State of Minnesota

HOUSE OF REPRESENTATIVES

NINETIETH SESSION

H. F. No. 3138

02/26/2018 Authored by Dean, M.,
The bill was read for the first time and referred to the Committee on Health and Human Services Finance
04/23/2018 Adoption of Report: Amended and re-referred to the Committee on Ways and Means

A bill for an act

relating to human services; modifying provisions governing Department of Health and public health, health care, chemical and mental health, opioids and prescription drugs, community supports and continuing care, protections for older adults and vulnerable adults, children and families, health licensing boards, and MNsure; establishing the Vulnerable Adult Maltreatment Prevention and Accountability Act; modifying requirements for data sharing and data classifications; modifying a criminal penalty; establishing working groups; establishing prescription drug repository program; entering into nurse licensure compact; providing for rulemaking; requiring reports; modifying fees; making forecast adjustments; appropriating money; amending Minnesota Statutes 2016, sections 13.83, subdivision 2; 13.851, by adding a subdivision; 62A.30, by adding a subdivision; 62A.65, subdivision 7; 62Q.55, subdivision 5; 62V.05, subdivisions 2, 5, 10; 103I.205, subdivision 9; 103I.301, subdivision 6; 119B.011, by adding a subdivision; 119B.02, subdivision 7; 119B.03, subdivision 9; 144.121, subdivision 1a, by adding a subdivision; 144.1501, subdivisions 1, 3; 144.1506, subdivision 2; 144.608, subdivision 1; 144.6501, subdivision 3, by adding a subdivision; 144.651, subdivisions 1, 2, 4, 14, 16, 20, 21; 144A.10, subdivision 1; 144A.26; 144A.43, subdivisions 11, 27, 30, by adding a subdivision; 144A.44, subdivision 1; 144A.442; 144A.45, subdivisions 1, 2; 144A.472, subdivision 5; 144A.473; 144A.474, subdivisions 2, 8, 9; 144A.475, subdivisions 1, 2, 5; 144A.476, subdivision 1; 144A.479, subdivision 7; 144A.4791, subdivisions 1, 3, 6, 7, 8, 9, 10, 13; 144A.4792, subdivisions 1, 2, 5, 10; 144A.4793, subdivision 6; 144A.4797, subdivision 3; 144A.4798; 144A.4799, subdivision 1; 144A.484, subdivision 1; 144A.53, subdivisions 1, 4, by adding subdivisions; 144D.01, subdivision 1; 144D.02; 144D.04, by adding a subdivision; 144E.16, by adding subdivisions; 144G.01, subdivision 1; 145.56, subdivision 2; 145.928, subdivisions 1, 7; 146B.03, by adding a subdivision; 147A.08; 148.512, subdivision 17a; 148.513, subdivisions 1, 2, by adding a subdivision; 148.515, subdivision 1; 148.516; 148.519, by adding a subdivision; 148.5192, subdivision 1; 148.5193, by adding a subdivision; 148.5194, subdivision 8, by adding a subdivision; 148.5195, subdivision 3; 148.5196, subdivision 3; 148.59; 148E.180; 149A.40, subdivision 11; 149A.95, subdivision 3; 150A.06, subdivision 1a, by adding subdivisions; 150A.091, by adding subdivisions; 151.15, by adding subdivisions; 151.19, subdivision 1; 151.214, subdivision 2; 151.46; 151.71, by adding a subdivision; 152.11, by adding a subdivision; 169.345, subdivision 2; 214.075, subdivisions 1, 4, 5, 6; 214.077; 214.10, subdivision 8; 214.12, by adding a subdivision; 243.166, subdivision 4b; 245A.04, subdivision 7, by adding a subdivision; 245C.22, subdivision 4; 245D.071, subdivision 5; 245D.091, subdivisions 2, 3, 4; 254B.02, subdivision 1; 256.01, by

adding a subdivision; 256.014, subdivision 2; 256.975, subdivision 7b; 256B.0575, subdivision 1; 256B.0595, subdivision 3; 256B.0625, subdivisions 2, 18d, 30, by adding subdivisions; 256B.0659, subdivisions 11, 21, 24, 28, by adding a subdivision; 256B.4914, subdivision 4; 256B.5012, by adding a subdivision; 256B.69, subdivision 5a; 256K.45, subdivision 2; 256M.41, subdivision 3; 256R.53, subdivision 2; 259.24, subdivision 2; 325F.71; 518A.32, subdivision 3; 518A.685; 609.2231, subdivision 8; 626.557, subdivisions 3, 4, 9, 9a, 9b, 9c, 9d, 10b, 12b, 14, 17; 626.5572, subdivision 6; 641.15, subdivision 3a; Minnesota Statutes 2017 Supplement, sections 13.69, subdivision 1; 103I.005, subdivisions 2, 8a, 17a; 103I.205, subdivisions 1, 4; 103I.208, subdivision 1; 103I.235, subdivision 3; 103I.601, subdivision 4; 119B.011, subdivision 20; 119B.025, subdivision 1; 119B.095, by adding a subdivision; 119B.13, subdivision 1; 144.1501, subdivision 2; 144A.10, subdivision 4; 144A.472, subdivision 7; 144A.474, subdivision 11; 144A.4796, subdivision 2; 144A.4799, subdivision 3; 144D.04, subdivision 2; 144H.01, subdivision 5; 144H.04, subdivision 1; 148.519, subdivision 1; 148.5193, subdivision 1; 148.5196, subdivision 1; 152.105, subdivision 2; 245A.03, subdivision 7; 245A.06, subdivision 8; 245A.11, subdivision 2a; 245A.50, subdivision 7; 245C.22, subdivision 5; 245D.03, subdivision 1; 245G.03, subdivision 1; 245G.22, subdivision 2; 252.41, subdivision 3; 254A.03, subdivision 3; 254B.03, subdivision 2; 256.045, subdivisions 3, 4; 256B.0625, subdivisions 3b, 56a; 256B.0921; 256B.4913, subdivision 7; 256B.4914, subdivisions 2, 3, 5, 6, 7, 8, 9, 10, 10a; 260C.007, subdivision 6; 364.09; Laws 2014, chapter 312, article 27, section 76; Laws 2017, First Special Session chapter 6, article 3, section 49; article 8, sections 71; 72; 74; article 18, sections 3, subdivision 2; 16, subdivision 2; proposing coding for new law in Minnesota Statutes, chapters 62Q; 137; 144; 144D; 144G; 148; 151; 245A; 256; 256B; 256K; 260C; repealing Minnesota Statutes 2016, sections 62A.65, subdivision 7a; 144A.45, subdivision 6; 144A.481; 151.55; 214.075, subdivision 8; 256.021; 256B.0705; Minnesota Statutes 2017 Supplement, section 146B.02, subdivision 7a.

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

ARTICLE 1

DEPARTMENT OF HEALTH AND PUBLIC HEALTH

Section 1. Minnesota Statutes 2017 Supplement, section 103I.005, subdivision 2, is amended to read:

Subd. 2. **Boring.** "Boring" means a hole or excavation that ~~is not used to extract water and~~ includes exploratory borings, bored geothermal heat exchangers, temporary borings, and elevator borings.

Sec. 2. Minnesota Statutes 2017 Supplement, section 103I.005, subdivision 8a, is amended to read:

Subd. 8a. **Environmental well.** "Environmental well" means an excavation 15 or more feet in depth that is drilled, cored, bored, washed, driven, dug, jetted, or otherwise constructed to:

(1) conduct physical, chemical, or biological testing of groundwater, and includes a groundwater quality monitoring or sampling well;

(2) lower a groundwater level to control or remove contamination in groundwater, and includes a remedial well and excludes horizontal trenches; or

(3) monitor or measure physical, chemical, radiological, or biological parameters of the earth and earth fluids, or for vapor recovery or venting systems. An environmental well includes an excavation used to:

(i) measure groundwater levels, including a piezometer;

(ii) determine groundwater flow direction or velocity;

(iii) measure earth properties such as hydraulic conductivity, bearing capacity, or resistance;

(iv) obtain samples of geologic materials for testing or classification; or

(v) remove or remediate pollution or contamination from groundwater or soil through the use of a vent, vapor recovery system, or sparge point.

An environmental well does not include an exploratory boring.

Sec. 3. Minnesota Statutes 2017 Supplement, section 103I.005, subdivision 17a, is amended to read:

Subd. 17a. **Temporary ~~environmental well~~ boring.** ~~"Temporary environmental well" means an environmental well as defined in section 103I.005, subdivision 8a, that is sealed within 72 hours of the time construction on the well begins.~~ "Temporary boring" means an excavation that is 15 feet or more in depth that is sealed within 72 hours of the start of construction and is drilled, cored, washed, driven, dug, jetted, or otherwise constructed to:

(1) conduct physical, chemical, or biological testing of groundwater, including groundwater quality monitoring;

(2) monitor or measure physical, chemical, radiological, or biological parameters of earth materials or earth fluids, including hydraulic conductivity, bearing capacity, or resistance;

(3) measure groundwater levels, including use of a piezometer;

(4) determine groundwater flow direction or velocity; or

(5) collect samples of geologic materials for testing or classification, or soil vapors for testing or extraction.

Sec. 4. Minnesota Statutes 2017 Supplement, section 103I.205, subdivision 1, is amended to read:

Subdivision 1. **Notification required.** (a) Except as provided in paragraph (d), a person may not construct a water-supply, dewatering, or environmental well until a notification of the proposed well on a form prescribed by the commissioner is filed with the commissioner with the filing fee in section 103I.208, and, when applicable, the person has met the requirements of paragraph (e). If after filing the well notification an attempt to construct a well is unsuccessful, a new notification is not required unless the information relating to the successful well has substantially changed. A notification is not required prior to construction of a temporary ~~environmental well~~ boring.

(b) The property owner, the property owner's agent, or the licensed contractor where a well is to be located must file the well notification with the commissioner.

(c) The well notification under this subdivision preempts local permits and notifications, and counties or home rule charter or statutory cities may not require a permit or notification for wells unless the commissioner has delegated the permitting or notification authority under section 103I.111.

(d) A person who is an individual that constructs a drive point water-supply well on property owned or leased by the individual for farming or agricultural purposes or as the individual's place of abode must notify the commissioner of the installation and location of the well. The person must complete the notification form prescribed by the commissioner and mail it to the commissioner by ten days after the well is completed. A fee may not be charged for the notification. A person who sells drive point wells at retail must provide buyers with notification forms and informational materials including requirements regarding wells, their location, construction, and disclosure. The commissioner must provide the notification forms and informational materials to the sellers.

(e) When the operation of a well will require an appropriation permit from the commissioner of natural resources, a person may not begin construction of the well until the person submits the following information to the commissioner of natural resources:

(1) the location of the well;

(2) the formation or aquifer that will serve as the water source;

(3) the maximum daily, seasonal, and annual pumpage rates and volumes that will be requested in the appropriation permit; and

(4) other information requested by the commissioner of natural resources that is necessary to conduct the preliminary assessment required under section 103G.287, subdivision 1, paragraph (c).

