.825, Subdivision 9

Audit Requirements	Results
Data Classification	No discrepancies noted.
Retention of Data	*Discrepancies noted.*
Access by Data Subjects	No discrepancies noted.
Inventory of Portable Recording System Technology	No discrepancies noted.
Use of Agency-Issued Portable Recording Systems	*Discrepancies noted.*
Authorization to Access Data	No discrepancies noted.

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Biennial Audit

MN State Statute 13.825, Subdivision 9

Audit Requirements	Results
Sharing Among Agencies	No discrepancies noted.
Biennial Audit	No discrepancies noted.
Portable Recording System Vendor	No discrepancies noted.
Public Comment	No discrepancies noted.
Body-Worn Camera Policy	No discrepancies noted.

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3 Listed Discrepancies

1. Retention periods listed in the Brooklyn Center Police Department's BWC policy are inconsistent with classification retention in the Arbitrator 360 software.
2. A server log report details that BWC data existed and was deleted from the server, but the report does not include a classification in order to determine if deleted data was appropriately destroyed.
3. The policy does not state that officers are only allowed to use agency issued portable recording systems issued and maintained by the agency.

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Discrepancy #1

Retention periods listed in the Brooklyn Center Police Department's BWC policy are inconsistent with classification retention in the Arbitrator 360 software.

- In 2017, BCPD updated it's BWC video classification retention categories to better align with squad and interview room video categories.
- Once the changes were made, the videos classified under the original categories (some of which no longer existed) for future videos, remained saved under their original category labels, for the remainder of their specific retention periods.

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Significant changes to classification labels once BWCs were fully implemented.

Previous Classification Label	New Classification Label
AOA	AOA/Emergency Vehicle Response
Booking	Arrest
Traffic Citation	Citation
DWI	Arrest
Emergency Vehicle Response	AOA/Emergency Vehicle Response
Informational	Field Contact/Routine Call/Warning
Traffic No Citation	Field Contact/Routine Call/Warning
Interview	Statement- All others, or Stmt.-CSC/Arson, or Homicide/Homicide Stmt.
Narcotics	Arrest

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"Current" Classifications Outlined in BCPD Policy 423 (during time of Audit)

Classifications	Retention Period
AOA/Emergency Vehicle Response	90 Days (3 months)
Arrest	730 Days (2 years)
Citation	730 Days (2 years)
Critical Incident/Flag for Review	180 Days (6 months)
Field Contact/Routine Call/Warning	90 Days (3 months)
Death/Death Statement	Permanent
Statement – Homicide/Homicide	Permanent

Classification	Retention Period
Statement – All Others	730 Days (2 years)
Statement – CSC/Arson	Permanent
Transport	90 Days (3 months)
Test/Accidental	90 Days (3 months)
Use of Force	2,190 Days (6 years)
Internal investigation	2,190 Days (6 years)
Videos Not Classified	90 Days (3 months)

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Discrepancy #2

A server log report details that BWC data existed and was deleted from the server, but the report does not include a classification in order to determine if deleted data was appropriately destroyed.

- City staff did not have the ability to run server log report with all the information requested by independent auditor.
- City IT has been working with the software manufacturer on the development of a new data query for pulling the desired information from server logs. This coordination and development is ongoing.

Discrepancy #3

The policy does not state that officers are only allowed to use agency issued portable recording systems issued and maintained by the agency.

- MN State Statute 13.825 Subd. 6 states that "while on duty, a peace officer may only use a portable recording system issued and maintained by the officer's agency in documenting the officer's activities."
- BCPD Policy 423 has been updated to include this statutory language.

Audit Results

Audit Results Provided to Legislative Commission on Data Practices and Personal Data Privacy

- Report summarizing results of audit must be provided within 60 days following completion of the audit.
- A copy of the final report, dated 03/22/2020, was forwarded to the Commission Administrator and Commission members on 04/07/2020.

Council Regular Meeting

DATE: 5/11/2020

TO: City Council
FROM: Curt Boganey, City Manager
THROUGH: N/A
BY: Meg Beekman, Community Development Director

SUBJECT: Resolution to Approve a Grant Program to Support Local Nonprofit Organizations

Background:

On March 13, 2020 Governor Walz declared a peacetime state of emergency in the State of Minnesota as result of the outbreak of the COVID-19 virus, commonly referred to as coronavirus. In the week following the Governor's announcement several additional executive orders were made by the Governor including discouraging gatherings of more than 10 people, partially closing dine-in restaurants, bars, and other venues, and shutting down Minnesota's K-12 schools. Since that time the Stay-at-Home order has been extended through May 4.

On March 17, 2020, the Brooklyn Center City Council adopted Resolution 2020-035, Extending the period of a Mayor-declared local emergency. Within that Resolution, the Council allocated $30,000 from the General Fund to support emergency food assistance to three organizations within the community in response to the immediate need caused by the pandemic. Those organizations were Community Emergency Assistance Programs (CEAP), Center for Asian Pacific Islanders (CAPI), and West African Family and Community Services (WAFCS).

Given the on-going and ever changing nature of the situation it is hard to predict when people will be able to return to work leaving many Minnesotans, including Brooklyn Center community members, unsure of how they will be able to provide basic necessities for their families. Additionally, as the pandemic continues, the needs of the community will also change, based on other resources available and how immediate needs are being met. This is increasing the strain on local nonprofit organizations that have limited resources and will likely see a downturn in funds being provided by businesses and donors who have also been negatively affected by the COVID-19 outbreak.

The city recently received a request from the Organization for Liberians in Minnesota (OLM) for $5,000 to support the work they are doing to serve local Brooklyn Center residents during this time of crisis. Their work includes direct food and rent assistance to elderly and undocumented individuals and outreach and communication.

On May 5 the City Council considered a proposal from staff to direct funds to a grant program to support local nonprofits directly serving the residents of Brooklyn Center with emergency support services. Grants would be issued up to a maximum of $3,000 per organization. The City Council reviewed the proposed program and directly staff to move forward with allocating $12,000 of funds to support it.

Applications from local nonprofits and charitable organizations would begin to be accepted on May 15 through May 27. Applications will be reviewed and scored administratively by an inter-department committee. Grant recipients will be asked to enter into a grant agreement. In order to track the effectiveness of these dollars, the

City will ask all organizations that receive funds to provide a report on how the funds were utilized and outcomes including; number of people served, types of services utilized and any significant results of services received. A report of how the funds were allocated and spent would be provided back to the City Council.

This program will allow any local nonprofit, serving Brooklyn Center residents, to apply for funding to support their work through an open and transparent process. It will further allow the city to continue to build relationships with smaller nonprofit and charitable organizations in the community.

City staff will work with community partners to disseminate information about the program to local organizations and religious groups so they may apply. Staff is proposing that organizations which have already received emergency funding from the City would not be eligible to apply. This would allow more organizations to be served, particularly smaller ones which may otherwise be overlooked.

A full program description, along with application and application review process is attached.

Budget Issues:

$12,000 from the General Fund would be allocated for this program.

Strategic Priorities and Values:

Resident Economic Stability

ATTACHMENTS:

Description	Upload Date	Type
Powerpoint	5/5/2020	Backup Material
Grant Program to Support Local Nonprofit Organizations Program Description and Application	5/5/2020	Backup Material
Resolution	5/7/2020	Resolution Letter

Emergency Funding Support for Local Nonprofit Organizations

City Council Work Session, 5/4/2020
Meg Beekman, Community Development Director

Background

- March 13, 2020 – Executive Order 20-01 Declaring Peacetime Emergency
  - Weeks that followed, several additional Executive Orders; limiting gatherings of 10 or more people, closing places of public accommodations, and closing K-12 schools.
  - Stay-at-Home order has been extended through May 18
- March 17, 2020 – City Council adopted Resolution 2020-035, extended Mayor-declared local emergency
  - 2020-035 Allocated $30,000 to support three local organizations with emergency food assistance: CAPI, CEAP, and WAFCS

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Background

- Continued uncertainty and changing needs of community members
- Increasing strain on local nonprofit and charitable organizations
- City received a request from OLM for $5,000 to support their work serving local residents
- City recognizes these and other efforts of organizations in the community serving residents

Support for Local Nonprofits

- Purpose: Support for existing local charitable organizations directly serving the residents of Brooklyn Center with emergency support services
- Maximum Grant Amount: $3,000
- Eligibility:
  - Recipients must be a nonprofit organization or a charitable agencies providing existing services to Brooklyn Center residents.
  - Funds must be used to provide emergency resources to Brooklyn Center residents.
  - Eligible uses include direct costs of emergency services such as food, shelter, and other critical life or safety needs identified by local nonprofit and charitable organizations.
  - Organization must be able to spend all grant funds by September 1, 2020.
  - Organization has not already received emergency funding from the City of Brooklyn Center

Support for Local Nonprofits

- Scoring Criteria:

SCORING CRITERIA	POINTS
Proposed use of direct emergency support funds fills a visible life/safety need in Brooklyn Center	10
Organization's reputation and experience in providing quality emergency service in Brooklyn Center	10
Organization's ability to implement in timely manner as demonstrated by existing organizational and programmatic infrastructure	10
TOTAL	30

- Reporting
  - Grant agreement required
  - Email update monthly summarizing how the funds are being used (amount spent and services provided);
  - Submit a final report that includes:
    - Number of Brooklyn Center residents served
    - Types of services utilized
    - An itemized summary of how the dollars are used
    - Any significant results of services received

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Support for Local Nonprofits

- Application Questions:
  - Describe a brief history of the direct services you provide in Brooklyn Center. Approximately what percent of your services go to Brooklyn Center residents?
  - Please describe the services the funds will provide. Include a breakdown of how the requested funds from this grant will specifically be used and distributed (do not include other services that are provided but not funded with these funds).
  - What steps will you take to ensure these resources will be used by Brooklyn Center residents? How will you provide evidence of this at the reporting stage?
  - Is there anything else you would like to add that pertains to the scoring criteria?

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Support for Local Nonprofits

- Application process/Timeline:
  - Applications reviewed and scored by an intern-department committee of city staff
  - Application period opens
  - Applications due: 1 week later
  - Applicants who advance: Video conference interviews
  - Applicants selected and enter into grant agreements
  - Funds available within 1 week of entering into grant agreement
  - Funds must be spent by September 1

Next Steps

- Based on discussion, program could be brought back at May 11 EDA meeting for approval
- Could begin advertising week of May 11

Policy Questions

- Does the City Council have any questions or concerns about the proposed Program?
- Does the City Council have any changes they would like made to the program?
- Is the City Council supportive of moving forward with the program?

Brooklyn Center Emergency Assistance for Direct Support Services

Overview

This grant program from the City of Brooklyn Center is a direct response to the increased need for basic services as a result of sudden job losses and business closures during the coronavirus pandemic. These funds will address immediate needs by supporting nonprofit organizations and other charitable agencies serving residents of Brooklyn Center and who that are seeing a much greater demand for services during this crisis. The goal of this grant is to quickly provide needed emergency services to Brooklyn Center residents. Up to $3,000 may be awarded per applicant and the total available pool is $12,000.

Eligibility and criteria

Grant criteria include:

- Recipients must be a nonprofit organization or a charitable agencies providing existing services to Brooklyn Center residents.
- Funds must be used to provide emergency resources to Brooklyn Center residents.
- Eligible uses include direct costs of emergency services such as food, shelter, and other critical life or safety needs identified by local nonprofit and charitable organizations.
- Organization must be able to spend all grant funds by September 1, 2020.
- Organization has not already received emergency funding from the City of Brooklyn Center

Scoring criteria will remain consistent through each step of the selection process (see chart below). However, scores could change as staff gains more information about the organization and proposed plans through the process.

SCORING CRITERIA	POINTS
Proposed **use** of direct emergency support funds fills a visible life/safety need in Brooklyn Center	10
Organization's **reputation and experience** in providing quality emergency service in Brooklyn Center	10
Organization's ability to implement in **timely manner** as demonstrated by existing organizational and programmatic infrastructure	10
TOTAL	30

Reporting

Because this grant is intended to deliver emergency services to residents quickly, there are streamlined reporting requirements. Grantees will be asked to:

- Enter into a grant agreement with the City of Brooklyn Center;
- Provide an email update after 1 month summarizing how the funds are being used (amount spent and services provided);
- Submit a report 3 months after the agreement has been signed that includes:

- Number of Brooklyn Center residents served
- Types of services utilized
- An itemized summary of how the dollars are used
- Any significant results of services received.

Process/Timeline

The City is putting in place a streamlined and flexible application process following the below steps. Times and dates may change, as needed, to advance the selection in a timely manner. Applications will be reviewed and scored by an inter-department committee of City staff.

1. Grant guidance issued – May 15
2. Application due – May 25
3. Applicants who advance: Video conference interviews – May 29
4. Applicants who advance: Recipients/City enter into Grant Agreements – Week of June 1
5. Funds available – Week of June 8
    - Funds will typically be dispersed within a week of entering into a fully executed grant agreement.
    - Applicants who advance will also be asked to fill out a W-9 form, which will be provided by the City.

Please contact Meg Beekman at mbeekman@ci.brooklyn-center.mn.us with any questions you may have. Applications are due on May 25, at Noon by email to mbeekman@ci.brooklyn-center.mn.us

Thank you for your service to our community!

Application

Organization information	
Organization name:	
Organization address:	
City, State, Zip:	
Is the organization a 501c3?	Yes ☐ No ☐ EIN: _____
Contact name:	
Contact title:	
Contact phone:	
Contact email:	
Budget	

Amount requested *(maximum $3,000)*:	

1. Describe a brief history of the direct services you provide in Brooklyn Center. Approximately what percent of your services go to Brooklyn Center residents?

2. Please describe the services the funds will provide. Include a breakdown of how the requested funds from this grant will specifically be used and distributed (do not include other services that are provided but not funded with these funds).

3. What steps will you take to ensure these resources will be used by Brooklyn Center residents? How will you provide evidence of this at the reporting stage?

4. Is there anything else you would like to add that pertains to the scoring criteria?

Member introduced the following resolution and moved its adoption:

RESOLUTION NO. 2020-___

RESOLUTION APPROVING ESTABLISHMENT OF THE LOCAL NONPROFIT EMERGENCY GRANT PROGRAM

WHEREAS, the COVID-19 pandemic resulted in the Governor acting on March 13, 2020 to declare a state of peacetime emergency and the Mayor acting on March 17, 2020 to declare a local emergency within the City of Brooklyn Center ("City"); and

WHEREAS, on March 17, 2020 the City Council adopted a resolution ("Emergency Resolution") agreeing with and extending the Mayor's local emergency declaration; and

WHEREAS, the City Council is authorized, particularly in times of a local emergency, to act to protect public health, safety, and welfare; and

WHEREAS, the spread of COVID-19 and the resulting emergency orders issued by the Governor to protect the public have placed a significant strain on residents and the nonprofit and charitable organizations working to serve the most vulnerable populations within the City; and

WHEREAS, the City acted as part of the Emergency Resolution to provide emergency financial assistance to CEAP, CAPI, and WAFCS (collectively, the "Past Recipients")to assist them in their efforts to provide food and other necessities to City residents in response to the emergency;

WHEREAS, the City Council recognized as part of its discussions at its May 4, 2020 work session there are other nonprofits and charitable organizations within the City that provide critical services to those living within the City and they are struggling to provide those services in this time of increased need; and

WHEREAS, City staff prepared and presented a memo, which is incorporated herein by reference, ("Staff Memo") at the City Council's May 11, 2020 meeting that set out the details of a proposed Local Nonprofit Emergency Grant Program ("Grant Program"); and

WHEREAS, the City Council determines it is in the best interest of the public, and is within its emergency powers, to establish the Grant Program to work with nonprofits and charitable organizations within the City to provide assistance to those living within the City.

NOW, THEREFORE, BE IT RESOLVED, by the City Council of the City of Brooklyn Center as follows:

1. The City Council hereby establishes the "Local Nonprofit Emergency Grant Program" as provided in this Resolution. The City Council authorizes a total of $10,000 to be used for the Grant Program, with individual grants of up to $3,000.

2. The Grant Program shall be structured in accordance with the provisions proposed in the Staff Memo. The Past Recipients are not be eligible to participate in this Grant Program.

3. The City Manager and City staff are hereby authorized and directed to do each of the following regarding the Grant Program:

    a. Prepare an application, grant agreement, policy and guidelines, and such other documents as may be needed;
    b. Receive applications and determine eligibility;
    c. Enter into such agreements on behalf of the City as may be needed;
    d. Distribute grants to eligible nonprofits and charitable organizations;
    e. Communicate with the grant recipients as needed to confirm the grants funds were used in accordance with the terms and conditions of the Grant Program; and
    f. Take all other actions, and execute such other documents, as may be needed to implement and carry out the Grant Program and the intent of this Resolution.