The person may begin construction after receiving preliminary approval from the commissioner of natural resources.

Sec. 5. Minnesota Statutes 2017 Supplement, section 103I.205, subdivision 4, is amended to read:

Subd. 4. **License required.** (a) Except as provided in paragraph (b), (c), (d), or (e), section 103I.401, subdivision 2, or 103I.601, subdivision 2, a person may not drill, construct, repair, or seal a well or boring unless the person has a well contractor's license in possession.

(b) A person may construct, repair, and seal an environmental well or temporary boring if the person:

(1) is a professional engineer licensed under sections 326.02 to 326.15 in the branches of civil or geological engineering;

(2) is a hydrologist or hydrogeologist certified by the American Institute of Hydrology;

(3) is a professional geoscientist licensed under sections 326.02 to 326.15;

(4) is a geologist certified by the American Institute of Professional Geologists; or

(5) meets the qualifications established by the commissioner in rule.

A person must be licensed by the commissioner as an environmental well contractor on forms provided by the commissioner.

(c) A person may do the following work with a limited well/boring contractor's license in possession. A separate license is required for each of the four activities:

(1) installing, repairing, and modifying well screens, pitless units and pitless adaptors, well pumps and pumping equipment, and well casings from the pitless adaptor or pitless unit to the upper termination of the well casing;

(2) sealing wells and borings;

(3) constructing, repairing, and sealing dewatering wells; or

(4) constructing, repairing, and sealing bored geothermal heat exchangers.

(d) A person may construct, repair, and seal an elevator boring with an elevator boring contractor's license.

(e) Notwithstanding other provisions of this chapter requiring a license, a license is not required for a person who complies with the other provisions of this chapter if the person is:

(1) an individual who constructs a water-supply well on land that is owned or leased by the individual and is used by the individual for farming or agricultural purposes or as the individual's place of abode; or

(2) an individual who performs labor or services for a contractor licensed under the provisions of this chapter in connection with the construction, sealing, or repair of a well or boring at the direction and under the personal supervision of a contractor licensed under the provisions of this chapter~~; or~~.

~~(3) a licensed plumber who is repairing submersible pumps or water pipes associated with well water systems if: (i) the repair location is within an area where there is no licensed well contractor within 50 miles, and (ii) the licensed plumber complies with all relevant sections of the plumbing code.~~

Sec. 6. Minnesota Statutes 2016, section 103I.205, subdivision 9, is amended to read:

Subd. 9. **Report of work.** Within ~~30~~ 60 days after completion or sealing of a well or boring, the person doing the work must submit a verified report to the commissioner containing the information specified by rules adopted under this chapter.

Within 30 days after receiving the report, the commissioner shall send or otherwise provide access to a copy of the report to the commissioner of natural resources, to the local soil and water conservation district where the well is located, and to the director of the Minnesota Geological Survey.

Sec. 7. Minnesota Statutes 2017 Supplement, section 103I.208, subdivision 1, is amended to read:

Subdivision 1. **Well notification fee.** The well notification fee to be paid by a property owner is:

(1) for construction of a water supply well, $275, which includes the state core function fee;

(2) for a well sealing, $75 for each well or boring, which includes the state core function fee, except that a single fee of $75 is required for all temporary ~~environmental wells~~ borings recorded on the sealing notification for a single property~~, having depths within a 25 foot range, and~~ sealed within 72 hours of start of construction, except that temporary borings

less than 25 feet in depth are exempt from the notification and fee requirements in this chapter;

(3) for construction of a dewatering well, $275, which includes the state core function fee, for each dewatering well except a dewatering project comprising five or more dewatering wells shall be assessed a single fee of $1,375 for the dewatering wells recorded on the notification; and

(4) for construction of an environmental well, $275, which includes the state core function fee, except that a single fee of $275 is required for all environmental wells recorded on the notification that are located on a single property, and except that no fee is required for construction of a temporary ~~environmental well~~ boring.

Sec. 8. Minnesota Statutes 2017 Supplement, section 103I.235, subdivision 3, is amended to read:

Subd. 3. **Temporary ~~environmental well~~ boring and unsuccessful well exemption.** This section does not apply to temporary ~~environmental wells~~ borings or unsuccessful wells that have been sealed by a licensed contractor in compliance with this chapter.

Sec. 9. Minnesota Statutes 2016, section 103I.301, subdivision 6, is amended to read:

Subd. 6. **Notification required.** A person may not seal a well or boring until a notification of the proposed sealing is filed as prescribed by the commissioner. Temporary borings less than 25 feet in depth are exempt from the notification requirements in this chapter.

Sec. 10. Minnesota Statutes 2017 Supplement, section 103I.601, subdivision 4, is amended to read:

Subd. 4. **Notification and map of borings.** (a) By ten days before beginning exploratory boring, an explorer must submit to the commissioner of health a notification of the proposed boring ~~on a form prescribed by the commissioner,~~ map and a fee of $275 ~~for each exploratory boring~~.

(b) By ten days before beginning exploratory boring, an explorer must submit to the commissioners of health and natural resources a county road map on a single sheet of paper that is eight and one-half by 11 inches in size and having a scale of one-half inch equal to one mile, as prepared by the Department of Transportation, or a 7.5 minute series topographic map (1:24,000 scale), as prepared by the United States Geological Survey, showing the location of each proposed exploratory boring to the nearest estimated 40 acre parcel.

Exploratory boring that is proposed on the map may not be commenced later than 180 days after submission of the map, unless a new map is submitted.

Sec. 11. **[137.68] ADVISORY COUNCIL ON RARE DISEASES.**

Subdivision 1. **Establishment.** The Board of Regents of the University of Minnesota is requested to establish an advisory council on rare diseases to provide advice on research, diagnosis, treatment, and education related to rare diseases. For purposes of this section, "rare disease" has the meaning given in United States Code, title 21, section 360bb. The council shall be called the Chloe Barnes Advisory Council on Rare Diseases.

Subd. 2. **Membership.** (a) The advisory council may consist of public members appointed by the Board of Regents or a designee according to paragraph (b) and four members of the legislature appointed according to paragraph (c).

(b) The Board of Regents or a designee is requested to appoint the following public members:

(1) three physicians licensed and practicing in the state with experience researching, diagnosing, or treating rare diseases;

(2) one registered nurse or advanced practice registered nurse licensed and practicing in the state with experience treating rare diseases;

(3) at least two hospital administrators, or their designees, from hospitals in the state that provide care to persons diagnosed with a rare disease. One administrator or designee appointed under this clause must represent a hospital in which the scope of service focuses on rare diseases of pediatric patients;

(4) three persons age 18 or older who either have a rare disease or are a caregiver of a person with a rare disease;

(5) a representative of a rare disease patient organization that operates in the state;

(6) a social worker with experience providing services to persons diagnosed with a rare disease;

(7) a pharmacist with experience with drugs used to treat rare diseases;

(8) a dentist licensed and practicing in the state with experience treating rare diseases;

(9) a representative of the biotechnology industry;

(10) a representative of health plan companies;

(11) a medical researcher with experience conducting research on rare diseases;

(12) a genetic counselor with experience providing services to persons diagnosed with a rare disease or caregivers of those persons; and

(13) other public members, who may serve on an ad hoc basis.

(c) The advisory council shall include two members of the senate, one appointed by the majority leader and one appointed by the minority leader; and two members of the house of representatives, one appointed by the speaker of the house and one appointed by the minority leader.

(d) The commissioner of health or a designee, a representative of Mayo Medical School, and a representative of the University of Minnesota Medical School, shall serve as ex officio, nonvoting members of the advisory council.

(e) Initial appointments to the advisory council shall be made no later than July 1, 2018. Members appointed according to paragraph (b) shall serve for a term of three years, except that the initial members appointed according to paragraph (b) shall have an initial term of two, three, or four years determined by lot by the chairperson. Members appointed according to paragraph (b) shall serve until their successors have been appointed.

Subd. 3. **Meetings.** The Board of Regents or a designee is requested to convene the first meeting of the advisory council no later than September 1, 2018. The advisory council shall meet at the call of the chairperson or at the request of a majority of advisory council members.

Subd. 4. **Duties.** The advisory council's duties may include, but are not limited to:

(1) in conjunction with the state's medical schools, the state's schools of public health, and hospitals in the state that provide care to persons diagnosed with a rare disease, developing resources or recommendations relating to quality of and access to treatment and services in the state for persons with a rare disease, including but not limited to:

(i) a list of existing, publicly accessible resources on research, diagnosis, treatment, and education relating to rare diseases;

(ii) identifying best practices for rare disease care implemented in other states, at the national level, and at the international level, that will improve rare disease care in the state and seeking opportunities to partner with similar organizations in other states and countries;

(iii) identifying problems faced by patients with a rare disease when changing health plans, including recommendations on how to remove obstacles faced by these patients to finding a new health plan and how to improve the ease and speed of finding a new health plan that meets the needs of patients with a rare disease; and

(iv) identifying best practices to ensure health care providers are adequately informed of the most effective strategies for recognizing and treating rare diseases; and

(2) advising, consulting, and cooperating with the Department of Health, the Advisory Committee on Heritable and Congenital Disorders, and other agencies of state government in developing information and programs for the public and the health care community relating to diagnosis, treatment, and awareness of rare diseases.

Subd. 5. **Conflict of interest.** Advisory council members are subject to the Board of Regents policy on conflicts of interest.

Subd. 6. **Annual report.** By January 1 of each year, beginning January 1, 2019, the advisory council shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over higher education and health care policy on the advisory council's activities under subdivision 4 and other issues on which the advisory council may choose to report.

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

Sec. 12. **[144.064] THE VIVIAN ACT.**

Subdivision 1. **Short title.** This section shall be known and may be cited as the "Vivian Act."

Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings given them:

(1) "commissioner" means the commissioner of health;

(2) "health care practitioner" means a medical professional that provides prenatal or postnatal care;

(3) "CMV" means the human herpesvirus cytomegalovirus, also called HCMV, human herpesvirus 5, and HHV-5; and

(4) "congenital CMV" means the transmission of a CMV infection from a pregnant mother to her fetus.

Subd. 3. **Commissioner duties.** (a) The commissioner shall make available to health care practitioners and women who may become pregnant, expectant parents, and parents of infants up-to-date and evidence-based information about congenital CMV that has been reviewed by experts with knowledge of the disease. The information shall include the following:

(1) the recommendation to consider testing for congenital CMV in babies who did not pass their newborn hearing screen or in which a pregnancy history suggests increased risk for congenital CMV infection;

(2) the incidence of CMV;

(3) the transmission of CMV to pregnant women and women who may become pregnant;

(4) birth defects caused by congenital CMV;

(5) available preventative measures to avoid the infection of women who are pregnant or may become pregnant; and

(6) resources available for families of children born with congenital CMV.

(b) The commissioner shall follow existing department practice, inclusive of community engagement, to ensure that the information in paragraph (a) is culturally and linguistically appropriate for all recipients.

(c) The department shall establish an outreach program to:

(1) educate women who may become pregnant, expectant parents, and parents of infants about CMV; and

(2) raise awareness for CMV among health care providers who provide care to expectant mothers or infants.