May 11, 2020
Date

Mayor

ATTEST: _____
City Clerk

The motion for the adoption of the foregoing resolution was duly seconded by member

and upon vote being taken thereon, the following voted in favor thereof:

and the following voted against the same:

whereupon said resolution was declared duly passed and adopted.

Economic Development Authority
VIRTUAL meeting being conducted by electronic means in accordance with Minnesota Statutes, section 13D.021 Public portion available for connection via telephone Dial: 1-312-535-8110 Access Code: 281244297
May 11, 2020

AGENDA

1. Call to Order

The City Council requests that attendees turn off cell phones and pagers during the meeting. A copy of the full City Council packet, including EDA (Economic Development Authority), is available to the public. The packet ring binder is located at the entrance of the council chambers.

2. Roll Call

3. Approval of Consent Agenda

The following items are considered to be routine by the Economic Development Authority (EDA) and will been acted by one motion. There will be no separate discussion of these items unless a Commissioner so requests, in which event the item will be removed from the consent agenda and considered at the end of Commission Consideration Items.

a. Approval of Minutes

-Motion to approve the minutes for:

- *March 9, 2020*

4. Commission Consideration Items

a. Resolution Approving the Acquisition of Certain Property Located at: 7015 Kyle Avenue N

- Motion to approve the resolution approving the acquisition of certain property located at 7015 Kyle Avenue N, Brooklyn Center, MN.

b. Resolution Adopting a Small Business Emergency Forgivable Loan Program

- Motion to Approve a resolution adopting a Small Business Emergency Forgivable Loan Program

5. Adjournment

Economic Development Authority

DATE: 5/11/2020

TO: City Council
FROM: Curt Boganey, City Manager
THROUGH: Dr. Reggie Edwards, Deputy City Manager
BY: Barb Suciu, City Clerk

SUBJECT: Approval of Minutes

Background:

In accordance with Minnesota State Statute 15.17, the official records of all meetings must be documented and approved by the governing body.

Strategic Priorities and Values:

Operational Excellence

ATTACHMENTS:

Description	Upload Date	Type
March 9 EDA	5/5/2020	Backup Material

MINUTES OF THE PROCEEDINGS OF THE
ECONOMIC DEVELOPMENT AUTHORITY
OF THE CITY OF BROOKLYN CENTER
IN THE COUNTY OF HENNEPIN AND THE
STATE OF MINNESOTA

REGULAR SESSION
MARCH 9, 2020
CITY HALL – COUNCIL CHAMBERS

1. CALL TO ORDER

The Brooklyn Center Economic Development Authority (EDA) met in Regular Session called to order by President Mike Elliott at 8:55 p.m.

2. ROLL CALL

President Mike Elliott and Commissioners Marquita Butler, April Graves, Kris Lawrence-Anderson. Commissioner Dan Ryan was absent and excused. Also present were Executive Director Curt Boganey, Deputy City Manager Reggie Edwards, Community Development Director Meg Beekman, City Attorney Troy Gilchrist, and City Clerk Barb Suciu.

3. APPROVAL OF AGENDA AND CONSENT AGENDA

Executive Director Boganey stated Agenda Item 4b, included on the final agenda, has been removed. He added the individual who was selling the property has withdrawn their interest in selling the property at this time. He noted no action is required, and Item 4b has been removed from the amended Agenda.

Commissioner Graves moved and Commissioner Lawrence-Anderson seconded to approve the Agenda and Consent Agenda, and the following item was approved:

3a. APPROVAL OF MINUTES

- February 24, 2020

Motion passed unanimously.

4. COMMISSION CONSIDERATION ITEMS

4a. RESOLUTION NO. 2020-07 APPROVING THE BUSINESS SUBSIDY PROGRAM

Mr. Boganey stated approval of amended language for the EDA Business Subsidy Policy is recommended. He added this is the same language amendment that was adopted by the City Council. He noted it is necessary to add the amendment to the EDA's policy as well.

City Attorney Gilchrist confirmed the language amendment falls under EDA Business Subsidy Policy Section 4.2C5D.

Commissioner Graves stated the substance of the change was that the terms “market rate” and “luxury” were replaced with “high quality”. She added that she and Commissioners Lawrence-Anderson and Ryan voted to support the amendment. President Elliott and Commissioner Butler voted against the amendment as President Elliott wanted to add “affordable” and “accessible” to the amended language.

Commissioner Graves stated the language that was approved was “high-quality amenities”, and President Elliott and Commissioner Butler voted against the amendment.

Mr. Boganey stated the amended language that was approved, included in the meeting packet, in a motion made by Commissioner Ryan and seconded by Commissioner Lawrence-Anderson, states, “… to amend Section 4.2, Item D, Business Subsidy Policy to read “multi-family housing with high-quality amenities.”

Commissioner Graves moved and Commissioner Lawrence-Anderson seconded to adopt RESOLUTION NO. 2020-07 Approving an Amendment to the Business Subsidy Program.

Motion passed unanimously.

5. ADJOURNMENT

Commissioner Graves moved and Commissioner Lawrence-Anderson seconded adjournment of the Economic Development Authority meeting at 9:00 p.m.

Motion passed unanimously.

STATE OF MINNESOTA)
COUNTY OF HENNEPIN) ss. Certification of Minutes
CITY OF BROOKLYN CENTER)

The undersigned, being the duly qualified and appointed Secretary of the Economic Development Authority (EDA) of the City of Brooklyn Center, Minnesota, certifies:

1. That attached hereto is a full, true, and complete transcript of the minutes of a Regular Session of the Economic Development Authority (EDA) of the City of Brooklyn Center held on March 9, 2020.

2. That said meeting was held pursuant to due call and notice thereof and was duly held at Brooklyn Center City Hall.

3. That the Economic Development Authority (EDA) adopted said minutes at its May 11, 2020 Regular Session.

_____ _____

Secretary President

Economic Development Authority

DATE: 5/11/2020

TO: City Council
FROM: Curt Boganey, City Manager
THROUGH: N/A
BY: Meg Beekman, Community Development Director

SUBJECT: Resolution Approving the Acquisition of Certain Property Located at: 7015 Kyle Avenue N

Background:

The property, 7015 Kyle Avenue N, is a residential property with a total size of 0.65 acres. It is accessed off of 70th Avenue by a public roadway which functions as the driveway to the property. The property is currently zoned R-5: Multiple Family Residence, and is guided under the 2040 Comprehensive Plan with a Future Land Use of Neighborhood Mixed-Use. Although zoned as an R-5 property, the property has been utilized as a single-family residence with the primary home being constructed in 1965. The property had a 2019 assessed market value of $240,000 and a 2020 assess market value of $258,000.

The property is currently owned by Marcella Hagen. Conversations with the property owner and the City regarding a potential sale have been happening for the past 5-10 years, though no terms were discussed as Mrs. Hagen had indicated she was not ready to sell her property. Early in 2020, Mrs Hagen and her family had a representative reach out to the City to inquire about a potential purchase. The City provided a draft purchase agreement to indicate the terms of a sale. Mrs. Hagen and her family met to discuss the terms and decided to proceed with the sale. A purchase price based on the then current assessed market value of $240,000 plus $5,000 for relocation was agreed to. The purchase agreement was signed by Mrs Hagen, however before it could be presented to the EDA, Mrs. Hagen changed her mind and asked that it be withdrawn.

Recently, Mrs. Hagen and her family decided that selling the property would be the best option and once again reached out the EDA. The same terms were agreed to with the exception of a delayed closing date to September 1 to allow time for Mrs. Hagen to move out of the home.

The total cost to the EDA associated with the acquisition of the property is $245,000. This amount includes the purchase price of the property of $240,000 and moving expenses to the homeowner of $5,000. The purchase agreement allows for the property owner to remove any fixtures within the home under the condition it does not affect the safety or security of the structure. The purchase agreement allows the City to inspect the property, which would occur to determine the cost of demolition. Upon closing on the property, the City would demolish the structure on the property, which is estimated to cost around $20,000.

The EDA currently owns the two properties directly to the west and south this property. The EDA-owned property has a total size of 0.8 acres. Staff has also been in communication with the staff and board of St. Alphonsus church, which has indicated a possible interest in leveraging excess land they own that is adjacent to Mrs. Hagen's property. Staff will continue these conversations with the church.

The EDA has had a policy of acquiring and assembling single family properties along Brooklyn Boulevard for many years. With the reconstruction of Brooklyn Boulevard and the upcoming land use study and creation of an overlay district it is anticipated that the corridor will transition to higher intensity land uses over time. Acquiring properties as they become available is a strategy for targeted redevelopment.

Budget Issues:

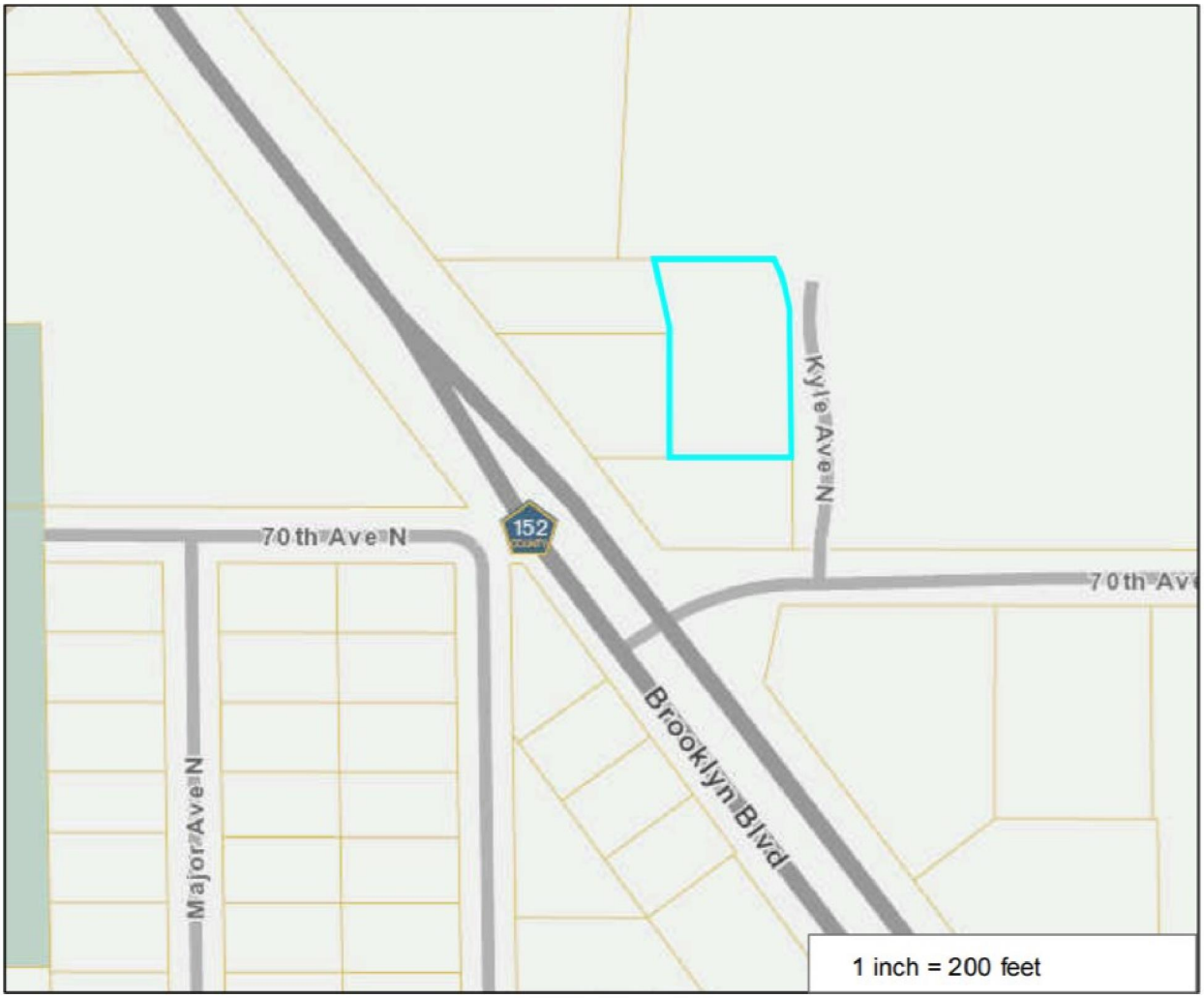
TIF #3 Funds will be used for the acquisition of the property.

Strategic Priorities and Values:

Targeted Redevelopment

ATTACHMENTS:

Description	Upload Date	Type
Location Map	3/2/2020	Backup Material
Aerial Map	3/2/2020	Backup Material
Purchase Agreement	5/4/2020	Backup Material
Resolution	5/4/2020	Resolution Letter



Location Map: 7015 Kyle Avenue N.



Aerial Map: 7015 Kyle Avenue N

PURCHASE AGREEMENT

1. PARTIES. This Purchase Agreement ("Purchase Agreement") is entered into this ___ day of _____, 2020, by and between Marcella Hagen ("Seller") and the Economic Development Authority of Brooklyn Center, Minnesota, a public body corporate and politic under the laws of the State of Minnesota ("Buyer").

2. SALE OF PROPERTY. Seller is the owner of that certain real estate ("Property") located at 7015 Kyle Avenue N, Brooklyn Center, MN 55429, Hennepin County, Minnesota and legally described as follows:

3. OFFER/ACCEPTANCE. In consideration of the mutual agreements herein contained, Buyer offers and agrees to purchase and Seller agrees to sell and hereby grants to Buyer the exclusive right to purchase the Property and all buildings, improvements, and fixtures thereon, together with all appurtenances, including, but not limited to, plant, shrubs, trees, and grass.

4. NO PERSONAL PROPERTY INCLUDED IN SALE: There are no items of personal property or fixtures owned by Seller and currently located on the Property included in the Purchase Price for purposes of this sale.

5. PURCHASE PRICE AND TERMS:

A. PURCHASE PRICE: The total Purchase Price ("Purchase Price") for the Property is Two Hundred Forty Thousand and No/100ths Dollars ($240,000.00).

B. MOVING EXPENSES: The sum of Five Thousand Dollars ($5,000.00) to reimburse Seller for Seller's moving expenses ("Moving Expenses") shall be paid by Buyer to Seller at Closing.

C. TERMS:

(1) BALANCE DUE SELLER: Buyer agrees to pay the Purchase Price to Seller by check or wire transfer on the Closing Date ("Closing").

(2) DEED/MARKETABLE TITLE: Subject to performance by Buyer, Seller agrees to execute and deliver a Warranty Deed conveying marketable title to the Property to Buyer, subject only to the following exceptions:

a. Building and zoning laws, ordinances, and state and federal regulations.

b. Reservation of minerals or mineral rights to the State of Minnesota, if any.

c. Public utility and drainage easements of record which will not interfere with Buyer's intended use of the Property.

d. Title defects waived by Buyer pursuant to paragraph 6 below.

6. CONTINGENCIES.

A. Notwithstanding any other provision in this Agreement to the contrary, the parties agree that the purchase of the Property is subject to the following contingencies, which must be accepted or waived before the expiration of the Due Diligence Period hereafter defined, unless a shorter period is expressly provided herein:

(1) Title to the Property shall be acceptable to Buyer, in its sole discretion.

(2) The Property's environmental condition must be acceptable to Buyer, in its sole discretion.

(3) Buyer shall have the right during the Due Diligence Period to conduct such soil tests/geotechnical analyses, inspections, reviews, examinations, storm water/drainage requirement analyses, pre-demolition assessments, and surveys, if any, as Buyer deems necessary at Buyer's expense. The results of the same shall be satisfactory to Buyer in its sole discretion.

B. Buyer shall satisfy or waive the above contingencies on or before the expiration of the Due Diligence Period. On or before the expiration of the Due Diligence Period, Buyer shall, by giving written notice to Seller, either:

(1) Terminate this Agreement if any one or more of the contingencies above have not been satisfied to the satisfaction of Buyer; or

(2) Waive the contingencies listed above and proceed to closing.

If Buyer elects to terminate this Agreement under paragraph (B)(1) above, then upon, Seller's receipt of Buyer's written notice of termination, this Purchase Agreement shall be null and void and neither party shall have any further obligation to the other.

If Buyer elects to waive the contingencies and proceed under paragraph (B)(2) above, the parties shall proceed to closing as provided in this Purchase Agreement.

7. DOCUMENTS TO BE DELIVERED AT CLOSING BY SELLER.

A. Warranty Deed free and clear of encumbrances subject only to the exceptions stated in paragraphs 5 (C) (2) (a), (b), (c), and (d) of this Purchase Agreement.