Sec. 13. Minnesota Statutes 2016, section 144.121, subdivision 1a, is amended to read:

Subd. 1a. **Fees for ionizing radiation-producing equipment.** (a) A facility with ionizing radiation-producing equipment must pay an annual initial or annual renewal registration fee consisting of a base facility fee of $100 and an additional fee for each radiation source, as follows:

(1) medical or veterinary equipment	$ 100
(2) dental x-ray equipment	$ 40
(3) x-ray equipment not used on humans or animals	$ 100
(4) devices with sources of ionizing radiation not used on humans or animals	$ 100
(5) security screening system	$ 100

(b) A facility with radiation therapy and accelerator equipment must pay an annual registration fee of $500. A facility with an industrial accelerator must pay an annual registration fee of $150.

(c) Electron microscopy equipment is exempt from the registration fee requirements of this section.

(d) For purposes of this section, a security screening system means radiation-producing equipment designed and used for security screening of humans who are in custody of a correctional or detention facility, and is used by the facility to image and identify contraband items concealed within or on all sides of a human body. For purposes of this section, a correctional or detention facility is a facility licensed by the commissioner of corrections under section 241.021, and operated by a state agency or political subdivision charged with detection, enforcement, or incarceration in respect to state criminal and traffic laws.

Sec. 14. Minnesota Statutes 2016, section 144.121, is amended by adding a subdivision to read:

Subd. 9. **Exemption from examination requirements; operators of security screening systems.** (a) An employee of a correctional or detention facility who operates a security screening system and the facility in which the system is being operated are exempt from the requirements of subdivisions 5 and 6.

(b) An employee of a correctional or detention facility who operates a security screening system and the facility in which the system is being operated must meet the requirements of a variance to Minnesota Rules, parts 4732.0305 and 4732.0565, issued under Minnesota Rules, parts 4717.7000 to 4717.7050. This paragraph expires on December 31 of the year that the permanent rules adopted by the commissioner governing security screening systems are published in the State Register.

EFFECTIVE DATE. This section is effective 30 days following final enactment.

Sec. 15. **[144.131] ADVISORY COUNCIL ON PANDAS AND PANS.**

Subdivision 1. **Advisory council established.** The commissioner of health shall establish an advisory council on pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and pediatric acute-onset neuropsychiatric syndrome (PANS) to advise the commissioner regarding research, diagnosis, treatment, and education relating to PANDAS and PANS.

Subd. 2. **Membership.** (a) The advisory council shall consist of 14 public members appointed according to paragraph (b) and two members of the legislature appointed according to paragraph (c).

(b) The commissioner shall appoint the following public members to the advisory council in the manner provided in section 15.0597:

(1) an immunologist who is licensed by the Board of Medical Practice and who has experience treating PANS with the use of intravenous immunoglobulin;

(2) a health care provider who is licensed and practicing in Minnesota and who has experience treating persons with PANS and autism spectrum disorder;

(3) a representative of a nonprofit PANS advocacy organization;

(4) a family practice physician who is licensed by the Board of Medical Practice and practicing in Minnesota and who has experience treating persons with PANS;

(5) a medical researcher with experience conducting research on PANDAS, PANS, obsessive-compulsive disorder, and other neurological disorders;

(6) a health care provider who is licensed and practicing in Minnesota and who has expertise in treating patients with eating disorders;

(7) a representative of a professional organization in Minnesota for school psychologists or school social workers;

(8) a child psychiatrist who is licensed by the Board of Medical Practice and practicing in Minnesota and who has experience treating persons with PANS;

(9) a pediatrician who is licensed by the Board of Medical Practice and practicing in Minnesota and who has experience treating persons with PANS;

(10) a representative of an organization focused on autism spectrum disorder;

(11) a parent of a child who has been diagnosed with PANS and autism spectrum disorder;

(12) a social worker licensed by the Board of Social Work and practicing in Minnesota;

(13) a designee of the commissioner of education with expertise in special education; and

(14) a representative of health plan companies that offer health plans in the individual or group markets.

(c) Legislative members shall be appointed to the advisory council as follows:

(1) the Subcommittee on Committees of the Committee on Rules and Administration in the senate shall appoint one member from the senate; and

(2) the speaker of the house shall appoint one member from the house of representatives.

(d) The commissioner of health or a designee shall serve as a nonvoting member of the advisory council.

Subd. 3. **Terms.** Members of the advisory council shall serve for a term of three years and may be reappointed. Members shall serve until their successors have been appointed.

Subd. 4. **Administration.** The commissioner of health or the commissioner's designee shall provide meeting space and administrative services for the advisory council.

Subd. 5. **Compensation and expenses.** Public members of the advisory council shall not receive compensation but may be reimbursed for allowed actual and necessary expenses incurred in the performance of the member's duties for the advisory council, in the same manner and amount as authorized by the commissioner's plan adopted under section 43A.18, subdivision 2.

Subd. 6. **Chair; meetings.** (a) At the advisory council's first meeting, and every two years thereafter, the members of the advisory council shall elect from among their membership a chair and a vice-chair, whose duties shall be established by the advisory council.

(b) The chair of the advisory council shall fix a time and place for regular meetings. The advisory council shall meet at least four times each year at the call of the chair or at the request of a majority of the advisory council's members.

Subd. 7. **Duties.** The advisory council shall:

(1) advise the commissioner regarding research, diagnosis, treatment, and education relating to PANDAS and PANS;

(2) annually develop recommendations on the following issues related to PANDAS and PANS:

(i) practice guidelines for diagnosis and treatment;

(ii) ways to increase clinical awareness and education of PANDAS and PANS among pediatricians, other physicians, school-based health centers, and providers of mental health services;

(iii) outreach to educators and parents to increase awareness of PANDAS and PANS; and

(iv) development of a network of volunteer experts on the diagnosis and treatment of PANDAS and PANS to assist in education and research; and

(3) by October 1, 2019, and each October 1 thereafter, complete an annual report with the advisory council's recommendations on the issues listed in clause (2), and submit the report to the chairs and ranking minority members of the legislative committees with jurisdiction over health care and education. The commissioner shall also post a copy of each annual report on the Department of Health Web site.

Subd. 8. **Expiration.** The advisory council expires October 1, 2024.

Sec. 16. Minnesota Statutes 2016, section 144.1501, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** (a) For purposes of this section, the following definitions apply.

(b) "Advanced dental therapist" means an individual who is licensed as a dental therapist under section 150A.06, and who is certified as an advanced dental therapist under section 150A.106.

(c) "Alcohol and drug counselor" means an individual who is licensed as an alcohol and drug counselor under chapter 148F.

~~(c)~~ (d) "Dental therapist" means an individual who is licensed as a dental therapist under section 150A.06.

~~(d)~~ (e) "Dentist" means an individual who is licensed to practice dentistry.

~~(e)~~ (f) "Designated rural area" means a statutory and home rule charter city or township that is outside the seven-county metropolitan area as defined in section 473.121, subdivision 2, excluding the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud.

~~(f)~~ (g) "Emergency circumstances" means those conditions that make it impossible for the participant to fulfill the service commitment, including death, total and permanent disability, or temporary disability lasting more than two years.

~~(g)~~ (h) "Mental health professional" means an individual providing clinical services in the treatment of mental illness who is qualified in at least one of the ways specified in section 245.462, subdivision 18.

~~(h)~~ (i) "Medical resident" means an individual participating in a medical residency in family practice, internal medicine, obstetrics and gynecology, pediatrics, or psychiatry.

~~(i)~~ (j) "Midlevel practitioner" means a nurse practitioner, nurse-midwife, nurse anesthetist, advanced clinical nurse specialist, or physician assistant.

~~(j)~~ (k) "Nurse" means an individual who has completed training and received all licensing or certification necessary to perform duties as a licensed practical nurse or registered nurse.

~~(k)~~ (l) "Nurse-midwife" means a registered nurse who has graduated from a program of study designed to prepare registered nurses for advanced practice as nurse-midwives.

~~(l)~~ (m) "Nurse practitioner" means a registered nurse who has graduated from a program of study designed to prepare registered nurses for advanced practice as nurse practitioners.

~~(m)~~ (n) "Pharmacist" means an individual with a valid license issued under chapter 151.

~~(n)~~ (o) "Physician" means an individual who is licensed to practice medicine in the areas of family practice, internal medicine, obstetrics and gynecology, pediatrics, or psychiatry.

~~(o)~~ (p) "Physician assistant" means a person licensed under chapter 147A.

~~(p)~~ (q) "Public health nurse" means a registered nurse licensed in Minnesota who has obtained a registration certificate as a public health nurse from the Board of Nursing in accordance with Minnesota Rules, chapter 6316.

~~(q)~~ (r) "Qualified educational loan" means a government, commercial, or foundation loan for actual costs paid for tuition, reasonable education expenses, and reasonable living expenses related to the graduate or undergraduate education of a health care professional.

~~(r)~~ (s) "Underserved urban community" means a Minnesota urban area or population included in the list of designated primary medical care health professional shortage areas (HPSAs), medically underserved areas (MUAs), or medically underserved populations (MUPs) maintained and updated by the United States Department of Health and Human Services.

Sec. 17. Minnesota Statutes 2017 Supplement, section 144.1501, subdivision 2, is amended to read:

Subd. 2. **Creation of account.** (a) A health professional education loan forgiveness program account is established. The commissioner of health shall use money from the account to establish a loan forgiveness program:

(1) for medical residents and mental health professionals agreeing to practice in designated rural areas or underserved urban communities or specializing in the area of pediatric psychiatry;

(2) for midlevel practitioners agreeing to practice in designated rural areas or to teach at least 12 credit hours, or 720 hours per year in the nursing field in a postsecondary program at the undergraduate level or the equivalent at the graduate level;

(3) for nurses who agree to practice in a Minnesota nursing home; an intermediate care facility for persons with developmental disability; a hospital if the hospital owns and operates a Minnesota nursing home and a minimum of 50 percent of the hours worked by the nurse is in the nursing home; a housing with services establishment as defined in section 144D.01, subdivision 4; or for a home care provider as defined in section 144A.43, subdivision 4; or agree to teach at least 12 credit hours, or 720 hours per year in the nursing field in a postsecondary program at the undergraduate level or the equivalent at the graduate level;

(4) for other health care technicians agreeing to teach at least 12 credit hours, or 720 hours per year in their designated field in a postsecondary program at the undergraduate level or the equivalent at the graduate level. The commissioner, in consultation with the Healthcare Education-Industry Partnership, shall determine the health care fields where the need is the greatest, including, but not limited to, respiratory therapy, clinical laboratory technology, radiologic technology, and surgical technology;

(5) for pharmacists, advanced dental therapists, dental therapists, ~~and~~ public health nurses, and alcohol and drug counselors who agree to practice in designated rural areas; and

(6) for dentists agreeing to deliver at least 25 percent of the dentist's yearly patient encounters to state public program enrollees or patients receiving sliding fee schedule discounts through a formal sliding fee schedule meeting the standards established by the United States Department of Health and Human Services under Code of Federal Regulations, title 42, section 51, chapter 303.