B. Standard form Affidavit of Seller.

C. Well disclosure certificate, if required.

D. Waiver of Relocation Benefits in the form attached hereto as Exhibit A.

E. Escrow and Occupancy Agreement in the form attached hereto as Exhibit B.

F. Such other documents as may be reasonably required by Buyer's title examiner or title insurance company.

8. CLOSING DATE/DUE DILIGENCE PERIOD. For a maximum of 90 days after the mutual execution of the Purchase Agreement (the "Due Diligence Period"), Buyer shall have the right, but not the obligation, to conduct an investigation of the Property as described in paragraph 6 (A) of this Purchase Agreement. The closing of the sale of the Property shall take place September 1, 2020. The closing shall take place at the offices of Economic Development Authority of Brooklyn Center, 6301 Shingle Creek Parkway, Brooklyn Center, MN 55430 (or at such other location as the parties shall agree, including a remote closing, with documents to be delivered in escrow to the title company).

9. DELIVERY OF DOCUMENTS. Within seven business days of signing the Purchase Agreement, Seller shall have provided Buyer with copies of all relevant material in Seller's possession relating to the Property, including but not limited to, title reports, soil reports, environmental studies, surveys, environmental reports, agreements with governmental authorities, or other records of the Property that Seller has in Seller's possession (collectively, the "***Documents***").

10. INSPECTION OF PROPERTY. During the Due Diligence Period, Seller shall allow Buyer and Buyer's agents access to the Property without charge and at all reasonable times for Buyer's inspection of the Property. This includes the right of Buyer and its agents to take soil borings of the Property. Buyer shall pay all costs and expenses of such inspections and any testing carried out in connection therewith, and shall hold Seller and the Property harmless from all costs and liabilities relating to Buyer's activities. Buyer shall not damage, encumber, or permit a lien or claim to result from its activities, or alter the Property in any way. Buyer shall not have the right to do any intrusive testing without the prior written authorization of Seller. Buyer shall repair and restore any damage to the Property caused by or occurring during Buyer's inspection and testing and return the Property to substantially the same condition as existed prior to such entry. Buyer's obligations under this paragraph shall survive termination of this Agreement.

11. ENVIRONMENTAL INSPECTION. Seller, prior to vacation of the Property, shall remove all substances that, under state or federal law, must be disposed of at an approved disposal facility. This requirement does not apply to hazardous substances integrated into the building improvements (e.g., asbestos) or soil but applies only to movable equipment, supplies and materials that are located or stored on the Property. Buyer and Seller will conduct a joint inspection of the Property at a time to be mutually agreed upon prior to closing for the purpose of identifying materials that must be removed by Seller.

12. LEAD. If the dwelling structure on the Property was constructed prior to 1978, a lead paint disclosure accompanies this Agreement.

13. REAL ESTATE TAXES.

A. Seller will pay at or prior to closing all real estate taxes due and payable in 2019 and prior years on the Property, including any delinquent real estate taxes.

B. Real estate taxes due and payable in 2020 shall be prorated as of the date of closing between Buyer and Seller. If the amount of real estate taxes due and payable in 2020 is not available on the date of closing, the pro-rated taxes will be based on the amount of real estate taxes due and payable in 2019.

14. SPECIAL ASSESSMENTS.

A. Seller shall pay on or prior to closing the balance of all special assessments levied for payment in 2019 and prior years. Buyer shall pay all special assessments pending or levied for payment with real estate taxes payable in 2020.

B. Seller shall pay any deferred real estate taxes or special assessments, payment of which is required as a result of the Closing of this sale.

C. As of the date of this Purchase Agreement, Seller has not received a notice of hearing for a new public improvement project from any governmental assessing authority, the costs of which project may be assessed against the Property.

D. Notwithstanding any other provision of this Agreement, Seller shall at all times be responsible to pay special assessments, if any, for delinquent sewer or water bills, removal of diseased trees prior to the date of this Purchase Agreement, snow removal, or other current services provided to the Property by the assessing authority while Seller is in possession of the Property.

15. MARKETABILITY OF TITLE. Buyer shall, within a reasonable time after execution of this Purchase Agreement by both parties, obtain a commitment for title insurance or other evidence satisfactory to Buyer ("Title Evidence") for the Property. Buyer shall have ten (10) business days after receipt of a fully executed purchase agreement and the Title Evidence to examine the same and to deliver written objections to title, if any, to Seller. Seller shall have until the expiration of the Due Diligence Period (or such later date as the parties may agree upon) to make title marketable, at Seller's expense. In the event that title to the Property cannot be made marketable or is not made marketable by Seller by the expiration of the Due Diligence Period, then, at the option of Buyer, Buyer may terminate this Purchase Agreement in accordance with paragraph 6 (B)(1) of this Purchase Agreement.

16. CLOSING COSTS AND RELATED ITEMS. Seller will pay: (a) any deed transfer taxes and conservation fees and recording fees for all instruments required to establish marketable title in Seller; (b) any deed transfer taxes and conservation fees required to enable

Buyer to record its deed from Seller under this Purchase Agreement; (c) the cost of the title commitment, title search, name searches, and exam fees; and (d) one-half of the closing fee charged by the title insurance or other closing agent, if any, utilized to close the transaction contemplated by this Purchase Agreement. Buyer shall be responsible for the payment of the following costs: (a) recording fees for deed from Seller under this Purchase Agreement; (b) the title insurance premium, and endorsements, if any; and (c) one-half of the closing fee charged by the title insurance or other closing agent, if any, utilized to close the transaction contemplated by this Purchase Agreement. Each party shall be responsible for its own attorneys' fees and costs.

17. DISCLOSURE; INDIVIDUAL SEWAGE TREATMENT SYSTEM. Seller discloses that there **is not** an individual sewage treatment system on or serving the Property. If there is an individual sewage treatment system on or serving the Property, Seller discloses that the system **is not** in use. In the event there is a sewage treatment system, a map of said location of the system is attached.

18. WELL DISCLOSURE. Seller discloses that the status and number of wells on the Property has not changed since the last previously filed Well Disclosure Certificate No. 1017287.

19. SELLER'S WARRANTIES. Seller warrants that buildings, if any, are entirely within the boundary lines of the Property. Seller warrants that there is a right of access to the Property from a public right-of-way. Seller warrants that there has been no labor or materials furnished to the Property for which payment has not been made. Seller warrants that there are no present violations of any restrictions relating to the use or improvement of the Property. Seller represents that Seller has good and marketable simple title interest to the Property and no consents or approvals from any third parties are required. Seller represents that there are no third parties in possession of the Property, or any part thereof; and that there are no leases, oral, or written, affecting the Property or any part thereof. Seller agrees that Seller will not enter into a lease for the Property after the date of this Purchase Agreement. Seller agrees to pay all charges for sewer, water, electric, gas, rubbish removal, Internet, cable/satellite television, and any other utility charges incurred prior to closing and during Seller's occupancy of the Property pursuant to the Escrow and Occupancy Agreement. These warranties shall survive the Closing of this transaction.

20. RELOCATION BENEFITS. Seller acknowledges that Seller initiated negotiations with Buyer for the transaction contemplated by this Purchase Agreement, and that this transaction is not made under threat of condemnation by Buyer. Seller agrees to waive any and all relocation benefits, assistance and services to which Seller might otherwise be eligible. Seller agrees to provide to Buyer at closing an executed waiver of relocation benefits in substantially the form of the attached Exhibit A.

21. NO MERGER OF REPRESENTATIONS, WARRANTIES. All representations and warranties contained in this Purchas Agreement shall not be merged into any instruments or conveyance delivered at closing, and the parties shall be bound accordingly.

22. ENTIRE AGREEMENT; AMENDMENTS. This Purchase Agreement constitutes the entire agreement between the parties, and no other agreement prior to this Purchase Agreement or contemporaneous herewith shall be effective except as expressly set forth or incorporated herein. Any purported amendment to this Purchase Agreement shall not be effective unless it shall be set forth in writing and executed by both parties or their respective successors or assigns.

23. BINDING EFFECT; ASSIGNMENT. This Agreement shall be binding upon and inure to the benefit of the parties and their respective heirs, executors, administrators, successors, and assigns. Buyer shall not assign its rights and interest hereunder without notice to Seller.

24. NOTICE. Any notice, demand, request or other communication which may or shall be given or served by the parties shall be deemed to have been given or served on the date the same is deposited in the United States Mail, registered or certified, postage prepaid and addressed as follows:

SELLER: Marcella Hagen
7015 Kyle Avenue N
Brooklyn Center, MN 55430

BUYER: Economic Development Authority of Brooklyn Center
Attn: Meg Beekman
6301 Shingle Creek Parkway
Brooklyn Center, MN 55430-2113

AGENT: Kennedy & Graven, Chartered
Attn: Troy Gilchrist
470 U.S. Bank Plaza
200 South Sixth Street
Minneapolis, MN 55402

25. BROKER COMMISSIONS. Buyer and Seller each represent and warrant to the other that there is no broker involved in this transaction with whom either has negotiated or to whom the representing party has agreed to pay a broker commission or finder's fee in connection with negotiations for purchase or sale of the Property. Buyer and Seller agree to indemnify, defend, and hold the other party harmless against any and all claims of brokers, finders, or the like, and against the claims of all third parties, claiming any right to commission or compensation by or through acts of the indemnifying party or its partners, agents, or affiliates in connection with this Purchase Agreement. The indemnifying party's indemnity obligations shall include all damages, losses, costs, liabilities, and expenses, including reasonable attorneys' fees and litigation costs, which may be incurred by the other party.

26. METHAMPHETAMINE DISCLOSURE. To the best of Seller's knowledge, methamphetamine production has not occurred on the Property.

27. SPECIFIC PERFORMANCE. This Purchase Agreement may be specifically enforced by the parties, provided that any action for specific enforcement is brought within six months after the date of the alleged breach. This paragraph is not intended to create an exclusive remedy for breach of this agreement; the parties reserve all other remedies available at law or in equity.

28. REMOVAL OF FIXTURES AND MATERIALS. The Seller shall have the opportunity to salvage any fixtures or materials from the buildings on the Property provided that the buildings are left secure and provided that removal does not create any hazardous conditions. Removal must be complete as of closing. Any fixtures or materials which remain on the Property after Seller's occupancy has been terminated shall be deemed to have been abandoned and shall become the exclusive property of Buyer. Seller assumes all risk in undertaking any salvage operations. Seller shall not permit the attachment of any lien or encumbrance on the Property as a result of this or other work thereof.

IN WITNESS WHEREOF, the parties have executed this agreement as of the date written above.

SELLER

By: _____
Marcella Hagen

BUYER

Economic Development Authority of Brooklyn Center, Minnesota

By: _____
Its: President

By: _____
Its: Executive Director

EXHIBIT A

FORM OF
WAIVER OF RELOCATION BENEFITS

The undersigned, acknowledges that I met with a representative of the Economic Development Authority of Brooklyn Center, Minnesota (EDA) on _____, 2020. The representative, _____, explained that in the event that the EDA acquires my property located at 7015 Kyle Avenue North, Brooklyn Center, Minnesota, I may be entitled to certain relocation benefits, in addition to the amount of money being paid to me to acquire my property. These benefits may include:

1. Moving Expenses:

   a. A payment for actual reasonable moving expenses; or

   b. A fixed payment determined in accordance with the applicable schedule approved by the Federal Highway Administration.

2. Replacement Housing Payment:

   A 180-day homeowner is eligible to receive a replacement housing payment to cover the following costs:

   a. If the homeowner must pay more to buy a comparable replacement home than homeowner receives for the property, then homeowner may be compensated for the difference.

   b. Homeowners may be entitled to compensation for incidental and closing expenses related to the purchase of a decent, safe, and sanitary replacement home, such as recording fees, title insurance, appraisal, and inspection fees.

   c. If a homeowner must pay a higher interest rate on a mortgage to finance the purchase of a replacement home than the rate on the mortgage of the property, then homeowner may be entitled to compensation for increased mortgage interest costs.

3. Other Relocation Assistance:

   This includes referrals and other assistance to help the owner(s) relocate to a comparable decent, safe, and sanitary dwelling. These payments and services are required under the regulations of the Department of Housing and Urban Development (HUD). The owner(s) cannot be required to move from his/her home unless he/she is given reasonable opportunities to relocate to a comparable decent, safe and sanitary dwelling unit that he/she can afford.

Finally, it was explained to me that the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 as amended, entitles me to these relocation benefits; and if I sign this waiver, I will be waiving those relocation benefits.

After having these benefits explained to me, I agree to waive them. In signing this waiver, I acknowledge that no threats have been made to me, either expressly or by implication that my property will be taken from me through condemnation. If after signing this waiver, I attempt to collect relocation benefits, I will have to prove that, contrary to what I am agreeing to in this waiver, my waiver of relocation benefits was not entered into voluntarily. This wavier is conditioned upon the Economic Development Authority of Brooklyn Center, Minnesota purchasing my property for the gross purchase price of $240,000.00 and payment of $5,000.00 in moving expenses. If this commitment to me is not fulfilled, this waiver is null and void.

_____
Date

By _____

WITNESS:

_____

PURCHASE AGREEMENT

1. PARTIES. This Purchase Agreement ("Purchase Agreement") is entered into this ___ day of _____, 2020, by and between Marcella Hagen ("Seller") and the Economic Development Authority of Brooklyn Center, Minnesota, a public body corporate and politic under the laws of the State of Minnesota ("Buyer").

2. SALE OF PROPERTY. Seller is the owner of that certain real estate ("Property") located at 7015 Kyle Avenue N, Brooklyn Center, MN 55429, Hennepin County, Minnesota and legally described as follows:

3. OFFER/ACCEPTANCE. In consideration of the mutual agreements herein contained, Buyer offers and agrees to purchase and Seller agrees to sell and hereby grants to Buyer the exclusive right to purchase the Property and all buildings, improvements, and fixtures thereon, together with all appurtenances, including, but not limited to, plant, shrubs, trees, and grass.

4. NO PERSONAL PROPERTY INCLUDED IN SALE: There are no items of personal property or fixtures owned by Seller and currently located on the Property included in the Purchase Price for purposes of this sale.

5. PURCHASE PRICE AND TERMS:

A. PURCHASE PRICE: The total Purchase Price ("Purchase Price") for the Property is Two Hundred Forty Thousand and No/100ths Dollars ($240,000.00).

B. MOVING EXPENSES: The sum of Five Thousand Dollars ($5,000.00) to reimburse Seller for Seller's moving expenses ("Moving Expenses") shall be paid by Buyer to Seller at Closing.

C. TERMS:

(1) BALANCE DUE SELLER: Buyer agrees to pay the Purchase Price to Seller by check or wire transfer on the Closing Date ("Closing").

(2) DEED/MARKETABLE TITLE: Subject to performance by Buyer, Seller agrees to execute and deliver a Warranty Deed conveying marketable title to the Property to Buyer, subject only to the following exceptions:

a. Building and zoning laws, ordinances, and state and federal regulations.

b. Reservation of minerals or mineral rights to the State of Minnesota, if any.

c. Public utility and drainage easements of record which will not interfere with Buyer's intended use of the Property.

d. Title defects waived by Buyer pursuant to paragraph 6 below.

6. CONTINGENCIES.

A. Notwithstanding any other provision in this Agreement to the contrary, the parties agree that the purchase of the Property is subject to the following contingencies, which must be accepted or waived before the expiration of the Due Diligence Period hereafter defined, unless a shorter period is expressly provided herein:

(1) Title to the Property shall be acceptable to Buyer, in its sole discretion.

(2) The Property's environmental condition must be acceptable to Buyer, in its sole discretion.

(3) Buyer shall have the right during the Due Diligence Period to conduct such soil tests/geotechnical analyses, inspections, reviews, examinations, storm water/drainage requirement analyses, pre-demolition assessments, and surveys, if any, as Buyer deems necessary at Buyer's expense. The results of the same shall be satisfactory to Buyer in its sole discretion.

B. Buyer shall satisfy or waive the above contingencies on or before the expiration of the Due Diligence Period. On or before the expiration of the Due Diligence Period, Buyer shall, by giving written notice to Seller, either:

(1) Terminate this Agreement if any one or more of the contingencies above have not been satisfied to the satisfaction of Buyer; or

(2) Waive the contingencies listed above and proceed to closing.

If Buyer elects to terminate this Agreement under paragraph (B)(1) above, then upon, Seller's receipt of Buyer's written notice of termination, this Purchase Agreement shall be null and void and neither party shall have any further obligation to the other.

If Buyer elects to waive the contingencies and proceed under paragraph (B)(2) above, the parties shall proceed to closing as provided in this Purchase Agreement.

7. DOCUMENTS TO BE DELIVERED AT CLOSING BY SELLER.

A. Warranty Deed free and clear of encumbrances subject only to the exceptions stated in paragraphs 5 (C) (2) (a), (b), (c), and (d) of this Purchase Agreement.