(b) Appropriations made to the account do not cancel and are available until expended, except that at the end of each biennium, any remaining balance in the account that is not committed by contract and not needed to fulfill existing commitments shall cancel to the fund.

Sec. 18. Minnesota Statutes 2016, section 144.1501, subdivision 3, is amended to read:

Subd. 3. **Eligibility.** (a) To be eligible to participate in the loan forgiveness program, an individual must:

(1) be a medical or dental resident; a licensed pharmacist; or be enrolled in a training or education program to become a dentist, dental therapist, advanced dental therapist, mental health professional, pharmacist, public health nurse, midlevel practitioner, registered nurse, ~~or a~~ licensed practical nurse, or alcohol and drug counselor. The commissioner may also

consider applications submitted by graduates in eligible professions who are licensed and in practice; and

(2) submit an application to the commissioner of health.

(b) An applicant selected to participate must sign a contract to agree to serve a minimum three-year full-time service obligation according to subdivision 2, which shall begin no later than March 31 following completion of required training, with the exception of a nurse, who must agree to serve a minimum two-year full-time service obligation according to subdivision 2, which shall begin no later than March 31 following completion of required training.

Sec. 19. Minnesota Statutes 2016, section 144.1506, subdivision 2, is amended to read:

Subd. 2. **Expansion grant program.** (a) The commissioner of health shall award primary care residency expansion grants to eligible primary care residency programs to plan and implement new residency slots. A planning grant shall not exceed $75,000, and a training grant shall not exceed $150,000 per new residency slot for the first year, $100,000 for the second year, and $50,000 for the third year of the new residency slot. For eligible residency programs longer than three years, training grants may be awarded for the duration of the residency, not exceeding an average of $100,000 per residency slot per year.

(b) Funds may be spent to cover the costs of:

(1) planning related to establishing an accredited primary care residency program;

(2) obtaining accreditation by the Accreditation Council for Graduate Medical Education or another national body that accredits residency programs;

(3) establishing new residency programs or new resident training slots;

(4) recruitment, training, and retention of new residents and faculty;

(5) travel and lodging for new residents;

(6) faculty, new resident, and preceptor salaries related to new residency slots;

(7) training site improvements, fees, equipment, and supplies required for new primary care resident training slots; and

(8) supporting clinical education in which trainees are part of a primary care team model.

Sec. 20. **[144.397] STATEWIDE TOBACCO CESSATION SERVICES.**

(a) The commissioner of health shall administer, or contract for the administration of, statewide tobacco cessation services to assist Minnesotans who are seeking advice or services to help them quit using tobacco products. The commissioner shall establish statewide public awareness activities to inform the public of the availability of the services and encourage the public to utilize the services because of the dangers and harm of tobacco use and dependence.

(b) Services to be provided may include, but are not limited to:

(1) telephone-based coaching and counseling;

(2) referrals;

(3) written materials mailed upon request;

(4) Web-based texting or e-mail services; and

(5) free Food and Drug Administration-approved tobacco cessation medications.

(c) Services provided must be consistent with evidence-based best practices in tobacco cessation services. Services provided must be coordinated with employer, health plan company, and private sector tobacco prevention and cessation services that may be available to individuals depending on their employment or health coverage.

Sec. 21. Minnesota Statutes 2016, section 144.608, subdivision 1, is amended to read:

Subdivision 1. **Trauma Advisory Council established.** (a) A Trauma Advisory Council is established to advise, consult with, and make recommendations to the commissioner on the development, maintenance, and improvement of a statewide trauma system.

(b) The council shall consist of the following members:

(1) a trauma surgeon certified by the American Board of Surgery or the American Osteopathic Board of Surgery who practices in a level I or II trauma hospital;

(2) a general surgeon certified by the American Board of Surgery or the American Osteopathic Board of Surgery whose practice includes trauma and who practices in a designated rural area as defined under section 144.1501, subdivision 1, paragraph ~~(e)~~ (f);

(3) a neurosurgeon certified by the American Board of Neurological Surgery who practices in a level I or II trauma hospital;

(4) a trauma program nurse manager or coordinator practicing in a level I or II trauma hospital;

(5) an emergency physician certified by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine whose practice includes emergency room care in a level I, II, III, or IV trauma hospital;

(6) a trauma program manager or coordinator who practices in a level III or IV trauma hospital;

(7) a physician certified by the American Board of Family Medicine or the American Osteopathic Board of Family Practice whose practice includes emergency department care in a level III or IV trauma hospital located in a designated rural area as defined under section 144.1501, subdivision 1, paragraph ~~(e)~~ (f);

(8) a nurse practitioner, as defined under section 144.1501, subdivision 1, paragraph ~~(l)~~ (m), or a physician assistant, as defined under section 144.1501, subdivision 1, paragraph ~~(o)~~ (p), whose practice includes emergency room care in a level IV trauma hospital located in a designated rural area as defined under section 144.1501, subdivision 1, paragraph ~~(e)~~ (f);

(9) a physician certified in pediatric emergency medicine by the American Board of Pediatrics or certified in pediatric emergency medicine by the American Board of Emergency Medicine or certified by the American Osteopathic Board of Pediatrics whose practice primarily includes emergency department medical care in a level I, II, III, or IV trauma hospital, or a surgeon certified in pediatric surgery by the American Board of Surgery whose practice involves the care of pediatric trauma patients in a trauma hospital;

(10) an orthopedic surgeon certified by the American Board of Orthopaedic Surgery or the American Osteopathic Board of Orthopedic Surgery whose practice includes trauma and who practices in a level I, II, or III trauma hospital;

(11) the state emergency medical services medical director appointed by the Emergency Medical Services Regulatory Board;

(12) a hospital administrator of a level III or IV trauma hospital located in a designated rural area as defined under section 144.1501, subdivision 1, paragraph ~~(e)~~ (f);

(13) a rehabilitation specialist whose practice includes rehabilitation of patients with major trauma injuries or traumatic brain injuries and spinal cord injuries as defined under section 144.661;

(14) an attendant or ambulance director who is an EMT, EMT-I, or EMT-P within the meaning of section 144E.001 and who actively practices with a licensed ambulance service

in a primary service area located in a designated rural area as defined under section 144.1501, subdivision 1, paragraph ~~(e)~~ (f); and

(15) the commissioner of public safety or the commissioner's designee.

Sec. 22. Minnesota Statutes 2016, section 144A.43, subdivision 11, is amended to read:

Subd. 11. **Medication administration.** "Medication administration" means performing a set of tasks ~~to ensure a client takes medications, and includes~~ that include the following:

(1) checking the client's medication record;

(2) preparing the medication as necessary;

(3) administering the medication to the client;

(4) documenting the administration or reason for not administering the medication; and

(5) reporting to a registered nurse or appropriate licensed health professional any concerns about the medication, the client, or the client's refusal to take the medication.

Sec. 23. Minnesota Statutes 2016, section 144A.43, is amended by adding a subdivision to read:

Subd. 12a. **Medication reconciliation.** "Medication reconciliation" means the process of identifying the most accurate list of all medications the client is taking, including the name, dosage, frequency, and route by comparing the client record to an external list of medications obtained from the client, hospital, prescriber, or other provider.

Sec. 24. Minnesota Statutes 2016, section 144A.43, subdivision 27, is amended to read:

Subd. 27. **Service ~~plan~~ agreement.** "Service ~~plan~~ agreement" means the written ~~plan~~ agreement between the client or client's representative and the temporary licensee or licensee about the services that will be provided to the client.

Sec. 25. Minnesota Statutes 2016, section 144A.43, subdivision 30, is amended to read:

Subd. 30. **Standby assistance.** "Standby assistance" means the presence of another person ~~within arm's reach to minimize the risk of injury while performing daily activities through physical intervention or cuing~~ to assist a client with an assistive task by providing cues, oversight, and minimal physical assistance.

Sec. 26. Minnesota Statutes 2016, section 144A.472, subdivision 5, is amended to read:

Subd. 5. **~~Transfers prohibited;~~ Changes in ownership.** ~~Any~~ (a) A home care license issued by the commissioner may not be transferred to another party. Before acquiring ownership of or a controlling interest in a home care provider business, a prospective ~~applicant~~ owner must apply for a new ~~temporary~~ license. A change of ownership is a transfer of operational control ~~to a different business entity~~ of the home care provider business and includes:

(1) transfer of the business to a different or new corporation;

(2) in the case of a partnership, the dissolution or termination of the partnership under chapter 323A, with the business continuing by a successor partnership or other entity;

(3) relinquishment of control of the provider to another party, including to a contract management firm that is not under the control of the owner of the business' assets;

(4) transfer of the business by a sole proprietor to another party or entity; or

(5) ~~in the case of a privately held corporation, the change in~~ transfer of ownership or control of 50 percent or more of the ~~outstanding voting stock~~ controlling interest of a home care provider business not covered by clauses (1) to (4).

(b) An employee who was employed by the previous owner of the home care provider business prior to the effective date of a change in ownership under paragraph (a), and who will be employed by the new owner in the same or a similar capacity, shall be treated as if no change in employer occurred, with respect to orientation, training, tuberculosis testing, background studies, and competency testing and training on the policies identified in subdivision 1, clause (14), and subdivision 2, if applicable.

(c) Notwithstanding paragraph (b), a new owner of a home care provider business must ensure that employees of the provider receive and complete training and testing on any provisions of policies that differ from those of the previous owner, within 90 days after the date of the change in ownership.

Sec. 27. Minnesota Statutes 2017 Supplement, section 144A.472, subdivision 7, is amended to read:

Subd. 7. **Fees; application, change of ownership, and renewal.** (a) An initial applicant seeking temporary home care licensure must submit the following application fee to the commissioner along with a completed application:

(1) for a basic home care provider, $2,100; or

(2) for a comprehensive home care provider, $4,200.

(b) A home care provider who is filing a change of ownership as required under subdivision 5 must submit the following application fee to the commissioner, along with the documentation required for the change of ownership:

(1) for a basic home care provider, $2,100; or

(2) for a comprehensive home care provider, $4,200.

(c) For the period ending June 30, 2018, a home care provider who is seeking to renew the provider's license shall pay a fee to the commissioner based on revenues derived from the provision of home care services during the calendar year prior to the year in which the application is submitted, according to the following schedule:

License Renewal Fee

Provider Annual Revenue	**Fee**
greater than $1,500,000	$6,625
greater than $1,275,000 and no more than $1,500,000	$5,797
greater than $1,100,000 and no more than $1,275,000	$4,969
greater than $950,000 and no more than $1,100,000	$4,141
greater than $850,000 and no more than $950,000	$3,727
greater than $750,000 and no more than $850,000	$3,313
greater than $650,000 and no more than $750,000	$2,898
greater than $550,000 and no more than $650,000	$2,485
greater than $450,000 and no more than $550,000	$2,070
greater than $350,000 and no more than $450,000	$1,656
greater than $250,000 and no more than $350,000	$1,242
greater than $100,000 and no more than $250,000	$828
greater than $50,000 and no more than $100,000	$500
greater than $25,000 and no more than $50,000	$400
no more than $25,000	$200

(d) For the period between July 1, 2018, and June 30, 2020, a home care provider who is seeking to renew the provider's license shall pay a fee to the commissioner in an amount that is ten percent higher than the applicable fee in paragraph (c). A home care provider's fee shall be based on revenues derived from the provision of home care services during the calendar year prior to the year in which the application is submitted.