B. Standard form Affidavit of Seller.

C. Well disclosure certificate, if required.

D. Waiver of Relocation Benefits in the form attached hereto as Exhibit A.

E. Escrow and Occupancy Agreement in the form attached hereto as Exhibit B.

F. Such other documents as may be reasonably required by Buyer's title examiner or title insurance company.

8. CLOSING DATE/DUE DILIGENCE PERIOD. For a maximum of 90 days after the mutual execution of the Purchase Agreement (the "Due Diligence Period"), Buyer shall have the right, but not the obligation, to conduct an investigation of the Property as described in paragraph 6 (A) of this Purchase Agreement. The closing of the sale of the Property shall take place September 1, 2020. The closing shall take place at the offices of Economic Development Authority of Brooklyn Center, 6301 Shingle Creek Parkway, Brooklyn Center, MN 55430 (or at such other location as the parties shall agree).

9. DELIVERY OF DOCUMENTS. Within seven business days of signing the Purchase Agreement, Seller shall have provided Buyer with copies of all relevant material in Seller's possession relating to the Property, including but not limited to, title reports, soil reports, environmental studies, surveys, environmental reports, agreements with governmental authorities, or other records of the Property that Seller has in Seller's possession (collectively, the "***Documents***").

10. INSPECTION OF PROPERTY. During the Due Diligence Period, Seller shall allow Buyer and Buyer's agents access to the Property without charge and at all reasonable times for Buyer's inspection of the Property. This includes the right of Buyer and its agents to take soil borings of the Property. Buyer shall pay all costs and expenses of such inspections and any testing carried out in connection therewith, and shall hold Seller and the Property harmless from all costs and liabilities relating to Buyer's activities. Buyer shall not damage, encumber, or permit a lien or claim to result from its activities, or alter the Property in any way. Buyer shall not have the right to do any intrusive testing without the prior written authorization of Seller. Buyer shall repair and restore any damage to the Property caused by or occurring during Buyer's inspection and testing and return the Property to substantially the same condition as existed prior to such entry. Buyer's obligations under this paragraph shall survive termination of this Agreement.

11. ENVIRONMENTAL INSPECTION. Seller, prior to vacation of the Property, shall remove all substances that, under state or federal law, must be disposed of at an approved disposal facility. This requirement does not apply to hazardous substances integrated into the building improvements (e.g., asbestos) or soil but applies only to movable equipment, supplies and materials that are located or stored on the Property. Buyer and Seller will conduct a joint inspection of the Property at a time to be mutually agreed upon prior to closing for the purpose of identifying materials that must be removed by Seller.

12. LEAD. If the dwelling structure on the Property was constructed prior to 1978, a lead paint disclosure accompanies this Agreement.

13. REAL ESTATE TAXES.

A. Seller will pay at or prior to closing all real estate taxes due and payable in 2019 and prior years on the Property, including any delinquent real estate taxes.

B. Real estate taxes due and payable in 2020 shall be prorated as of the date of closing between Buyer and Seller. If the amount of real estate taxes due and payable in 2020 is not available on the date of closing, the pro-rated taxes will be based on the amount of real estate taxes due and payable in 2019.

14. SPECIAL ASSESSMENTS.

A. Seller shall pay on or prior to closing the balance of all special assessments levied for payment in 2019 and prior years. Buyer shall pay all special assessments pending or levied for payment with real estate taxes payable in 2020.

B. Seller shall pay any deferred real estate taxes or special assessments, payment of which is required as a result of the Closing of this sale.

C. As of the date of this Purchase Agreement, Seller has not received a notice of hearing for a new public improvement project from any governmental assessing authority, the costs of which project may be assessed against the Property.

D. Notwithstanding any other provision of this Agreement, Seller shall at all times be responsible to pay special assessments, if any, for delinquent sewer or water bills, removal of diseased trees prior to the date of this Purchase Agreement, snow removal, or other current services provided to the Property by the assessing authority while Seller is in possession of the Property.

15. MARKETABILITY OF TITLE. Buyer shall, within a reasonable time after execution of this Purchase Agreement by both parties, obtain a commitment for title insurance or other evidence satisfactory to Buyer ("Title Evidence") for the Property. Buyer shall have ten (10) business days after receipt of a fully executed purchase agreement and the Title Evidence to examine the same and to deliver written objections to title, if any, to Seller. Seller shall have until the expiration of the Due Diligence Period (or such later date as the parties may agree upon) to make title marketable, at Seller's expense. In the event that title to the Property cannot be made marketable or is not made marketable by Seller by the expiration of the Due Diligence Period, then, at the option of Buyer, Buyer may terminate this Purchase Agreement in accordance with paragraph 6 (B)(1) of this Purchase Agreement.

16. CLOSING COSTS AND RELATED ITEMS. Seller will pay: (a) any deed transfer taxes and conservation fees and recording fees for all instruments required to establish marketable title in Seller; (b) any deed transfer taxes and conservation fees required to enable

Buyer to record its deed from Seller under this Purchase Agreement; (c) the cost of the title commitment, title search, name searches, and exam fees; and (d) one-half of the closing fee charged by the title insurance or other closing agent, if any, utilized to close the transaction contemplated by this Purchase Agreement. Buyer shall be responsible for the payment of the following costs: (a) recording fees for deed from Seller under this Purchase Agreement; (b) the title insurance premium, and endorsements, if any; and (c) one-half of the closing fee charged by the title insurance or other closing agent, if any, utilized to close the transaction contemplated by this Purchase Agreement. Each party shall be responsible for its own attorneys' fees and costs.

17. DISCLOSURE; INDIVIDUAL SEWAGE TREATMENT SYSTEM. Seller discloses that there **is not** an individual sewage treatment system on or serving the Property. If there is an individual sewage treatment system on or serving the Property, Seller discloses that the system **is not** in use. In the event there is a sewage treatment system, a map of said location of the system is attached.

18. WELL DISCLOSURE. Seller discloses that the status and number of wells on the Property has not changed since the last previously filed Well Disclosure Certificate No. 1017287.

19. SELLER'S WARRANTIES. Seller warrants that buildings, if any, are entirely within the boundary lines of the Property. Seller warrants that there is a right of access to the Property from a public right-of-way. Seller warrants that there has been no labor or materials furnished to the Property for which payment has not been made. Seller warrants that there are no present violations of any restrictions relating to the use or improvement of the Property. Seller represents that Seller has good and marketable simple title interest to the Property and no consents or approvals from any third parties are required. Seller represents that there are no third parties in possession of the Property, or any part thereof; and that there are no leases, oral, or written, affecting the Property or any part thereof. Seller agrees that Seller will not enter into a lease for the Property after the date of this Purchase Agreement. Seller agrees to pay all charges for sewer, water, electric, gas, rubbish removal, Internet, cable/satellite television, and any other utility charges incurred prior to closing and during Seller's occupancy of the Property pursuant to the Escrow and Occupancy Agreement. These warranties shall survive the Closing of this transaction.

20. RELOCATION BENEFITS. Seller acknowledges that Seller initiated negotiations with Buyer for the transaction contemplated by this Purchase Agreement, and that this transaction is not made under threat of condemnation by Buyer. Seller agrees to waive any and all relocation benefits, assistance and services to which Seller might otherwise be eligible. Seller agrees to provide to Buyer at closing an executed waiver of relocation benefits in substantially the form of the attached Exhibit A.

21. NO MERGER OF REPRESENTATIONS, WARRANTIES. All representations and warranties contained in this Purchas Agreement shall not be merged into any instruments or conveyance delivered at closing, and the parties shall be bound accordingly.

22. ENTIRE AGREEMENT; AMENDMENTS. This Purchase Agreement constitutes the entire agreement between the parties, and no other agreement prior to this Purchase Agreement or contemporaneous herewith shall be effective except as expressly set forth or incorporated herein. Any purported amendment to this Purchase Agreement shall not be effective unless it shall be set forth in writing and executed by both parties or their respective successors or assigns.

23. BINDING EFFECT; ASSIGNMENT. This Agreement shall be binding upon and inure to the benefit of the parties and their respective heirs, executors, administrators, successors, and assigns. Buyer shall not assign its rights and interest hereunder without notice to Seller.

24. NOTICE. Any notice, demand, request or other communication which may or shall be given or served by the parties shall be deemed to have been given or served on the date the same is deposited in the United States Mail, registered or certified, postage prepaid and addressed as follows:

SELLER:

BUYER: Economic Development Authority of Brooklyn Center
Attn: Brett Angell
6301 Shingle Creek Parkway
Brooklyn Center, MN 55430-2113

AGENT: Kennedy & Graven, Chartered
Attn: Troy Gilchrist
470 U.S. Bank Plaza
200 South Sixth Street
Minneapolis, MN 55402

25. BROKER COMMISSIONS. Buyer and Seller each represent and warrant to the other that there is no broker involved in this transaction with whom either has negotiated or to whom the representing party has agreed to pay a broker commission or finder's fee in connection with negotiations for purchase or sale of the Property. Buyer and Seller agree to indemnify, defend, and hold the other party harmless against any and all claims of brokers, finders, or the like, and against the claims of all third parties, claiming any right to commission or compensation by or through acts of the indemnifying party or its partners, agents, or affiliates in connection with this Purchase Agreement. The indemnifying party's indemnity obligations shall include all damages, losses, costs, liabilities, and expenses, including reasonable attorneys' fees and litigation costs, which may be incurred by the other party.

26. METHAMPHETAMINE DISCLOSURE. To the best of Seller's knowledge, methamphetamine production has not occurred on the Property.

27. SPECIFIC PERFORMANCE. This Purchase Agreement may be specifically enforced by the parties, provided that any action for specific enforcement is brought within six months after the date of the alleged breach. This paragraph is not intended to create an exclusive remedy for breach of this agreement; the parties reserve all other remedies available at law or in equity.

28. REMOVAL OF FIXTURES AND MATERIALS. The Seller shall have the opportunity to salvage any fixtures or materials from the buildings on the Property provided that the buildings are left secure and provided that removal does not create any hazardous conditions. Any fixtures or materials which remain on the Property after Seller's occupancy has been terminated shall be deemed to have been abandoned and shall become the exclusive property of Buyer. Seller assumes all risk in undertaking any salvage operations. Seller shall not permit the attachment of any lien or encumbrance on the Property as a result of this or other work thereof.

IN WITNESS WHEREOF, the parties have executed this agreement as of the date written above.

SELLER

By: _____
Its:

BUYER

Economic Development Authority of Brooklyn Center, Minnesota

By: _____
Its: President

By: _____
Its: Executive Director

EXHIBIT A

FORM OF
WAIVER OF RELOCATION BENEFITS

The undersigned, acknowledges that I met with a representative of the Economic Development Authority of Brooklyn Center, Minnesota (EDA) on _____, 2020. The representative, _____, explained that in the event that the EDA acquires my property located at 7015 Kyle Avenue North, Brooklyn Center, Minnesota, I may be entitled to certain relocation benefits, in addition to the amount of money being paid to me to acquire my property. These benefits may include:

1. Moving Expenses:

   a. A payment for actual reasonable moving expenses; or

   b. A fixed payment determined in accordance with the applicable schedule approved by the Federal Highway Administration.

2. Replacement Housing Payment:

   A 180-day homeowner is eligible to receive a replacement housing payment to cover the following costs:

   a. If the homeowner must pay more to buy a comparable replacement home than homeowner receives for the property, then homeowner may be compensated for the difference.

   b. Homeowners may be entitled to compensation for incidental and closing expenses related to the purchase of a decent, safe, and sanitary replacement home, such as recording fees, title insurance, appraisal, and inspection fees.

   c. If a homeowner must pay a higher interest rate on a mortgage to finance the purchase of a replacement home than the rate on the mortgage of the property, then homeowner may be entitled to compensation for increased mortgage interest costs.

3. Other Relocation Assistance:

   This includes referrals and other assistance to help the owner(s) relocate to a comparable decent, safe, and sanitary dwelling. These payments and services are required under the regulations of the Department of Housing and Urban Development (HUD). The owner(s) cannot be required to move from his/her home unless he/she is given reasonable opportunities to relocate to a comparable decent, safe and sanitary dwelling unit that he/she can afford.

Finally, it was explained to me that the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 as amended, entitles me to these relocation benefits; and if I sign this waiver, I will be waiving those relocation benefits.

After having these benefits explained to me, I agree to waive them. In signing this waiver, I acknowledge that no threats have been made to me, either expressly or by implication that my property will be taken from me through condemnation. If after signing this waiver, I attempt to collect relocation benefits, I will have to prove that, contrary to what I am agreeing to in this waiver, my waiver of relocation benefits was not entered into voluntarily. This wavier is conditioned upon the Economic Development Authority of Brooklyn Center, Minnesota purchasing my property for the gross purchase price of $240,000.00 and payment of $5,000.00 in moving expenses. If this commitment to me is not fulfilled, this waiver is null and void.

_____
Date

By _____

WITNESS:

_____

Economic Development Authority

DATE: 5/11/2020

TO: City Council
FROM: Curt Boganey, City Manager
THROUGH: N/A
BY: Meg Beekman, Community Development Director

SUBJECT: Resolution Adopting a Small Business Emergency Forgivable Loan Program

Background:

On March 13, 2020, Governor Walz issued Executive Order 20-01 declaring a state of peacetime emergency to address the COVID-19 pandemic in Minnesota. On March 16, Governor Walz issued Executive Order 20-04 ordering the closure of bars, restaurants, and other places of public accommodation offering food and/or beverage for on-premise consumption. The Order also included the closure of spas, beauty shops, nail salons, tattoo shops, health clubs, indoor fitness centers, art and music studios, and recreational or entertainment facilities. Restaurants were allowed to continue to provide delivery, drive-thru, and take-out accommodations.

On March 25, Governor Walz issued Executive Orders 20-18, extending and clarifying Executive Order 20-04, and also issued Executive Order 20-20 issuing a Stay-at-Home order to all Minnesotan's except to engage in exempt activities and critical sector work as described in the Order and further clarified by DEED through their Critical Sector Clarification and Definitions document: https://mn.gov/deed/assets/critical-worker-definitions-ACC_tcm1045-425195.pdf.

The Governor has since extended the Stay-at-Home order twice and issued several amendments and clarifications to the definition of Critical Sector Workers.

While it is estimated by DEED that 82% of working Minnesotan's fall within a critical sector and can therefore continue to work, the Executive Order's have had a dramatic affect on the state's unemployment rate. The affect of the Stay-at-Home order has been most especially felt by small businesses, which have had to adapt to changing operating requirements with limited resources while facing barriers to accessing state and federal stimulus programs to provide much needed assistance.

Recently the National Federation of Independent Businesses (NFIB) released the results of a survey of its businesses. The NFIB which represents thousands of small business across the nation reports that business optimism, unsurprisingly, decreased dramatically in March. Of the 627 businesses surveyed, 35% expressed they weren’t sure they’d be able to operate their business for more than one to two months in the current economic climate.

State and Federal Programs

Both the Federal Small Business Administration (SBA) and the Minnesota Department of Employment and Economic Development (DEED) have rolled out financial aid programs designed to assist businesses affected by the COVID-19 crisis. Aside from the regular small business support programs offered by these

agencies, there are three new programs that are the primary focus of the state and federal stimulus funds:

- The Paycheck Protection Program (PPP): an SBA program available to small businesses including sole proprietors, self-employed individuals and independent contractors meant to cover payroll, rent/mortgage, utilities, and other immediate payments. Loans are applied for and disbursed through private lenders and backed by the SBA. The loan is forgivable, less the 1% interest rate, if a business can demonstrate that 75% of the loan proceeds were used to cover eligible expenses over an 8-week period.

- The Economic Injury Disaster Loan (EIDL): an SBA program available to small business that including sole proprietors, self-employed individuals, and independent contractors that can demonstrate economic loss as a result of the COVID-19 outbreak. Loans are available directly through the SBA for up to $2 million and payments are deferred up to one year and can be paid back over a term up to 30 years. Businesses that apply for EIDL can also request an advance of funds up to $10,000 which will not have to be paid back.

- The Small Business Emergency Loan Fund: a DEED program available to businesses specifically impacted by the Governor Executive Order 20-04 and 20-18, which closed restaurants, bars, beauty salons, health clubs, entertainment venues, and other places of public accommodation. Eligible businesses can apply for an up to $35,000 loan at 0% interest that may be partially forgiven. Businesses considered non-essential under Executive Order 20-20, but not identified under Executive Order 20-04 or 20-18 are not eligible.

The PPP and EIDL programs were depleted of funds after just 13 days. On April 24 the President signed a bill authorizing an additional $320 billion of funding for these programs, which reopened on April 27.

Brooklyn Center Small Business Emergency Forgivable Loan Program

Despite the available State and Federal programs aimed at assisting businesses there will likely still be businesses that are not able to access assistance. There are several reasons for the barriers that exist to accessing state and federal programs for small and micro businesses, particularly female and minority-owned businesses, which make up a large percentage of Brooklyn Center small businesses. The first round of federal funds were depleted within 13 days of being released. Banks and the SBA were overwhelmed with applications. As a result, businesses that already had strong relationships with their banks and had their documents in order were first in line to receive funding.

Further SBA funds are just now beginning to be released, and some applications continue to remain pending. In the meantime, business owners are faced with immediate expenses and a high degree of uncertainty as to whether their applications will be approved or when.

At their May 5 work session, the City Council considered a proposed program to support small businesses in Brooklyn Center designed to help those businesses facing the greatest barriers to accessing state and federal funds. The program would provide emergency deferred forgivable loans up to $3,000 at 0% interest with payments deferred for one year. This program is intended to provide immediate emergency relief to assist with short term expenses. Allowable uses for funds would include rent/mortgage payments, payroll and employee benefits, accounts payable, and vendor payments.

Eligibility for forgiveness would be based upon demonstration that the funds were used on eligible expenses and that the business owner received technical assistance from a local or regional business resource center. Part of the purpose of the program is to get needed technical assistance to business owners in order to ensure they have the resources they need to be successful through this period of time and into the future. Staff will work with loan recipients to identify their needs and direct them to resources that will ensure they get the capacity building and technical assistance they may need.

Staff is proposing $150,000 to fund the program. This would allow approximately 50 businesses to be served. If demand far outpaces funding, the EDA could consider additional funding to the program at a later date. The funds for this program would come from the Brooklyn Center Economic Development Authority fund. As these are not budgeted funds, they would come directly out of cash reserves. The current unreserved fund balance of the EDA fund is $1.597 million.

A full description of the program including eligibility is attached to this memo.

The Council directed staff to move forward with the program. Staff met internally to discuss in detail the logistics of rolling out and administering the program, as well as the Council's comments, and is proposing a few minor changes.

- A $30 annual fee was added to loans that do not receive forgiveness and enter repayment. This equates to a 1% interest rate. The fee would be in lieu of interest but would provide both an incentive for repayment and also a consideration for staff time to administer the repayment schedule.
- Operating cash was removed from the list of allowed uses for funds to make tracking easier and simplify reporting.
- The process for receiving loan forgiveness was simplified to eliminate the need for loan recipients to fill out an additional form to apply for loan forgiveness.
- The end date for the program was amended to "until funds are expended, or the EDA terminates the program, whichever comes first".

Application Process
Applications will be submitted electronically. An inter-departmental committee will review the applications on a rolling basis for eligibility and to ensure they are complete. If information is missing or unclear, applications will be contacted to have an opportunity to provide additional information.

Loan recipients will be asked to enter into a loan agreement, which will be provided for electronic signature. Checks will be sent out within a week upon receipt of an executed loan agreement. Staff will then work with loan recipients to identify what other needs they may have to seek out additional support resources and technical assistance.

Outreach and Engagement
Given the demographics of Brooklyn Center, and in particular the small business community, it is critically important that women and minority-owned businesses be engaged and made aware of resources available to them. Demographic information will be tracked as part of the application process, and intentional efforts will be made to ensure broad outreach and engagement.

The City has entered into contracts with LiBA and Jude Nnadi to provide technical assistance and small business support. These contracts include disseminating information to small business owners and assisting with filling out applications for funding. Staff has already been in communication about this program and will work with these groups to deepen outreach about the program to the community.

In addition, staff is in discussions with ACER to enter into a similar contract to seek their assistance with outreach and engagement of small business owners as well as providing technical support to businesses with loan applications.

Information about the program will also be shared with other community partners and organizations.

Next Steps

If the Council chooses to approve the program, the application period will open May 15 and remain open until funds are expended or the EDA terminates the program. Staff will provide regular updates to the EDA as well as a final report on the recipients of the funding.

Budget Issues:

$150,000 from the EDA. This is not a budgeted expenditure.

Strategic Priorities and Values:

Resident Economic Stability

ATTACHMENTS:

Description	Upload Date	Type
Small Business Forgivable Loan Program	5/5/2020	Backup Material
Proposed Emergency Small Business Loan Application	4/27/2020	Backup Material
Resolution	5/7/2020	Resolution Letter

Brooklyn Center Economic Development Authority
Small Business Emergency Forgivable Loan Program

Brooklyn Center is home to a high number of micro businesses, many owned by immigrants and people of color. Small businesses are integral and vital to the economic, social, and religious fabric of the Brooklyn Center community. Accordingly, the Brooklyn Center Economic Development Authority (EDA) has determined to offer locally owned and operated businesses within the community a forgivable loan opportunity to address working capital needs upon the declaration of a state of emergency by the State of Minnesota (State) and the City of Brooklyn Center (City).

The purpose of this program is to ensure the viability of the community's small businesses faced with the current COVID-19 health emergency, which is adversely affecting the City's economy. The goal of this program is to provide businesses small loans with deferred payment and forgiveness options to allow for access to working capital and to encourage businesses to seek out technical assistance and other resources which may help them weather this difficult time.

Loan funds are available on a first-come, first-served basis for eligible applicants. The program is subject to funding availability from the EDA. The EDA retains the authority and discretion to approve or deny an application, and reserves the right to subsequently add further priorities, change eligibility criteria, or discontinue the program in response to changing circumstances.

Maximum Loan Amount: $3,000

Interest Rate:
Loan interest rate is fixed at 0%

Loan Terms:

- Loan recipients shall enter into a Loan Agreement with the Brooklyn Center EDA. Funds will not be distributed for any loan award until a Loan Agreement has been executed by all required parties.
- Loan payments will be deferred with no interest for one (1) year from the date of award
- Loans may be eligible for forgiveness within the first 12 months from the date of award
- If a business does not meet the terms for forgiveness the loan will be paid back monthly for 3 years with an annual fee of $30 and no pre-payment penalty

Eligible Business Criteria:

- Business must have a physical address within the City of Brooklyn Center
- Business must have been in operation prior to February 20th 2020
- Employ 10 or fewer full time or part time employees prior to the issuance of the State of Emergency Executive Order 20-04 (March 16, 2020). Sole proprietors and individual contractors are eligible.

- Business must have annual gross revenue of less than $200,000
- Be able to demonstrate that its revenues have been directly and adversely affected by the COVID-19 Health Pandemic and/or that it operates in a category adversely affected by Executive Orders 20-04 and 20-08, or other locally owned and operated business deemed non-essential under Executive Order 20-20
- Business must serve the general public and be a conforming or legally non-conforming use under the current zoning regulations of the City, and have no adverse actions or open violations with the City
- A business owners' immigration status does not affect eligibility
- Applicants are strongly encouraged to claim all applicable private insurance and utilize all other sources of applicable assistance available from other private and public sources. Applicants are also strongly encouraged to apply for an Economic Injury Disaster Loan through the Small Business Administration (SBA) and Small Business Emergency Loan through the Minnesota Department of Employment and Economic Development (DEED) prior to applying for this grant. For more information, visit:

  Guide to financial resources for Minnesota small businesses

Assistance cannot be provided to businesses that:

- Do not have a physical address within the City of Brooklyn Center
- Derive income from passive investments without operational ties to operating businesses or whose primary source of revenue is from business-to-business transactions
- Primarily generate income from gambling activities, adult entertainment, tobacco/vaping-related activities, registered lobbying, multi-level marketing, billboards, or renting commercial or residential property
- Have no current or historical financial statements

Allowable Uses:

- Rent/mortgage payments
- Payroll, employee benefits and leave
- Accounts payable
- Vendor payments

Forgiveness:

Loans are forgiven if the recipients demonstrate that they have met the terms of forgiveness within the 12-month deferral period. A portion or the remaining loan balance may be forgiven after the 12-month deferral period. The conditions for loan forgiveness are as follows:

- Submission of receipts, paid invoices, statements, or similar documents demonstrating loan funds were used on eligible expenses.
- Business owner has met with an area business resource center and received technical assistance. City staff will be available to work with the business owner to assist with connecting them with a business resource center that can provide resources specific to their needs.

Application Process:

- Application Period Opens: May 15
- Applications are available on the City's website:
- Applications will be accepted on a first come first served basis until funds are expended or the EDA determines to terminate the program, whichever comes first.
- Applications will be reviewed and approved by City staff on a rolling basis, based on eligibility, and submission of a complete application.
- Upon submission of application, applicants will receive an email confirming receipt of application.
- A staff committee will review application for eligibility and completeness. If additional information or documentation is necessary, EDA staff will contact the applicant. Due to an expected high volume of applications, please consider your application complete if staff does not request additional information within 10 business days after application acceptance.

Funding Process:

- Businesses will be notified within 10 business days if their application has been approved.
- Loan agreements will be provided via email for signatures.
- Loan funds shall be distributed by check within two weeks after a loan agreement has been executed by all required parties.
- Brooklyn Center City staff will provide a report to the Brooklyn Center EDA of all businesses funded through the program.

Questions:

Any questions related to the application process should be directed to:

Jimmy Loyd, Economic Development Coordinator
mjloyd@ci.brooklyn-center.mn.us

Brooklyn Center Small Business Assistance Application

1. **Applicant Contact**

First Name

Last Name

Title

Company Name

Street Address

Apt/Suite/Office

City

State

Zip

Email Address

Primary Phone

2. **Business Type**

- Retail
- Service
- Manufacturing
- Construction
- Other - Write In

3. **Number of FTE**

- 1-5
- 6-10
- More than 10

4. **Supporting documentation for proof of business residency in Brooklyn Center. Examples include: statement of lease, mortgage statement, property tax statement, or other document to show proof of occupancy within Brooklyn Center.**

Browse...

5. **2019 Gross Revenue**

6. **Estimated 2020 Gross Revenue**

7. **Grant amount requested** (up to $####)

8. **Briefly describe how your business has been impacted by the COVID-19 pandemic and/or related Executive Orders.**

9. **Current status of your business:**

- Fully open for business and/or operating online
- Open but with reduced hours
- Reduced operations and/or operating online
- Closed to public but still operating onsite, online, or remotely
- Closed completely
- Other - Write In

10. **If awarded grant funding, how would you use the funds? Eligible expenses include current payroll obligations (i.e. may not include employees who have been laid off), lease or mortgage payments, utilities, accounts payable, property taxes and other critical business expenses. Please be detailed with uses and associated costs**.

11. **Is there anything else that we should be aware of in relation to your application or business?**

Commissioner _____ introduced the following resolution and moved its adoption:

EDA RESOLUTION NO. _____

RESOLUTION APPROVING ESTABLISHMENT OF THE SMALL BUSINESS EMERGENCY FORGIVABLE LOAN PROGRAM

WHEREAS, the Economic Development Authority of Brooklyn Center, Minnesota (the "EDA") was created pursuant to Minnesota Statutes, sections 469.090 through 469.1082 to exercise its powers to promote and protect economic development within the City of Brooklyn Center ("City"); and

WHEREAS, the spread of COVID-19 and the resulting emergency declarations and emergency orders issued by the Governor have created a great deal of uncertainty and has dramatically impacted local businesses, particularly small businesses; and

WHEREAS, the City has a large number of micro businesses, many owned by immigrants and people of color, that are a critical part of the economic vitality of the City and, as the EDA discussed at its May 4, 2020 work session, are the businesses that have been hit particularly hard by this emergency; and

WHEREAS, EDA staff prepared and presented a memo, which is incorporated herein by reference, ("Staff Memo") at the EDA's May 11, 2020 meeting that set out the details of a proposed Small Business Emergency Forgivable Loan Program ("Loan Program"); and

WHEREAS, it is consistent with the goals of the EDA, and is within its powers, to establish the proposed Loan Program in this extraordinary time to assist small businesses to remain in operation and maintain its employees to help protect the City's economy and reduce unemployment.

NOW, THEREFORE, BE IT RESOLVED, by the Economic Development Authority of Brooklyn Center, Minnesota Board of Commissioners as follows:

1. The EDA hereby establishes the "Small Business Emergency Forgivable Loan Program" as provided in this Resolution. The EDA authorizes a total of $150,000 to be used for the Loan Program, with individual loans of up to $3,000.

2. The Loan Program shall be structured in accordance with the provisions proposed in the Staff Memo.

3. The Executive Director and EDA staff are hereby authorized and directed to do each of the following regarding the Loan Program:

    a. Prepare an application, forgivable loan agreement, policy and guidelines, and such other documents as may be needed;
    b. Receive applications and determine eligibility;

c. Enter into such agreements on behalf of the EDA as may be needed;
d. Distribute loans to eligible small businesses;
e. Communicate with the loan recipients as needed to determine if they are eligible to have the loan forgiven and, if not, to collect the unforgiven portion of the loan with interest; and
f. Take all other actions, and execute such other documents, as may be needed to implement and carry out the Loan Program and the intent of this Resolution.

_____ _____

Date President

ATTEST: _____
Secretary

The motion for the adoption of the foregoing resolution was duly seconded by Commissioner _____

and upon vote being taken thereon, the following voted in favor thereof:

and the following voted against the same:

whereupon said resolution was declared duly passed and adopted.

Council/EDA Work Session
VIRTUAL meeting being conducted by electronic means in accordance with Minnesota Statutes, section 13D.021 Public portion available for connection via telephone Dial: 1-312-535-8110 Access Code: 281244297
May 11, 2020

AGENDA

ACTIVE DISCUSSION ITEMS

1. Concept Review from C Allan Homes for Sites along Brooklyn Boulevard

PENDING LIST FOR FUTURE WORK SESSIONS

1. Pending Items
   - Commemoration of 400 years of Slavery Activities
   - Livable Wages
   - Use of EDA Owned Property
   - Food Trucks
   - Strategic Plans for years 2018-2020 and 2021-2023
   - Discussion of Mayor/City Council roles & responsibilities (CommonSense Inc.)

MEMORANDUM - COUNCIL WORK SESSION

DATE: 5/11/2020

TO: City Council

FROM: Curt Boganey, City Manager

THROUGH: N/A

BY: Meg Beekman, Community Development Director

SUBJECT: Concept Review from C Allan Homes for Sites along Brooklyn Boulevard

Background:

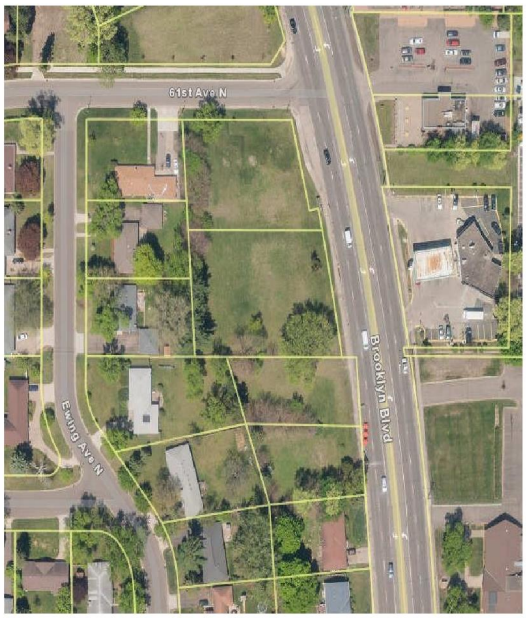
Concept Review Process
The concept review process is an opportunity for the City Council to review a development concept prior to a formal proposal from an applicant, and provide comments, ask questions, and indicate whether or not the City would be open to the project. Concept reviews are helpful for projects that would involve EDA-owned land or public subsidy, as it provides insight to staff and the developer as to the City Council's level of interest, and any specific concerns related to a project.

A concept review is considered advisory and is non-binding to the City and the applicant. No formal action can be taken at a work session, and the Council is not being asked to vote on the proposal. If the developer chooses to submit a formal application to the City, it would be subject to the full review process, as with any other development application.

Background
The EDA has been acquiring single family and undersized parcels along Brooklyn Boulevard for many years as part of a larger strategy to improve safety by reducing and consolidating access points, and to assemble land for redevelopment into high density land uses. The 2040 Comprehensive Plan created an overlay district along the corridor and re-guided most of the future land uses to neighborhood mixed use; allowing medium density residential and/or neighborhood-serving commercial uses. The 2040 Plan also called for a comprehensive land use study for the corridor to coincide with the road reconstruction plans as well as to create development standards that would create a more walkable, neighborhood-oriented development pattern.

The Brooklyn Boulevard land use study is underway, and a market analysis of the area in terms of feasible land uses has been completed. One of the goals of the study is to look at the EDA-owned sites, particularly those that are only as deep as a single family lot to determine how they could be redeveloped in a way that puts them back into productive use for the City.

The EDA currently owns four properties located at the southwest corner of 61st Avenue North and Brooklyn Boulevard, which total 1.55 acres. The EDA also owns four properties on the west side of the 6900 block of Brooklyn Boulevard that total .88 acres in size. The parcels were acquired between 1995 and 2018.