(e) Beginning July 1, 2020, a home care provider who is seeking to renew the provider's license shall pay a fee to the commissioner based on revenues derived from the provision of home care services during the calendar year prior to the year in which the application is submitted, according to the following schedule:

License Renewal Fee

Provider Annual Revenue	**Fee**
greater than $1,500,000	$7,651
greater than $1,275,000 and no more than $1,500,000	$6,695
greater than $1,100,000 and no more than $1,275,000	$5,739
greater than $950,000 and no more than $1,100,000	$4,783
greater than $850,000 and no more than $950,000	$4,304
greater than $750,000 and no more than $850,000	$3,826
greater than $650,000 and no more than $750,000	$3,347
greater than $550,000 and no more than $650,000	$2,870
greater than $450,000 and no more than $550,000	$2,391
greater than $350,000 and no more than $450,000	$1,913
greater than $250,000 and no more than $350,000	$1,434
greater than $100,000 and no more than $250,000	$957
greater than $50,000 and no more than $100,000	$577
greater than $25,000 and no more than $50,000	$462
no more than $25,000	$231

(f) If requested, the home care provider shall provide the commissioner information to verify the provider's annual revenues or other information as needed, including copies of documents submitted to the Department of Revenue.

(g) At each annual renewal, a home care provider may elect to pay the highest renewal fee for its license category, and not provide annual revenue information to the commissioner.

(h) A temporary license or license applicant, or temporary licensee or licensee that knowingly provides the commissioner incorrect revenue amounts for the purpose of paying a lower license fee, shall be subject to a civil penalty in the amount of double the fee the provider should have paid.

(i) The fee for failure to comply with the notification requirements of section 144A.473, subdivision 2, paragraph (c), is $1,000.

(j) Fees and penalties collected under this section shall be deposited in the state treasury and credited to the state government special revenue fund. All fees are nonrefundable. Fees collected under paragraphs (c), (d), and (e) are nonrefundable even if received before July 1, 2017, for temporary licenses or licenses being issued effective July 1, 2017, or later.

Sec. 28. Minnesota Statutes 2016, section 144A.473, is amended to read:

144A.473 ISSUANCE OF TEMPORARY LICENSE AND LICENSE RENEWAL.

Subdivision 1. **Temporary license and renewal of license.** (a) The department shall review each application to determine the applicant's knowledge of and compliance with Minnesota home care regulations. Before granting a temporary license or renewing a license, the commissioner may further evaluate the applicant or licensee by requesting additional information or documentation or by conducting an on-site survey of the applicant to determine compliance with sections 144A.43 to 144A.482.

(b) Within 14 calendar days after receiving an application for a license, the commissioner shall acknowledge receipt of the application in writing. The acknowledgment must indicate whether the application appears to be complete or whether additional information is required before the application will be considered complete.

(c) Within 90 days after receiving a complete application, the commissioner shall issue a temporary license, renew the license, or deny the license.

(d) The commissioner shall issue a license that contains the home care provider's name, address, license level, expiration date of the license, and unique license number. All licenses, except for temporary licenses issued under subdivision 2, are valid for up to one year from the date of issuance.

Subd. 2. **Temporary license.** (a) For new license applicants, the commissioner shall issue a temporary license for either the basic or comprehensive home care level. A temporary license is effective for up to one year from the date of issuance, except that a temporary license may be extended according to subdivision 3. Temporary licensees must comply with sections 144A.43 to 144A.482.

(b) During the temporary license ~~year~~ period, the commissioner shall survey the temporary licensee within 90 calendar days after the commissioner is notified or has evidence that the temporary licensee is providing home care services.

(c) Within five days of beginning the provision of services, the temporary licensee must notify the commissioner that it is serving clients. The notification to the commissioner may be mailed or e-mailed to the commissioner at the address provided by the commissioner. If

the temporary licensee does not provide home care services during the temporary license ~~year~~ period, then the temporary license expires at the end of the ~~year~~ period and the applicant must reapply for a temporary home care license.

(d) A temporary licensee may request a change in the level of licensure prior to being surveyed and granted a license by notifying the commissioner in writing and providing additional documentation or materials required to update or complete the changed temporary license application. The applicant must pay the difference between the application fees when changing from the basic level to the comprehensive level of licensure. No refund will be made if the provider chooses to change the license application to the basic level.

(e) If the temporary licensee notifies the commissioner that the licensee has clients within 45 days prior to the temporary license expiration, the commissioner may extend the temporary license for up to 60 days in order to allow the commissioner to complete the on-site survey required under this section and follow-up survey visits.

Subd. 3. **Temporary licensee survey.** (a) If the temporary licensee is in substantial compliance with the survey, the commissioner shall issue either a basic or comprehensive home care license. If the temporary licensee is not in substantial compliance with the survey, the commissioner shall either: (1) not issue a ~~basic or comprehensive~~ license and ~~there will be no contested hearing right under chapter 14~~ terminate the temporary license; or (2) extend the temporary license for a period not to exceed 90 days and apply conditions, as permitted under section 144A.475, subdivision 2, to the extension of a temporary license. If the temporary licensee is not in substantial compliance with the survey within the time period of the extension, or if the temporary licensee does not satisfy the license conditions, the commissioner may deny the license.

(b) If the temporary licensee whose basic or comprehensive license has been denied or extended with conditions disagrees with the conclusions of the commissioner, then the temporary licensee may request a reconsideration by the commissioner or commissioner's designee. The reconsideration request process must be conducted internally by the commissioner or commissioner's designee, and chapter 14 does not apply.

(c) The temporary licensee requesting reconsideration must make the request in writing and must list and describe the reasons why the temporary licensee disagrees with the decision to deny the basic or comprehensive home care license or the decision to extend the temporary license with conditions.

(d) The reconsideration request and supporting documentation must be received by the commissioner within 15 calendar days after the date the temporary licensee receives the correction order.

(e) A temporary licensee whose license is denied, is permitted to continue operating as a home care provider during the period of time when:

(1) a reconsideration request is in process;

(2) an extension of a temporary license is being negotiated;

(3) the placement of conditions on a temporary license is being negotiated; or

(4) a transfer of home care clients from the temporary licensee to a new home care provider is in process.

(f) A temporary licensee whose license is denied must comply with the requirements for notification and transfer of clients in section 144A.475, subdivision 5.

Sec. 29. Minnesota Statutes 2016, section 144A.474, subdivision 2, is amended to read:

Subd. 2. **Types of home care surveys.** (a) "Initial full survey" means the survey of a new temporary licensee conducted after the department is notified or has evidence that the temporary licensee is providing home care services to determine if the provider is in compliance with home care requirements. Initial full surveys must be completed within 14 months after the department's issuance of a temporary basic or comprehensive license.

(b) "Change in ownership survey" means a full survey of a new licensee due to a change in ownership. Change in ownership surveys must be completed within six months after the department's issuance of a new license due to a change in ownership.

(c) "Core survey" means periodic inspection of home care providers to determine ongoing compliance with the home care requirements, focusing on the essential health and safety requirements. Core surveys are available to licensed home care providers who have been licensed for three years and surveyed at least once in the past three years with the latest survey having no widespread violations beyond Level 1 as provided in subdivision 11. Providers must also not have had any substantiated licensing complaints, substantiated complaints against the agency under the Vulnerable Adults Act or Maltreatment of Minors Act, or an enforcement action as authorized in section 144A.475 in the past three years.

(1) The core survey for basic home care providers must review compliance in the following areas:

(i) reporting of maltreatment;

(ii) orientation to and implementation of the home care bill of rights;

(iii) statement of home care services;

(iv) initial evaluation of clients and initiation of services;

(v) client review and monitoring;

(vi) service ~~plan~~ agreement implementation and changes to the service ~~plan~~ agreement;

(vii) client complaint and investigative process;

(viii) competency of unlicensed personnel; and

(ix) infection control.

(2) For comprehensive home care providers, the core survey must include everything in the basic core survey plus these areas:

(i) delegation to unlicensed personnel;

(ii) assessment, monitoring, and reassessment of clients; and

(iii) medication, treatment, and therapy management.

~~(c)~~ (d) "Full survey" means the periodic inspection of home care providers to determine ongoing compliance with the home care requirements that cover the core survey areas and all the legal requirements for home care providers. A full survey is conducted for all temporary licensees ~~and~~, for licensees that receive licenses due to an approved change in ownership, for providers who do not meet the requirements needed for a core survey, and when a surveyor identifies unacceptable client health or safety risks during a core survey. A full survey must include all the tasks identified as part of the core survey and any additional review deemed necessary by the department, including additional observation, interviewing, or records review of additional clients and staff.

~~(d)~~ (e) "Follow-up surveys" means surveys conducted to determine if a home care provider has corrected deficient issues and systems identified during a core survey, full survey, or complaint investigation. Follow-up surveys may be conducted via phone, e-mail, fax, mail, or on-site reviews. Follow-up surveys, other than complaint surveys, shall be concluded with an exit conference and written information provided on the process for requesting a reconsideration of the survey results.

~~(e)~~ (f) Upon receiving information alleging that a home care provider has violated or is currently violating a requirement of sections 144A.43 to 144A.482, the commissioner shall investigate the complaint according to sections 144A.51 to 144A.54.

Sec. 30. Minnesota Statutes 2016, section 144A.475, subdivision 1, is amended to read:

Subdivision 1. **Conditions.** (a) The commissioner may refuse to grant a temporary license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the home care provider or owner or managerial official of the home care provider:

(1) is in violation of, or during the term of the license has violated, any of the requirements in sections 144A.471 to 144A.482;

(2) permits, aids, or abets the commission of any illegal act in the provision of home care;

(3) performs any act detrimental to the health, safety, and welfare of a client;

(4) obtains the license by fraud or misrepresentation;

(5) knowingly made or makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter;

(6) denies representatives of the department access to any part of the home care provider's books, records, files, or employees;

(7) interferes with or impedes a representative of the department in contacting the home care provider's clients;

(8) interferes with or impedes a representative of the department in the enforcement of this chapter or has failed to fully cooperate with an inspection, survey, or investigation by the department;

(9) destroys or makes unavailable any records or other evidence relating to the home care provider's compliance with this chapter;

(10) refuses to initiate a background study under section 144.057 or 245A.04;

(11) fails to timely pay any fines assessed by the department;

(12) violates any local, city, or township ordinance relating to home care services;

(13) has repeated incidents of personnel performing services beyond their competency level; or

(14) has operated beyond the scope of the home care provider's license level.

(b) A violation by a contractor providing the home care services of the home care provider is a violation by the home care provider.