6100 Block 6900 Block

The market analysis for these sites found that a mid-density residential product such as row-homes or townhomes would be suitable for the sites, and that given their access constraints they were likely not suitable for retail. The market analysis did find that an office condo product could also be suitable for the sites, but that that market would not bear a speculative office development.

Development Plan
The City has been approached by Terry Robertson and Curt Brekke with C Allan Homes, a local builder and remodeling company specializing in high-end single family homes. Mr. Robertson and Mr. Brekke are interested in diversifying the focus of C Allan Homes and are seeking to develop both sites with a series of tri-plexes which would be available for rent. Each tri-plex would consist of three units with two and three bedrooms. Anticipated rents would range between $1,300/month up to $1,750 per month. They have indicated that each building would have the look and feel of a large, high quality single family home, with a combination of individual and shared on-site amenities.

Initial renderings of the proposed tri-plexes are attached, as well as a narrative from the developer describing their project in more detail and site plans for each site.

As this is a concept review, the submitted documents are early representations of the project and have not been reviewed in detail by staff.

The applicant is not seeking financial subsidy for the development. If the project were to proceed a purchase agreement would need to be negotiated and purchase price for the land determined.

Conformance with City Policies
The EDA has been acquiring property along Brooklyn Boulevard for decades with the intent of assembling it for higher and better use as the transportation and land use patterns of the corridor change. Brooklyn Boulevard is undergoing a complete reconstruction which will have an effect on the land use patterns as access points are consolidated and the roadway is altered.

With the adoption of the 2040 Comprehensive Plan, the City adopted new future land use designations for much of the Brooklyn Boulevard corridor, which included a new future land use designation of “Neighborhood Mixed Use (N-MU).” The NMU future land use designation contemplates an allowance of a mix of medium

density residential and/or commercial uses on a given site depending on its location along the corridor. For example, commercial uses, with a possible mix of housing, will likely converge around primary, signalized intersections, which offer better access and visibility; while medium density residential uses will make up the balance between these primary nodes.

The proposed development project is in keeping with the goals of the corridor, is consistent with the adjacent single family development, and provides a highest and best use for the affected EDA properties, some of which have been held by the City for many years.

Next Steps
The developer (C Allan Homes) will present their vision and concept in detail and take input from the City Council and incorporate comments received into any applications intended for formal submittal. If the projects were to proceed both sites would require preliminary and final plat. In addition, because the new zoning code work is not yet complete, the sites have not yet been rezoned. Therefore, a rezoning or PUD will also be required to accommodate the higher density land use.

The developer is also seeking a preliminary development agreement (PDA) from the EDA to gain development rights while they negotiate a purchase agreement and work through the land use approval process. Based on the discussion from the Council this evening, staff can begin drafting a PDA to be brought back to the EDA for consideration at a future meeting.

Policy Issues:

- Does the City Council/EDA have any questions/concerns for the developer?
- Is the City Council/EDA comfortable with the proposed land use for the two sites?
- Does the City Counicl/EDA have any feedback on the site plan or renderings?
- Is the City Council/EDA comfortable with moving forward with a Preliminary Development Agreement on the two sites?

Strategic Priorities and Values:

Targeted Redevelopment

ATTACHMENTS:

Description	Upload Date	Type
Resume	5/6/2020	Backup Material
Narrative	5/6/2020	Backup Material
6100 Block Aerial	5/5/2020	Backup Material
6900 Block Aerial	5/5/2020	Backup Material
Rendering 1	5/5/2020	Backup Material
Rendering 2	5/5/2020	Backup Material
Architectural Plans	5/5/2020	Backup Material
6100 Block Site Plan	5/6/2020	Backup Material
6900 Block Site Plan	5/6/2020	Backup Material

Terry Robertson

5215 Terraceview Lane N • Plymouth, MN 55446 • 763-228-1785 • Nationalchamp55442@yahoo.com

Terry Robertson has over 28 years of experience in both residential and commercial construction. He also has spent several years in residential and commercial development. Terry has the skill set to oversee projects as a project manager, general manager, construction manager and job superintendent. He is currently overseeing close to $12.9 million in projects in various phases of construction. Terry is a successful team manager from project start through completion, maximizing human capital and motivating and mentoring employees. His understanding of construction and development will benefit him from the development side as well as understanding cost structure on the construction side. Terry is excellent in communicating with diverse groups in different environments.

Millions of dollars in government contracts have been awarded to his company, C Alan Homes, LLC, through the Ramsey county 4R program including many projects with St Paul, Ramsey County, SPPH, MPHA and non-profits in Minneapolis and St. Paul.

Curt Brekke

10806 Gulden Avenue NW • Maple Lake, MN 55358 • 612-282-7546 • curtbrekke1962@gmail.com

Curt Brekke has over 19 years of residential and commercial construction experience and is a certified in residential energy auditing and lead-safe practices. He has successfully completed public housing projects with HUD. Curt is experienced in working and communicating with project developers, architects, designers and field managers to overcome obstacles in all phases of construction, as well as communicating with city staff through permitting and inspection. Curt manages multiple concurrent projects and schedules and overall cost management on construction projects.

C Alan Homes, LLC

Terry Robertson and Curt Brekke

A sample of addresses of custom homes built by C Alan Homes, LLC since 2017 include:

4648 Chowen Avenue S, Minneapolis	$900,000
5829 Fairfax Ave, Edina	$1.6 million
5608 Grove St, Edina	$1.4 million
4311 Morningside, Edina	$1.35 million
4001 Morningside, Edina	$1.53 million
5708 Fairfax, Edina	$1.3 million
5825 Saint John's, Edina	$1.3 million
2 Sunfish Lane, Mendota Heights	$5.5 million
5320 W. 60th St, Edina	$1 million

C Alan Homes, LLC

These homes will be built in the City of Minneapolis for low income affordable housing.

The triplexes will be built with high quality product that will last for years to come. For example, solid-core doors, custom cabinets, quality plumbing fixtures, granite countertops, Anderson or Pella windows, LVT flooring, and other products to ensure longevity for these homes. High efficiency furnaces, Hardie Board Color Plus siding with a 50-year warranty. Timberline shingles with a 30-year warranty.

C Alan Homes, LLC was started in 2010. We are a true Custom Home Builder and Developer. CAH Primarily builds homes starting in the low $1,000,000 range-$2,000,000, but we have homes as high as $6,000,000 currently under construction. CAH donates every year to low income families in Minneapolis, (NFL Alumni) Under privileged children, (Boulder Options) At risk kids and (Just 4 Kidz) Trying to better the quality of life for Minnesota Children.

Our vision is to build higher quality homes in Cities like Brooklyn Center that we have identified that our homes could benefit and work well in. Our homes will bring a quality product to tenants that normally would not be available in affordable homes. The tri-plex's are being decorated by award winning Designer Kimberly Niosi. The facades will vary. a non-row house look is what we will be bringing. Large floor plans 1175 to 1300 sq ft. Each Unit will have their own entrance.

Exterior will be James Hardi Color Plus Siding (Same siding we use on Million dollar plus homes.), Anderson or Pella windows. Lots of windows and large egress window pits to allow in tons of light on all 3 floors. Sound suppression between all floors to help with noise transfer. Granite or Quartz Countertops similar to our Custom builds. Custom Cabinets same as what we have in our $1.4 million dollar model home. Nicer higher end plumbing fixtures. Solid Core doors to help with the wear and tear of renting a home. Oversized trim similar to our custom home builds

Minimum 6 parking stalls per building. 3-Bedroom, 2-bath units.

Multiple raised vegetable gardens for tenants. In ground Charcoal Grills (1) per building. Large concrete patio's for each building

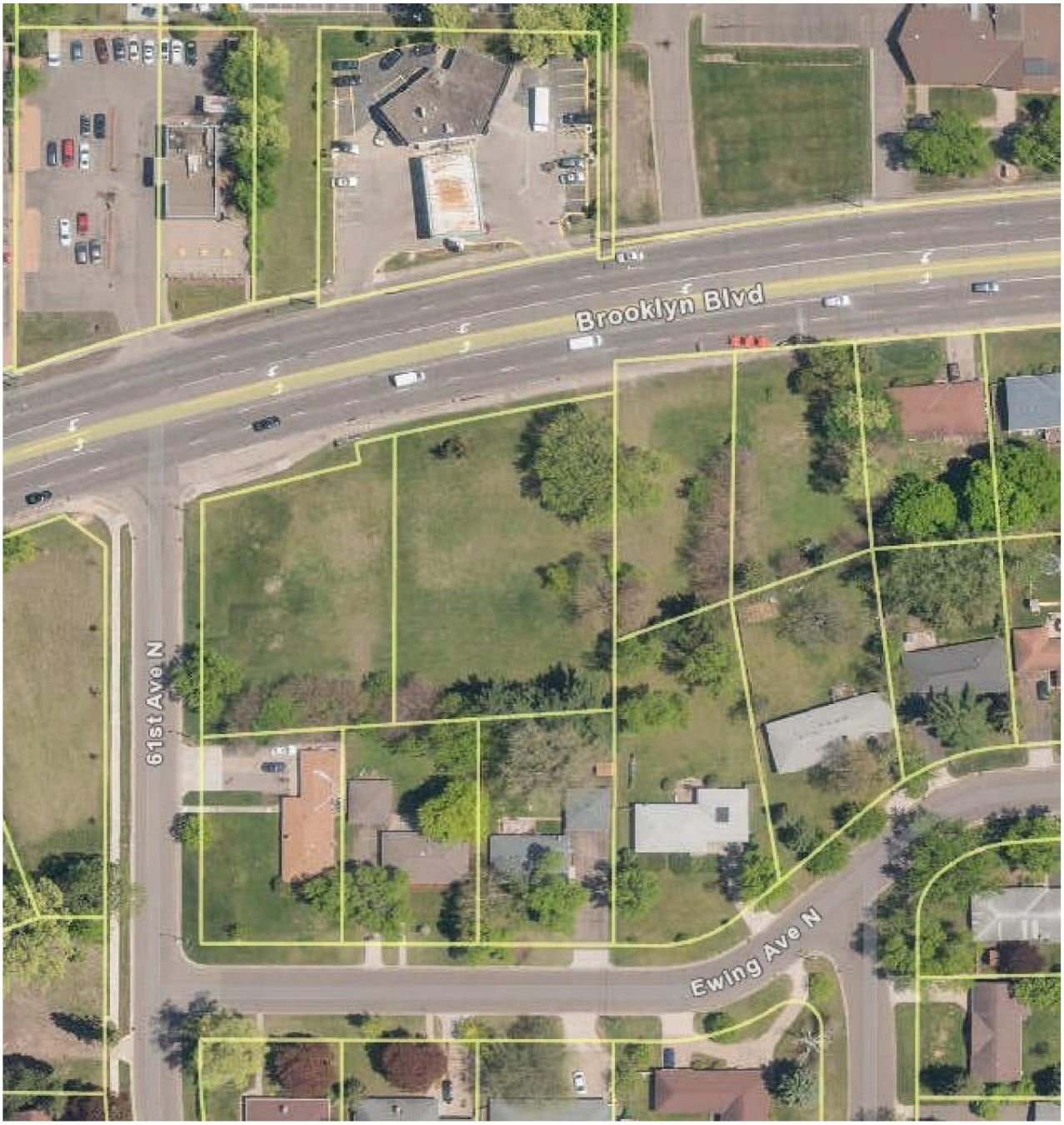
We anticipate charging $1650-$2200 monthly rent rates. This depends on the market and our final costs to build. These rates are still affordable for 3-bedroom, 2-bath units, and yet could easily be $2400-$2800. CAH is trying to bring an upper level product to the City but keep an affordable rate. (This is due to our personal backgrounds and upbringing.)

Bringing quality to the sites at 60th and 69th and Brooklyn Blvd will help revitalize and benefit the city with new tax revenue. While lending an upscale feel to the newly built up area. The City will also gain by having affordable housing that has a timeless feel, sustainable housing inside and outside, upscale look and a quality of life tenants are not accustomed to. Attracting new homebuyers, builders and developers will be a result of building nicer housing in the area. All this without requesting any City, State or Federal dollars, tax credits or repayment arrangements.

Our proposed entrance to the 60th parcel would be coming off 61st and exiting off Brooklyn Blvd turning right only. The proposed entrance to the 69th parcel would be coming off of Lee and exiting off of Brooklyn Blvd, turning right only.

We would highly encourage you and your team to come and visit one of our Custom home builds that will be similar in quality and spec. This will give you an idea of the type of sustainable living we are trying to bring to your City and your tenants!

Terry Robertson


Brooklyn Blvd
61st Ave N
Ewing Ave N


152
Brooklyn Blvd
le Ave N
70th Ave N
Lee Ave N
70th Ave N
Lee Ave N
Brooklyn Blvd
152





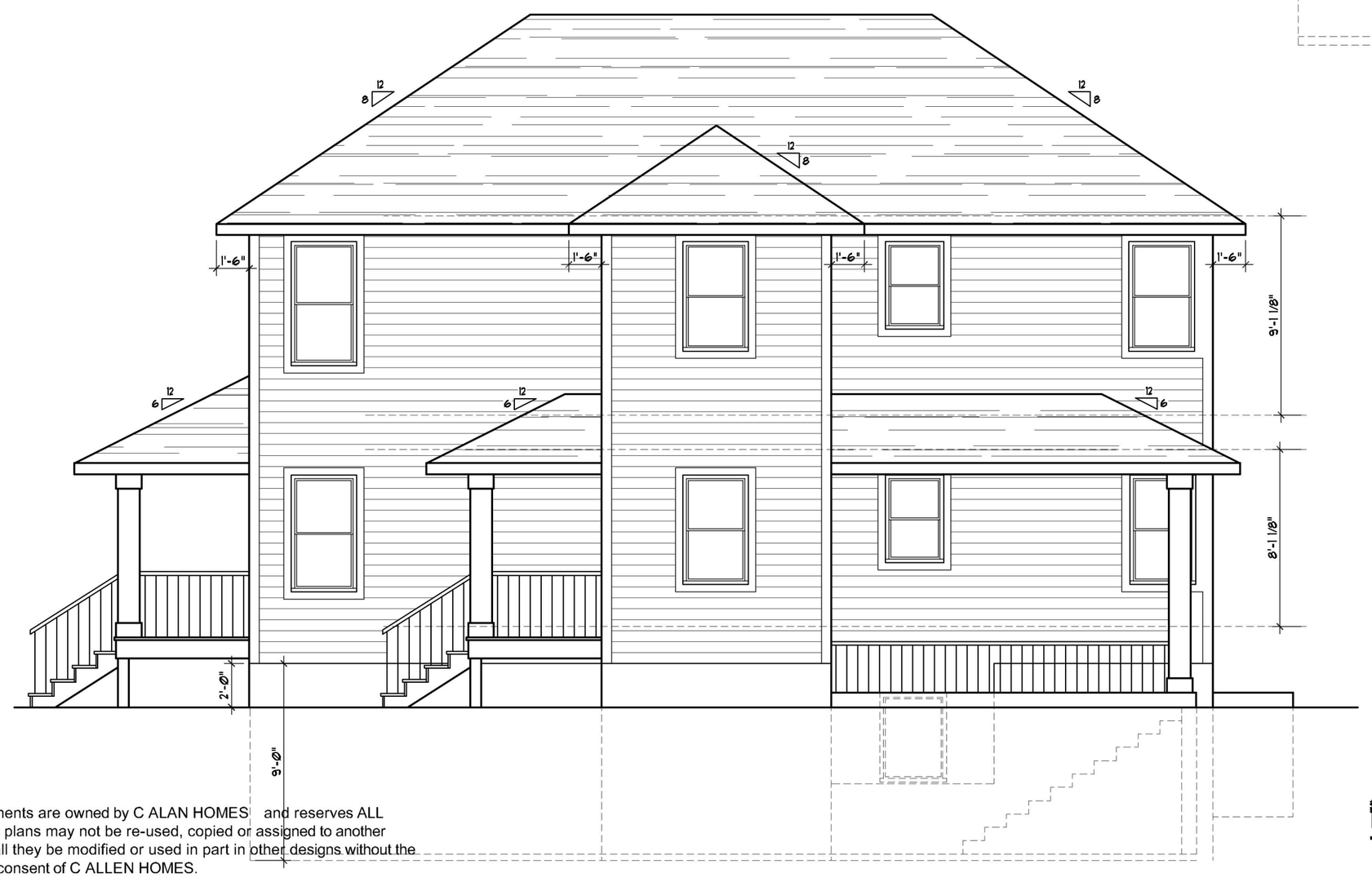




GENERAL NOTES:
1. ALL DOOR AND WINDOW HEADERS TO BE S.P.F. #2 OR BETTER, SEE PLANS FOR SIZES.
2. HOUSE TO BE BUILT PER CURRENT I.R.C. CODES.
3. VERIFY GRADES AND ADJUST FOUNDATION/FOOTING STEPS AS NEEDED.
4. SEE PLANS FOR CEILING HEIGHTS
5. 8' HIGH POURED FDN. WALLS STD.
6. FLOOR PLAN DIMENSIONS ARE TO FACE OF FRAMING AND FOUNDATION.
7. 1/2''' O.S.B. SHEATHING ON ALL EXTERIOR WALLS, SEE PLAN FOR LOCATION OF BRACED WALL PANELS.
8. ALL TRADES & SUPPLIERS TO REVIEW & VERIFY INFORMATION PERTINENT TO THEIR WORK AND NOTIFY "C ALLEN HOMES" OF ANY DISCREPANCIES PRIOR TO CONSTRUCTION.