Sec. 31. Minnesota Statutes 2016, section 144A.475, subdivision 2, is amended to read:

Subd. 2. **Terms to suspension or conditional license.** (a) A suspension or conditional license designation may include terms that must be completed or met before a suspension or conditional license designation is lifted. A conditional license designation may include restrictions or conditions that are imposed on the provider. Terms for a suspension or conditional license may include one or more of the following and the scope of each will be determined by the commissioner:

(1) requiring a consultant to review, evaluate, and make recommended changes to the home care provider's practices and submit reports to the commissioner at the cost of the home care provider;

(2) requiring supervision of the home care provider or staff practices at the cost of the home care provider by an unrelated person who has sufficient knowledge and qualifications to oversee the practices and who will submit reports to the commissioner;

(3) requiring the home care provider or employees to obtain training at the cost of the home care provider;

(4) requiring the home care provider to submit reports to the commissioner;

(5) prohibiting the home care provider from taking any new clients for a period of time; or

(6) any other action reasonably required to accomplish the purpose of this subdivision and section 144A.45, subdivision 2.

(b) A home care provider subject to this subdivision may continue operating during the period of time home care clients are being transferred to other providers.

Sec. 32. Minnesota Statutes 2016, section 144A.475, subdivision 5, is amended to read:

Subd. 5. **Plan required.** (a) The process of suspending or revoking a license must include a plan for transferring affected clients to other providers by the home care provider, which will be monitored by the commissioner. Within three business days of being notified of the final revocation or suspension action, the home care provider shall provide the commissioner, the lead agencies as defined in section 256B.0911, and the ombudsman for long-term care with the following information:

(1) a list of all clients, including full names and all contact information on file;

(2) a list of each client's representative or emergency contact person, including full names and all contact information on file;

(3) the location or current residence of each client;

(4) the payor sources for each client, including payor source identification numbers; and

(5) for each client, a copy of the client's service plan, and a list of the types of services being provided.

(b) The revocation or suspension notification requirement is satisfied by mailing the notice to the address in the license record. The home care provider shall cooperate with the commissioner and the lead agencies during the process of transferring care of clients to qualified providers. Within three business days of being notified of the final revocation or suspension action, the home care provider must notify and disclose to each of the home care provider's clients, or the client's representative or emergency contact persons, that the commissioner is taking action against the home care provider's license by providing a copy of the revocation or suspension notice issued by the commissioner.

(c) A home care provider subject to this subdivision may continue operating during the period of time home care clients are being transferred to other providers.

Sec. 33. Minnesota Statutes 2016, section 144A.476, subdivision 1, is amended to read:

Subdivision 1. **Prior criminal convictions; owner and managerial officials.** (a) Before the commissioner issues a temporary license, issues a license as a result of an approved change in ownership, or renews a license, an owner or managerial official is required to complete a background study under section 144.057. No person may be involved in the management, operation, or control of a home care provider if the person has been disqualified under chapter 245C. If an individual is disqualified under section 144.057 or chapter 245C, the individual may request reconsideration of the disqualification. If the individual requests reconsideration and the commissioner sets aside or rescinds the disqualification, the individual is eligible to be involved in the management, operation, or control of the provider. If an individual has a disqualification under section 245C.15, subdivision 1, and the disqualification is affirmed, the individual's disqualification is barred from a set aside, and the individual must not be involved in the management, operation, or control of the provider.

(b) For purposes of this section, owners of a home care provider subject to the background check requirement are those individuals whose ownership interest provides sufficient authority or control to affect or change decisions related to the operation of the home care provider. An owner includes a sole proprietor, a general partner, or any other individual whose individual ownership interest can affect the management and direction of the policies of the home care provider.

(c) For the purposes of this section, managerial officials subject to the background check requirement are individuals who provide direct contact as defined in section 245C.02, subdivision 11, or individuals who have the responsibility for the ongoing management or direction of the policies, services, or employees of the home care provider. Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12.

(d) The department shall not issue any license if the applicant or owner or managerial official has been unsuccessful in having a background study disqualification set aside under section 144.057 and chapter 245C; if the owner or managerial official, as an owner or managerial official of another home care provider, was substantially responsible for the other home care provider's failure to substantially comply with sections 144A.43 to 144A.482; or if an owner that has ceased doing business, either individually or as an owner of a home care provider, was issued a correction order for failing to assist clients in violation of this chapter.

Sec. 34. Minnesota Statutes 2016, section 144A.479, subdivision 7, is amended to read:

Subd. 7. **Employee records.** The home care provider must maintain current records of each paid employee, regularly scheduled volunteers providing home care services, and of each individual contractor providing home care services. The records must include the following information:

(1) evidence of current professional licensure, registration, or certification, if licensure, registration, or certification is required by this statute or other rules;

(2) records of orientation, required annual training and infection control training, and competency evaluations;

(3) current job description, including qualifications, responsibilities, and identification of staff providing supervision;

(4) documentation of annual performance reviews which identify areas of improvement needed and training needs;

(5) for individuals providing home care services, verification that ~~required~~ any health screenings required by infection control programs established under section 144A.4798 have taken place and the dates of those screenings; and

(6) documentation of the background study as required under section 144.057.

Each employee record must be retained for at least three years after a paid employee, home care volunteer, or contractor ceases to be employed by or under contract with the home care provider. If a home care provider ceases operation, employee records must be maintained for three years.

Sec. 35. Minnesota Statutes 2016, section 144A.4791, subdivision 1, is amended to read:

Subdivision 1. **Home care bill of rights; notification to client.** (a) The home care provider shall provide the client or the client's representative a written notice of the rights under section 144A.44 before the ~~initiation of~~ date that services are first provided to that client. The provider shall make all reasonable efforts to provide notice of the rights to the client or the client's representative in a language the client or client's representative can understand.

(b) In addition to the text of the home care bill of rights in section 144A.44, subdivision 1, the notice shall also contain the following statement describing how to file a complaint with these offices.

"If you have a complaint about the provider or the person providing your home care services, you may call, write, or visit the Office of Health Facility Complaints, Minnesota Department of Health. You may also contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities."

The statement should include the telephone number, Web site address, e-mail address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of the Ombudsman for Long-Term Care, and the Office of the Ombudsman for Mental Health and Developmental Disabilities. The statement should also include the home care provider's name, address, e-mail, telephone number, and name or title of the person at the provider to whom problems or complaints may be directed. It must also include a statement that the home care provider will not retaliate because of a complaint.

(c) The home care provider shall obtain written acknowledgment of the client's receipt of the home care bill of rights or shall document why an acknowledgment cannot be obtained. The acknowledgment may be obtained from the client or the client's representative. Acknowledgment of receipt shall be retained in the client's record.

Sec. 36. Minnesota Statutes 2016, section 144A.4791, subdivision 3, is amended to read:

Subd. 3. **Statement of home care services.** Prior to the ~~initiation of~~ date that services are first provided to the client, a home care provider must provide to the client or the client's representative a written statement which identifies if the provider has a basic or comprehensive home care license, the services the provider is authorized to provide, and which services the provider cannot provide under the scope of the provider's license. The home care provider shall obtain written acknowledgment from the clients that the provider has provided the statement or must document why the provider could not obtain the acknowledgment.

Sec. 37. Minnesota Statutes 2016, section 144A.4791, subdivision 6, is amended to read:

Subd. 6. **Initiation of services.** When a provider ~~initiates~~ provides home care services ~~and~~ to a client before the individualized review or assessment by a licensed health professional or registered nurse as required in subdivisions 7 and 8 ~~has not been~~ is completed, the ~~provider~~ licensed health professional or registered nurse must complete a temporary plan ~~and agreement~~ with the client ~~for services~~ and orient staff assigned to deliver services as identified in the temporary plan.

Sec. 38. Minnesota Statutes 2016, section 144A.4791, subdivision 7, is amended to read:

Subd. 7. **Basic individualized client review and monitoring.** (a) When services being provided are basic home care services, an individualized initial review of the client's needs and preferences must be conducted at the client's residence with the client or client's representative. This initial review must be completed within 30 days after the ~~initiation of the~~ date that home care services are first provided.

(b) Client monitoring and review must be conducted as needed based on changes in the needs of the client and cannot exceed 90 days from the date of the last review. The monitoring and review may be conducted at the client's residence or through the utilization of telecommunication methods based on practice standards that meet the individual client's needs.

Sec. 39. Minnesota Statutes 2016, section 144A.4791, subdivision 8, is amended to read:

Subd. 8. **Comprehensive assessment, monitoring, and reassessment.** (a) When the services being provided are comprehensive home care services, an individualized initial assessment must be conducted in person by a registered nurse. When the services are provided by other licensed health professionals, the assessment must be conducted by the appropriate

health professional. This initial assessment must be completed within five days after ~~initiation of~~ the date that home care services are first provided.

(b) Client monitoring and reassessment must be conducted in the client's home no more than 14 days after ~~initiation of~~ the date that home care services are first provided.

(c) Ongoing client monitoring and reassessment must be conducted as needed based on changes in the needs of the client and cannot exceed 90 days from the last date of the assessment. The monitoring and reassessment may be conducted at the client's residence or through the utilization of telecommunication methods based on practice standards that meet the individual client's needs.

Sec. 40. Minnesota Statutes 2016, section 144A.4791, subdivision 9, is amended to read:

Subd. 9. **Service ~~plan~~ agreement, implementation, and revisions to service ~~plan~~ agreement.** (a) No later than 14 days after the ~~initiation of~~ date that home care services are first provided, a home care provider shall finalize a current written service ~~plan~~ agreement.

(b) The service ~~plan~~ agreement and any revisions must include a signature or other authentication by the home care provider and by the client or the client's representative documenting agreement on the services to be provided. The service ~~plan~~ agreement must be revised, if needed, based on client review or reassessment under subdivisions 7 and 8. The provider must provide information to the client about changes to the provider's fee for services and how to contact the Office of the Ombudsman for Long-Term Care.

(c) The home care provider must implement and provide all services required by the current service ~~plan~~ agreement.

(d) The service ~~plan~~ agreement and revised service ~~plan~~ agreement must be entered into the client's record, including notice of a change in a client's fees when applicable.

(e) Staff providing home care services must be informed of the current written service ~~plan~~ agreement.

(f) The service ~~plan~~ agreement must include:

(1) a description of the home care services to be provided, the fees for services, and the frequency of each service, according to the client's current review or assessment and client preferences;

(2) the identification of the staff or categories of staff who will provide the services;

(3) the schedule and methods of monitoring reviews or assessments of the client;

(4) ~~the frequency of sessions of supervision of staff and type of personnel who will supervise staff; and~~ the schedule and methods of monitoring staff providing home care services; and

(5) a contingency plan that includes:

(i) the action to be taken by the home care provider and by the client or client's representative if the scheduled service cannot be provided;

(ii) information and a method for a client or client's representative to contact the home care provider;

(iii) names and contact information of persons the client wishes to have notified in an emergency or if there is a significant adverse change in the client's condition~~, including identification of and information as to who has authority to sign for the client in an emergency~~; and

(iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the client under those chapters.

Sec. 41. Minnesota Statutes 2016, section 144A.4792, subdivision 1, is amended to read:

Subdivision 1. **Medication management services; comprehensive home care license.** (a) This subdivision applies only to home care providers with a comprehensive home care license that provide medication management services to clients. Medication management services may not be provided by a home care provider who has a basic home care license.

(b) A comprehensive home care provider who provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines.

(c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and client and client representative, if any; disposing of unused medications; and educating clients and client representatives about medications. When controlled substances are being managed, stored, and secured by the comprehensive home care provider, the policies and procedures must

also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 22.

Sec. 42. Minnesota Statutes 2016, section 144A.4792, subdivision 2, is amended to read:

Subd. 2. **Provision of medication management services.** (a) For each client who requests medication management services, the comprehensive home care provider shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the client. The assessment must include an identification and review of all medications the client is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues.

(b) The assessment must:

(1) identify interventions needed in management of medications to prevent diversion of medication by the client or others who may have access to the medications~~.~~; and

(2) provide instructions to the client or client's representative on interventions to manage the client's medications and prevent diversion of medications.

"Diversion of medications" means the misuse, theft, or illegal or improper disposition of medications.

Sec. 43. Minnesota Statutes 2016, section 144A.4792, subdivision 5, is amended to read:

Subd. 5. **Individualized medication management plan.** (a) For each client receiving medication management services, the comprehensive home care provider must prepare and include in the service ~~plan~~ agreement a written statement of the medication management services that will be provided to the client. The provider must develop and maintain a current individualized medication management record for each client based on the client's assessment that must contain the following:

(1) a statement describing the medication management services that will be provided;

(2) a description of storage of medications based on the client's needs and preferences, risk of diversion, and consistent with the manufacturer's directions;

(3) documentation of specific client instructions relating to the administration of medications;

(4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;

(5) identification of medication management tasks that may be delegated to unlicensed personnel;

(6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and

(7) any client-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.

(b) The medication management record must be current and updated when there are any changes.

(c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.

Sec. 44. Minnesota Statutes 2016, section 144A.4792, subdivision 10, is amended to read:

Subd. 10. **Medication management for clients who will be away from home.** (a) A home care provider who is providing medication management services to the client and controls the client's access to the medications must develop and implement policies and procedures for giving accurate and current medications to clients for planned or unplanned times away from home according to the client's individualized medication management plan. The policy and procedures must state that:

(1) for planned time away, the medications must be obtained from the pharmacy or set up by ~~the registered~~ a licensed nurse according to appropriate state and federal laws and nursing standards of practice;

(2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall give the client or client's representative medications in amounts and dosages needed for the length of the anticipated absence, not to exceed ~~120 hours~~ seven calendar days;

(3) the client or client's representative must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances;

(4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the client's name and the dates and times that the medications are scheduled; and

(5) the client or client's representative must be provided in writing the home care provider's name and information on how to contact the home care provider.

(b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if:

(1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to clients; and

(2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the client. The procedures must address:

(i) the type of container or containers to be used for the medications appropriate to the provider's medication system;

(ii) how the container or containers must be labeled;

(iii) the written information about the medications to be given to the client or client's representative;

(iv) how the unlicensed staff must document in the client's record that medications have been given to the client or the client's representative, including documenting the date the medications were given to the client or the client's representative and who received the medications, the person who gave the medications to the client, the number of medications that were given to the client, and other required information;

(v) how the registered nurse shall be notified that medications have been given to the client or client's representative and whether the registered nurse needs to be contacted before the medications are given to the client or the client's representative; ~~and~~

(vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel~~.~~; and

(vii) how the unlicensed staff must document in the client's record any unused medications that are returned to the provider, including the name of each medication and the doses of each returned medication.

Sec. 45. Minnesota Statutes 2016, section 144A.4793, subdivision 6, is amended to read:

Subd. 6. **Treatment and therapy orders ~~or prescriptions.~~** There must be an up-to-date written or electronically recorded order ~~or prescription~~ from an authorized prescriber for all treatments and therapies. The order must contain the name of the client, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months.

Sec. 46. Minnesota Statutes 2017 Supplement, section 144A.4796, subdivision 2, is amended to read:

Subd. 2. **Content.** (a) The orientation must contain the following topics:

(1) an overview of sections 144A.43 to 144A.4798;

(2) introduction and review of all the provider's policies and procedures related to the provision of home care services by the individual staff person;

(3) handling of emergencies and use of emergency services;

(4) compliance with and reporting of the maltreatment of minors or vulnerable adults under sections 626.556 and 626.557;

(5) home care bill of rights under section 144A.44;

(6) handling of clients' complaints, reporting of complaints, and where to report complaints including information on the Office of Health Facility Complaints and the Common Entry Point;

(7) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county managed care advocates, or other relevant advocacy services; and

(8) review of the types of home care services the employee will be providing and the provider's scope of licensure.

(b) In addition to the topics listed in paragraph (a), orientation may also contain training on providing services to clients with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research-based, may include online training, and must include training on one or more of the following topics:

(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;

(2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or

(3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.

Sec. 47. Minnesota Statutes 2016, section 144A.4797, subdivision 3, is amended to read:

Subd. 3. **Supervision of staff providing delegated nursing or therapy home care tasks.** (a) Staff who perform delegated nursing or therapy home care tasks must be supervised by an appropriate licensed health professional or a registered nurse periodically where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the client.

(b) The direct supervision of staff performing delegated tasks must be provided within 30 days after the date on which the individual begins working for the home care provider and first performs delegated tasks for clients and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer.

Sec. 48. Minnesota Statutes 2016, section 144A.4798, is amended to read:

144A.4798 ~~EMPLOYEE HEALTH STATUS~~ DISEASE PREVENTION AND INFECTION CONTROL.

Subdivision 1. **Tuberculosis (TB) ~~prevention and~~ infection control.** (a) A home care provider must establish and maintain a ~~TB prevention and~~ comprehensive tuberculosis infection control program ~~based on~~ according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. ~~Components of a TB prevention and control program include screening all staff providing home care services, both paid and unpaid, at the time of hire for active TB disease and latent TB infection, and developing and implementing a written~~

~~TB infection control plan. The commissioner shall make the most recent CDC standards available to home care providers on the department's Web site.~~ This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines.

(b) Written evidence of compliance with this subdivision must be maintained by the home care provider.

Subd. 2. **Communicable diseases.** A home care provider must follow current ~~federal or state guidelines~~ state requirements for prevention, control, and reporting of ~~human immunodeficiency virus (HIV), hepatitis B virus (HBV), hepatitis C virus, or other~~ communicable diseases as defined in Minnesota Rules, ~~part~~ parts 4605.7040, 4605.7044, 4605.7050, 4605.7075, 4605.7080, and 4605.7090.

Subd. 3. **Infection control program.** A home care provider must establish and maintain an effective infection control program that complies with accepted health care, medical, and nursing standards for infection control.

Sec. 49. Minnesota Statutes 2016, section 144A.4799, subdivision 1, is amended to read:

Subdivision 1. **Membership.** The commissioner of health shall appoint eight persons to a home care and assisted living program advisory council consisting of the following:

(1) three public members as defined in section 214.02 who shall be ~~either~~ persons who are currently receiving home care services ~~or~~, persons who have received home care services within five years of the application date, persons who have family members receiving home care services, or persons who have family members who have received home care services within five years of the application date;

(2) three Minnesota home care licensees representing basic and comprehensive levels of licensure who may be a managerial official, an administrator, a supervising registered nurse, or an unlicensed personnel performing home care tasks;

(3) one member representing the Minnesota Board of Nursing; and

(4) one member representing the Office of Ombudsman for Long-Term Care.

Sec. 50. Minnesota Statutes 2017 Supplement, section 144A.4799, subdivision 3, is amended to read:

Subd. 3. **Duties.** (a) At the commissioner's request, the advisory council shall provide advice regarding regulations of Department of Health licensed home care providers in this chapter, including advice on the following:

(1) community standards for home care practices;

(2) enforcement of licensing standards and whether certain disciplinary actions are appropriate;

(3) ways of distributing information to licensees and consumers of home care;

(4) training standards;

(5) identifying emerging issues and opportunities in ~~the~~ home care ~~field, including~~ and assisted living;

(6) identifying the use of technology in home and telehealth capabilities;

~~(6)~~ (7) allowable home care licensing modifications and exemptions, including a method for an integrated license with an existing license for rural licensed nursing homes to provide limited home care services in an adjacent independent living apartment building owned by the licensed nursing home; and

~~(7)~~ (8) recommendations for studies using the data in section 62U.04, subdivision 4, including but not limited to studies concerning costs related to dementia and chronic disease among an elderly population over 60 and additional long-term care costs, as described in section 62U.10, subdivision 6.

(b) The advisory council shall perform other duties as directed by the commissioner.

(c) The advisory council shall annually review the balance of the account in the state government special revenue fund described in section 144A.474, subdivision 11, paragraph (i), and make annual recommendations by January 15 directly to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services regarding appropriations to the commissioner for the purposes in section 144A.474, subdivision 11, paragraph (i).

Sec. 51. Minnesota Statutes 2016, section 144A.484, subdivision 1, is amended to read:

Subdivision 1. **Integrated licensing established.** ~~(a) From January 1, 2014, to June 30, 2015, the commissioner of health shall enforce the home and community-based services~~

~~standards under chapter 245D for those providers who also have a home care license pursuant to this chapter as required under Laws 2013, chapter 108, article 8, section 60, and article 11, section 31. During this period, the commissioner shall provide technical assistance to achieve and maintain compliance with applicable law or rules governing the provision of home and community-based services, including complying with the service recipient rights notice in subdivision 4, clause (4). If during the survey, the commissioner finds that the licensee has failed to achieve compliance with an applicable law or rule under chapter 245D and this failure does not imminently endanger the health, safety, or rights of the persons served by the program, the commissioner may issue a licensing survey report with recommendations for achieving and maintaining compliance.~~

~~(b) Beginning July 1, 2015,~~ A home care provider applicant or license holder may apply to the commissioner of health for a home and community-based services designation for the provision of basic support services identified under section 245D.03, subdivision 1, paragraph (b). The designation allows the license holder to provide basic support services that would otherwise require licensure under chapter 245D, under the license holder's home care license governed by sections 144A.43 to ~~144A.481~~ 144A.4799.

Sec. 52. Minnesota Statutes 2016, section 144E.16, is amended by adding a subdivision to read:

Subd. 9. **Rules authorizing patient-assisted medication administration.** (a) The board shall adopt rules authorizing EMTs, AEMTs, and paramedics certified under section 144E.28 to assist a patient, in emergency situations, with administering prescription medications that are:

(1) carried by a patient;

(2) intended to treat adrenal insufficiency or another rare but previously diagnosed condition that requires emergency treatment with a previously prescribed medication;

(3) intended to treat a specific life-threatening condition; and

(4) administered via routes of delivery that are within the skill set of the EMT, AEMT, or paramedic.

(b) EMTs, AEMTs, and paramedics assisting a patient with medication administration according to the rules adopted under this subdivision may do so only under the authority of guidelines approved by the ambulance service medical director or under direct medical control.