FRONT ELEVATION
SCALE: 1/4" = 1'-0"



RIGHT ELEVATION
SCALE: 3/16'' = 1'-0"

PROJECT STATS:

BASEMENT S.F. = 1175
FIRST FLOOR S.F. = 1175
SECOND FLOOR S.F.=1175
TOTAL FINISHED S.F. =3525

BASEMENT CEILING = 8'-10''
FIRST FLR. CEILING = 8'-1''
SECOND FLR. CEILING = 9'-1''

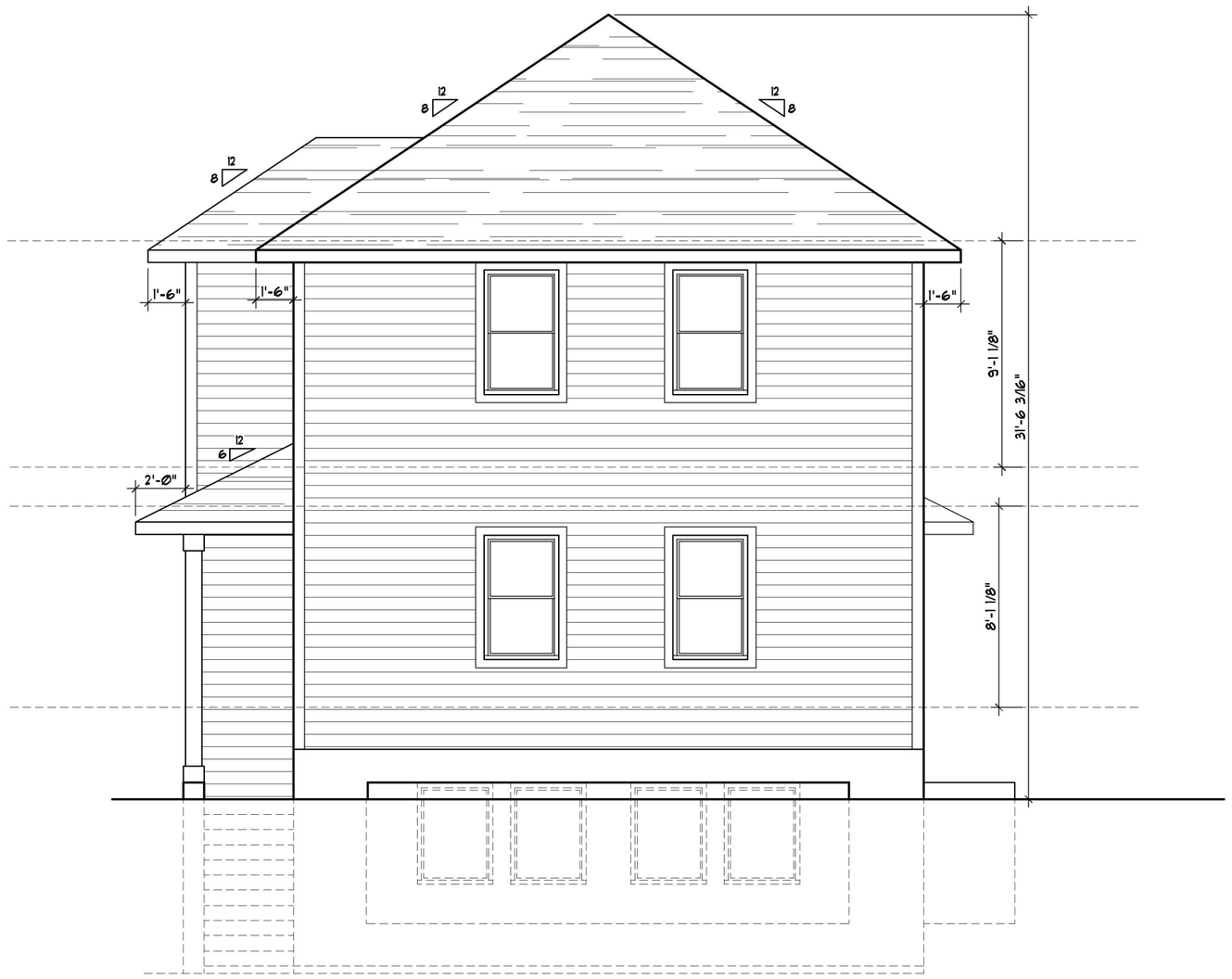
18'' FLOOR TRUSSES @19.2''
9'-0'' POURED FDN.

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designed living
Custom Designed Homes, Additions and Remodels
Steven R. Vespested
DESIGNER
Prior Lake, Minnesota 55372
cell 952-270-2797
ssvess@uiveramail.net

C Alan Homes
x x x Custom Tri-Plex Plans

PROJ. #	009-20 C Alan
START DATE:	02-22-20
DRAWN BY:	
CONTACT:	
APPROVED:	X-X-20
REVISIONS:	
changes per lot size	
x	
X	
X	



REAR ELEVATION

SCALE: 3/16" = 1'-0"



LRFT ELEVATION

SCALE: 3/16" = 1'-0"

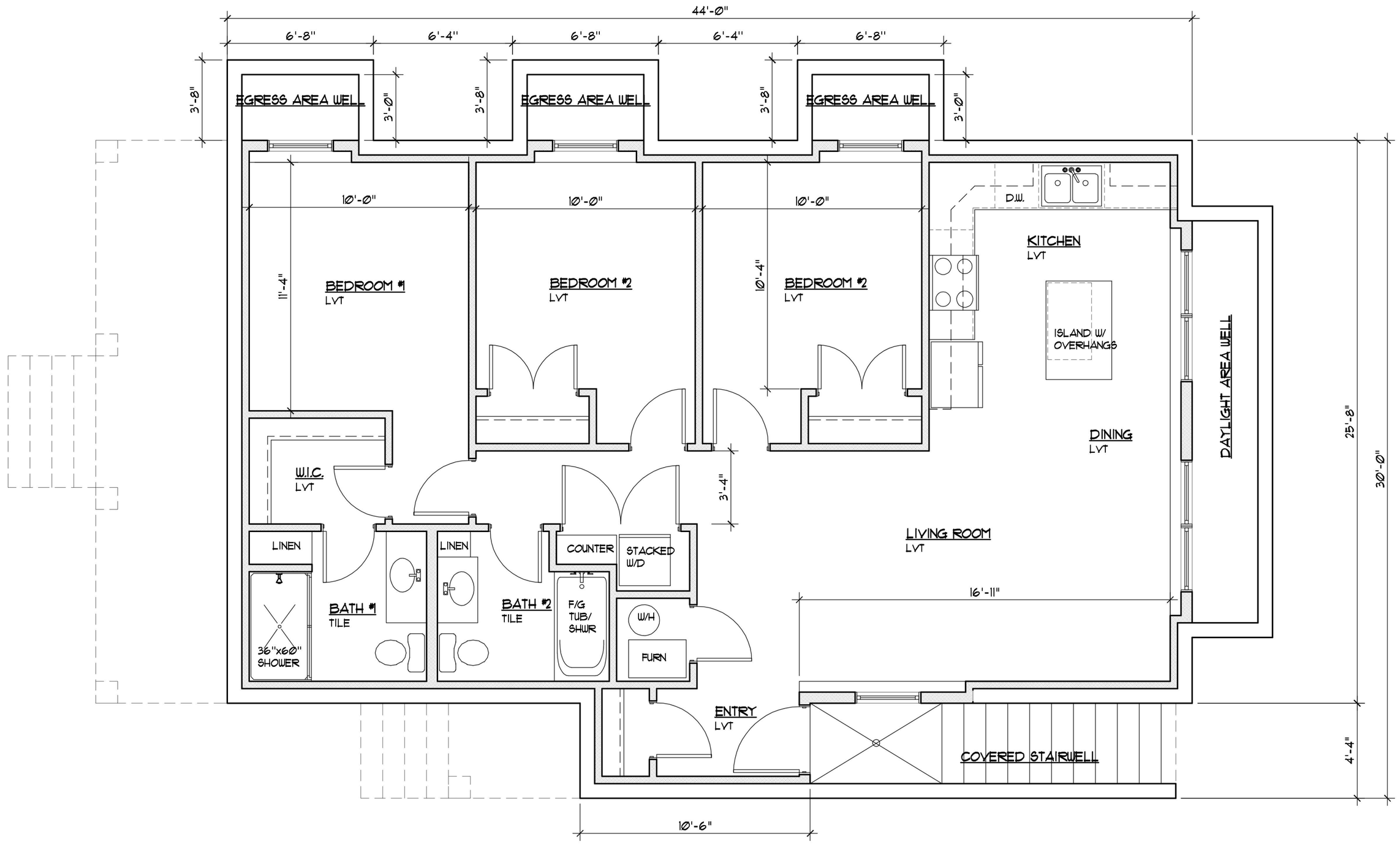
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x x
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X	
X	

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BASEMENT S.F. = 1,175

BASEMENT HEADERS= 7'-8" U.N.O.
BASEMENT CEILING = 8'-10"
ANDERSSEN 400 D.H. WINDOWS

BASEMENT / FOUNDATION PLAN

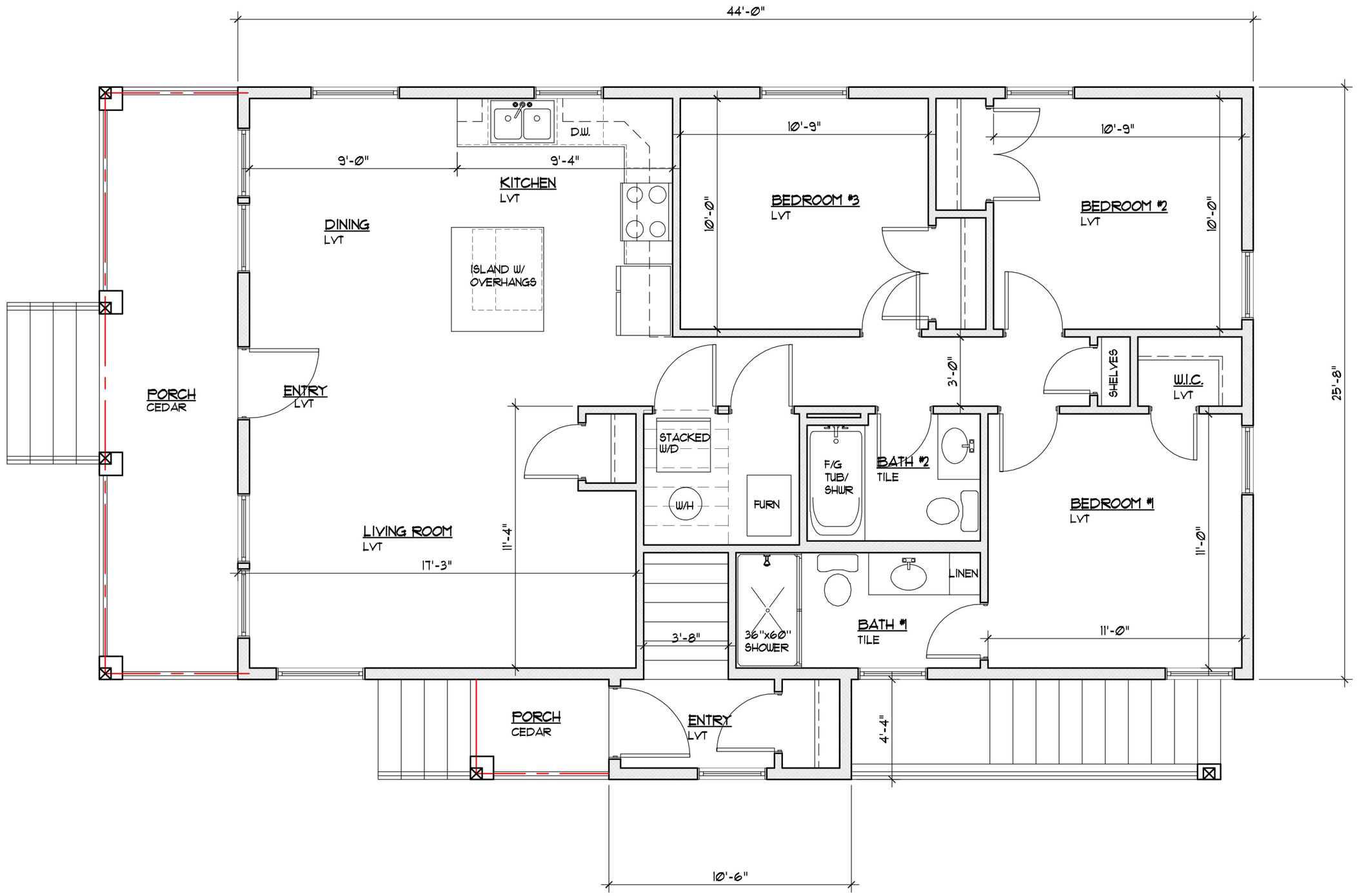
SCALE: 1/4" = 1'-0"

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C Alan Homes
x x x Custom Tri-Plex Plans

PROJ. #	009-20 C Alan
START DATE:	02-22-20
DRAWN BY:	
CONTACT:	
APPROVED:	X-X-20
REVISIONS:	
changes per lot size	
x	
X	
X	

SHEET 3 OF 8



FIRST FLOOR S.F. = 1,175

FRONT PORCH S.F. =152

FIRST FLOOR HEADERS= 7'-11" U.N.O.
FIRST FLOOR CEILING = 8'-Ø"
ANDERSSEN 400 D.H. WINDOWS

FIRST FLOOR PLAN

SCALE: 1/4" = 1'-Ø"

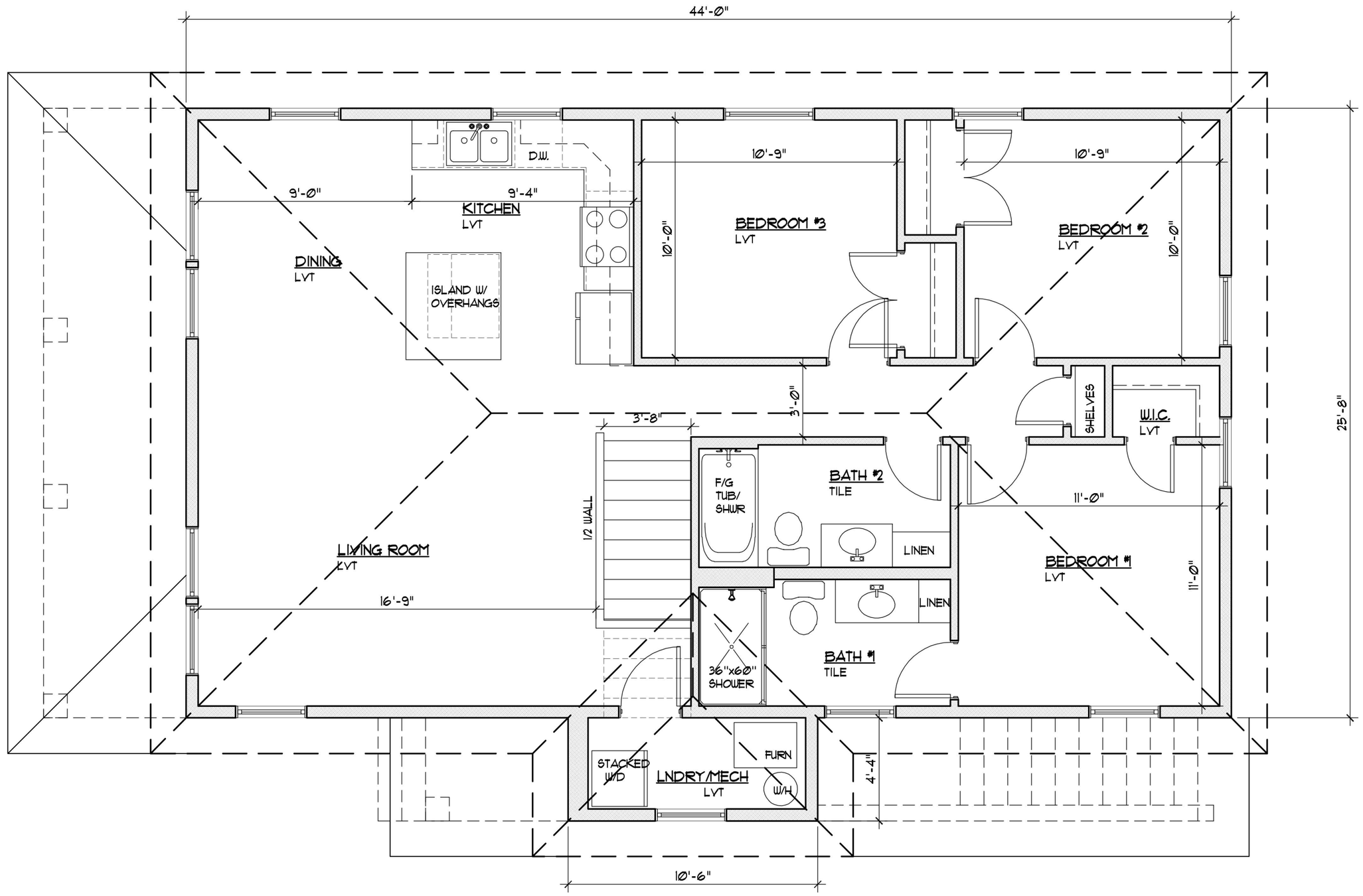
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C Alan Homes
x x
Custom Tri-Plex Plans

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REVISIONS:	
changes per lot size	
x	
X	
X	

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SECOND FLOOR S.F. = 1,175

SECOND FLOOR HEADERS= 7'-11" U.N.O.
SECOND FLOOR CEILING = 9'-Ø"
ANDERSSEN 400 D.H. WINDOWS

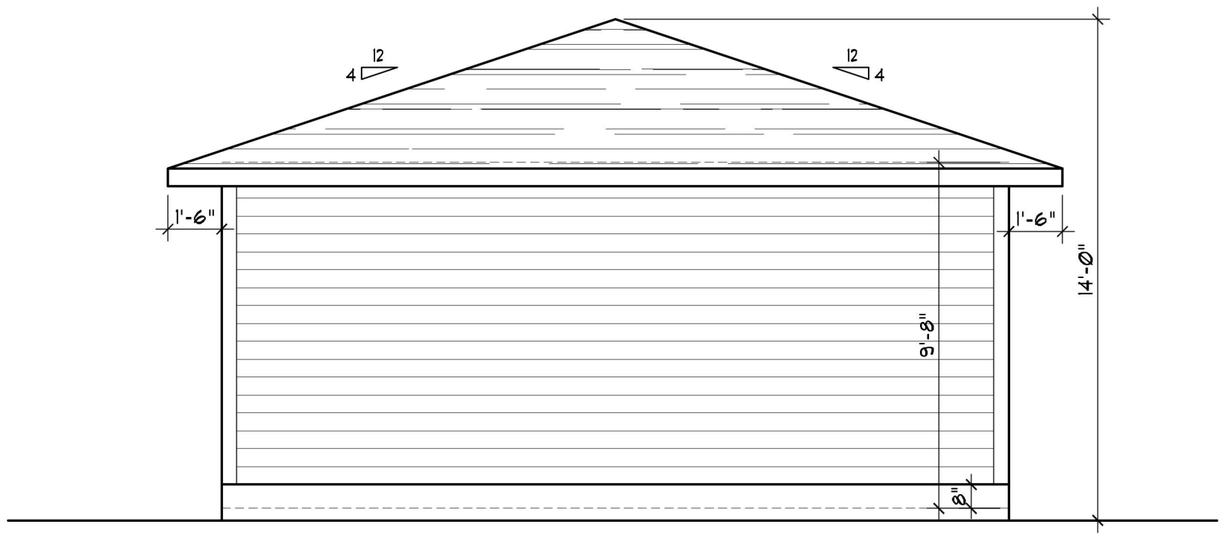
SECOND FLOOR PLAN

SCALE: 1/4" = 1'-Ø"

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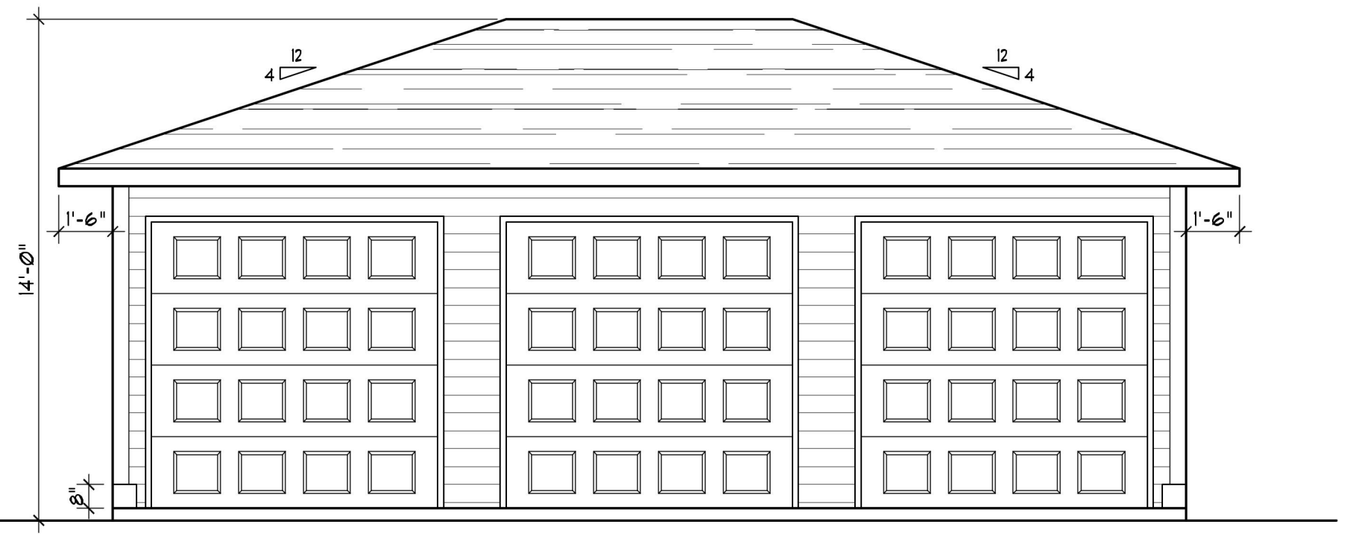
C Alan Homes
x x
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DRAWN BY:	
CONTACT:	
APPROVED:	X-X-20
REVISIONS:	
changes per lot size	
X	
X	
X	



SIDE ELEVATIONS

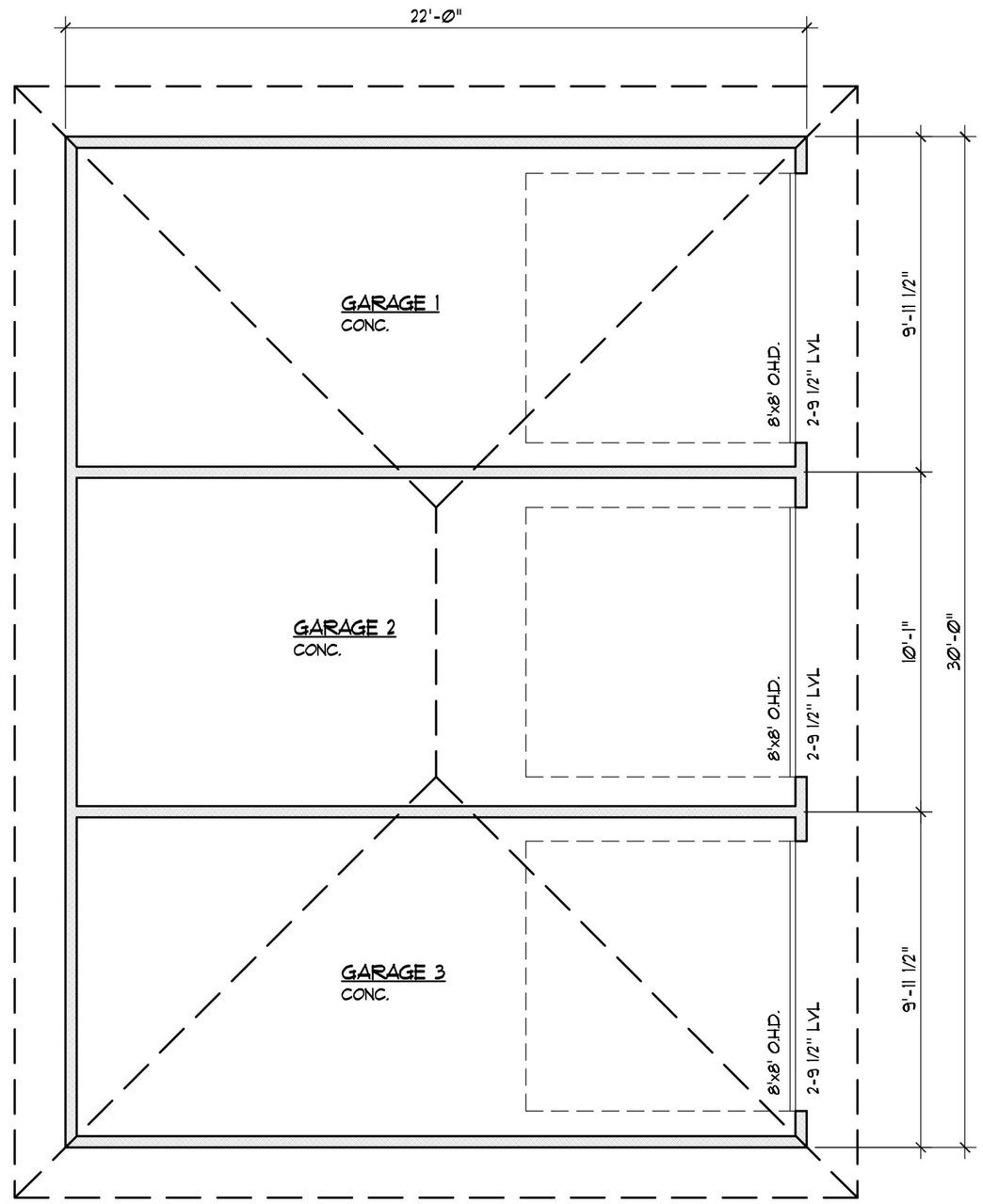
SCALE: 1/4" = 1'-0"



FRONT ELEVATION

SCALE: 1/4" = 1'-0"

REAR SIMILAR W/O DOORS



GARAGE PLAN

SCALE: 1/4" = 1'-0"

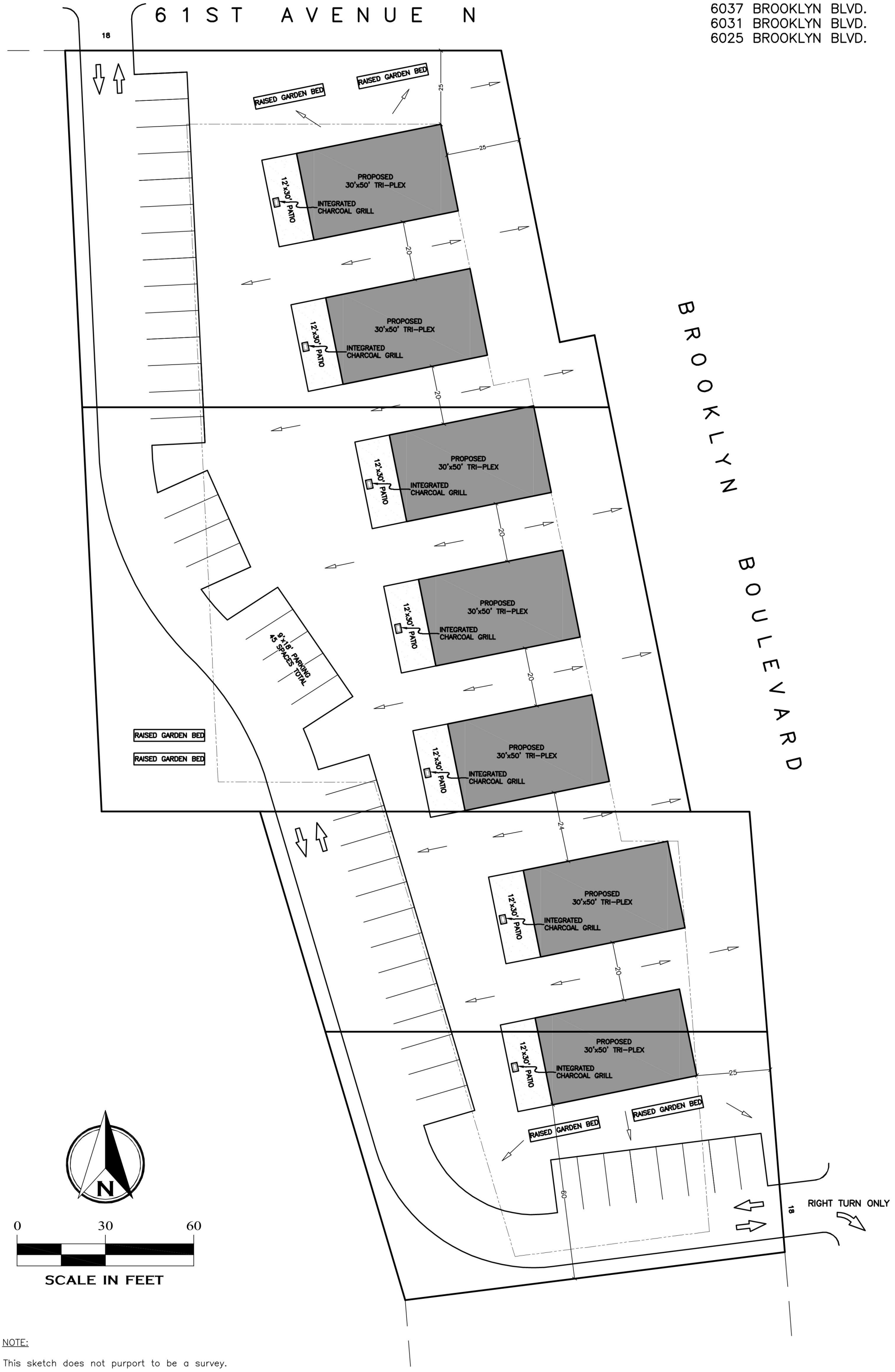
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x x x
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CONTACT:	
APPROVED:	X-X-20
REVISIONS:	
changes per lot size	
X	
X	
X	

6045 BROOKLYN BLVD.
6037 BROOKLYN BLVD.
6031 BROOKLYN BLVD.
6025 BROOKLYN BLVD.



SCALE IN FEET

NOTE:

This sketch does not purport to be a survey.

6939 BROOKLYN BLVD.
6933 BROOKLYN BLVD.
6927 BROOKLYN BLVD.
6921 BROOKLYN BLVD.

70TH AVE. N

LEE AVENUE NORTH

BROOKLYN BOULEVARD

EXISTING CURB

14

184

10.5

145

10

RAISED GARDEN BED

RAISED GARDEN BED

PROPOSED 30'x50' TRI-PLEX

INTEGRATED CHARCOAL GRILL

12'x30' PATIO

8

20

PROPOSED 30'x50' TRI-PLEX

INTEGRATED CHARCOAL GRILL

12'x30' PATIO

8

20

18

10

78

PROPOSED 30'x50' TRI-PLEX

INTEGRATED CHARCOAL GRILL

12'x30' PATIO

118

78

PROPOSED 30'x50' TRI-PLEX

INTEGRATED CHARCOAL GRILL

12'x30' PATIO

20

78

9'x18' PARKING
30 SPACES TOTAL

78

PROPOSED 30'x50' TRI-PLEX

INTEGRATED CHARCOAL GRILL

12'x30' PATIO

8

20

78

10

RIGHT TURN ONLY

18

PROPOSED 30'x50' TRI-PLEX

INTEGRATED CHARCOAL GRILL

12'x30' PATIO

25

58

78

118

N

0 30 60

SCALE IN FEET

NOTE:

This sketch does not purport to be a survey.

MEMORANDUM - COUNCIL WORK SESSION

DATE: 5/11/2020

TO: City Council

FROM: Curt Boganey, City Manager

THROUGH: Dr. Reggie Edwards, Deputy City Manager

BY: Barb Suciu, City Clerk

SUBJECT: Pending Items

Recommendation:

- Commemoration of 400 years of Slavery Activities
- Livable Wages
- Use of EDA Owned Property
- Food Trucks
- Strategic Plans for years 2018-2020 and 2021-2023
- Discussion of Mayor/City Council roles & responsibilities (CommonSense Inc.)

Background:

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Operational Excellence