Sec. 53. Minnesota Statutes 2016, section 144E.16, is amended by adding a subdivision to read:

Subd. 10. **Rules establishing standards for communication with patients regarding need for emergency medical services.** The board shall adopt rules to establish guidelines for ambulance services to communicate with a patient in the service area of the ambulance service, and with the patient's caregivers, concerning the patient's health condition, the likelihood that the patient will need emergency medical services, and how to collaboratively develop emergency medical services care plans to meet the patient's needs.

Sec. 54. Minnesota Statutes 2017 Supplement, section 144H.01, subdivision 5, is amended to read:

Subd. 5. **Medically complex or technologically dependent child.** "Medically complex or technologically dependent child" means a child under 21 years of age who~~, because of a medical condition, requires continuous therapeutic interventions or skilled nursing supervision which must be prescribed by a licensed physician and administered by, or under the direct supervision of, a licensed registered nurse~~ meets the criteria for medical complexity described in the federally approved community alternative care waiver.

Sec. 55. Minnesota Statutes 2017 Supplement, section 144H.04, subdivision 1, is amended to read:

Subdivision 1. **Licenses.** (a) A person seeking licensure for a PPEC center must submit a completed application for licensure to the commissioner, in a form and manner determined by the commissioner. The applicant must also submit the application fee, in the amount specified in section 144H.05, subdivision 1. ~~Effective~~ For the period January 1, 2019, through December 31, 2020, the commissioner shall issue licenses for no more than two PPEC centers according to the requirements in the phase-in of licensure of prescribed pediatric extended care centers in section 80. Beginning January 1, ~~2018~~ 2021, the commissioner shall issue a license for a PPEC center if the commissioner determines that the applicant and center meet the requirements of this chapter and rules that apply to PPEC centers. A license issued under this subdivision is valid for two years.

(b) The commissioner may limit issuance of PPEC center licenses to PPEC centers located in areas of the state with a demonstrated home care worker shortage.

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

Sec. 56. Minnesota Statutes 2016, section 145.56, subdivision 2, is amended to read:

Subd. 2. **Community-based programs.** To the extent funds are appropriated for the purposes of this subdivision, the commissioner shall establish a grant program to fund:

(1) community-based programs to provide education, outreach, and advocacy services to populations who may be at risk for suicide;

(2) community-based programs that educate community helpers and gatekeepers, such as family members, spiritual leaders, coaches, and business owners, employers, and coworkers on how to prevent suicide by encouraging help-seeking behaviors;

(3) community-based programs that educate populations at risk for suicide and community helpers and gatekeepers that must include information on the symptoms of depression and other psychiatric illnesses, the warning signs of suicide, skills for preventing suicides, and making or seeking effective referrals to intervention and community resources;

(4) community-based programs to provide evidence-based suicide prevention and intervention education to school staff, parents, and students in grades kindergarten through 12, and for students attending Minnesota colleges and universities;

(5) community-based programs to provide evidence-based suicide prevention and intervention to public school nurses, teachers, administrators, coaches, school social workers, peace officers, firefighters, emergency medical technicians, advanced emergency medical technicians, paramedics, primary care providers, and others; ~~and~~

(6) community-based, evidence-based postvention training to mental health professionals and practitioners in order to provide technical assistance to communities after a suicide and to prevent suicide clusters and contagion; and

(7) a nonprofit organization to provide crisis telephone counseling services across the state to people in suicidal crisis or emotional distress, 24 hours a day, seven days a week, 365 days a year.

Sec. 57. Minnesota Statutes 2016, section 145.928, subdivision 1, is amended to read:

Subdivision 1. **Goal; establishment.** It is the goal of the state, by 2010, to decrease by 50 percent the disparities in infant mortality rates and adult and child immunization rates for American Indians and populations of color, as compared with rates for whites. To do so and to achieve other measurable outcomes, the commissioner of health shall establish a program to close the gap in the health status of American Indians and populations of color as compared with whites in the following priority areas: infant mortality, access to and

utilization of high-quality prenatal care, breast and cervical cancer screening, HIV/AIDS and sexually transmitted infections, adult and child immunizations, cardiovascular disease, diabetes, and accidental injuries and violence.

Sec. 58. Minnesota Statutes 2016, section 145.928, subdivision 7, is amended to read:

Subd. 7. **Community grant program; immunization rates, prenatal care access and utilization, and infant mortality rates.** (a) The commissioner shall award grants to eligible applicants for local or regional projects and initiatives directed at reducing health disparities in one or ~~both~~ more of the following priority areas:

(1) decreasing racial and ethnic disparities in infant mortality rates; ~~or~~

(2) decreasing racial and ethnic disparities in access to and utilization of high-quality prenatal care; or

~~(2)~~ (3) increasing adult and child immunization rates in nonwhite racial and ethnic populations.

(b) The commissioner may award up to 20 percent of the funds available as planning grants. Planning grants must be used to address such areas as community assessment, coordination activities, and development of community supported strategies.

(c) Eligible applicants may include, but are not limited to, faith-based organizations, social service organizations, community nonprofit organizations, community health boards, tribal governments, and community clinics. Applicants must submit proposals to the commissioner. A proposal must specify the strategies to be implemented to address one or ~~both~~ more of the priority areas listed in paragraph (a) and must be targeted to achieve the outcomes established according to subdivision 3.

(d) The commissioner shall give priority to applicants who demonstrate that their proposed project or initiative:

(1) is supported by the community the applicant will serve;

(2) is research-based or based on promising strategies;

(3) is designed to complement other related community activities;

(4) utilizes strategies that positively impact ~~both~~ two or more priority areas;

(5) reflects racially and ethnically appropriate approaches; and

(6) will be implemented through or with community-based organizations that reflect the race or ethnicity of the population to be reached.

Sec. 59. Minnesota Statutes 2016, section 146B.03, is amended by adding a subdivision to read:

Subd. 7a. **Supervisors.** (a) A technician must have been licensed in Minnesota or in a jurisdiction with which Minnesota has reciprocity for at least:

(1) two years as a tattoo technician in order to supervise a temporary tattoo technician; or

(2) one year as a body piercing technician in order to supervise a temporary body piercing technician.

(b) Any technician who agrees to supervise more than two temporary tattoo technicians during the same time period, or more than four body piercing technicians during the same time period, must provide to the commissioner a supervisory plan that describes how the technician will provide supervision to each temporary technician in accordance with section 146B.01, subdivision 28.

(c) The commissioner may refuse to approve as a supervisor a technician who has been disciplined in Minnesota or in another jurisdiction after considering the criteria in section 146B.02, subdivision 10, paragraph (b).

Sec. 60. Minnesota Statutes 2016, section 147A.08, is amended to read:

147A.08 EXEMPTIONS.

(a) This chapter does not apply to, control, prevent, or restrict the practice, service, or activities of persons listed in section 147.09, clauses (1) to (6) and (8) to (13), persons regulated under section 214.01, subdivision 2, or persons defined in section 144.1501, subdivision 1, paragraphs ~~(i), (k), and~~ (j), (l), and (m).

(b) Nothing in this chapter shall be construed to require licensure of:

(1) a physician assistant student enrolled in a physician assistant educational program accredited by the Accreditation Review Commission on Education for the Physician Assistant or by its successor agency approved by the board;

(2) a physician assistant employed in the service of the federal government while performing duties incident to that employment; or

(3) technicians, other assistants, or employees of physicians who perform delegated tasks in the office of a physician but who do not identify themselves as a physician assistant.

Sec. 61. Minnesota Statutes 2016, section 148.512, subdivision 17a, is amended to read:

Subd. 17a. **Speech-language pathology assistant.** "Speech-language pathology assistant" means a person who ~~provides speech-language pathology services under the supervision of a licensed speech-language pathologist in accordance with section 148.5192~~ practices speech-language pathology assisting, meets the requirements under section 148.5185 or 148.5186, and is licensed by the commissioner.

EFFECTIVE DATE. This section is effective January 1, 2019.

Sec. 62. Minnesota Statutes 2016, section 148.513, subdivision 1, is amended to read:

Subdivision 1. **Unlicensed practice prohibited.** A person must not engage in the practice of speech-language pathology ~~or~~, audiology, or speech-language pathology assisting unless the person is licensed as a speech-language pathologist ~~or~~, an audiologist, or a speech-language pathology assistant under sections 148.511 to 148.5198 ~~or is practicing as a speech-language pathology assistant in accordance with section 148.5192. For purposes of this subdivision, a speech-language pathology assistant's duties are limited to the duties described in accordance with section 148.5192, subdivision 2~~.

EFFECTIVE DATE. This section is effective January 1, 2019.

Sec. 63. Minnesota Statutes 2016, section 148.513, subdivision 2, is amended to read:

Subd. 2. **Protected titles and restrictions on use; speech-language pathologists and audiologists.** ~~(a) Notwithstanding paragraph (b)~~ Except as provided in subdivision 2b, the use of the following terms or initials which represent the following terms, alone or in combination with any word or words, by any person to form an occupational title is prohibited unless that person is licensed as a speech-language pathologist or audiologist under sections 148.511 to 148.5198:

(1) speech-language;

(2) speech-language pathologist, S, SP, or SLP;

(3) speech pathologist;

(4) language pathologist;

(5) audiologist, A, or AUD;

(6) speech therapist;

(7) speech clinician;

(8) speech correctionist;

(9) language therapist;

(10) voice therapist;

(11) voice pathologist;

(12) logopedist;

(13) communicologist;

(14) aphasiologist;

(15) phoniatrist;

(16) audiometrist;

(17) audioprosthologist;

(18) hearing therapist;

(19) hearing clinician; or

(20) hearing aid audiologist.

Use of the term "Minnesota licensed" in conjunction with the titles protected under this ~~paragraph~~ subdivision by any person is prohibited unless that person is licensed as a speech-language pathologist or audiologist under sections 148.511 to 148.5198.

~~(b) A speech-language pathology assistant practicing under section 148.5192 must not represent, indicate, or imply to the public that the assistant is a licensed speech-language pathologist and shall only utilize one of the following titles: "speech-language pathology assistant," "SLP assistant," or "SLP asst."~~

EFFECTIVE DATE. This section is effective January 1, 2019.

Sec. 64. Minnesota Statutes 2016, section 148.513, is amended by adding a subdivision to read:

Subd. 2b. **Protected titles and restrictions on use; speech-language pathology assistants.** (a) Use of the following titles is prohibited, unless that person is licensed under section 148.5185 or 148.5186: "speech-language pathology assistant," "SLP assistant," or "SLP asst."

(b) A speech-language pathology assistant licensed under section 148.5185 or 148.5186 must not represent, indicate, or imply to the public that the assistant is a licensed speech-language pathologist and shall only utilize one of the following titles:

"speech-language pathology assistant," "SLP assistant," or "SLP asst." A speech-language pathology assistant licensed under section 148.5185 or 148.5186 may use the term "licensed" or "Minnesota licensed" in connection with a title listed in this paragraph. Use of the term "Minnesota licensed" in conjunction with any of the titles protected under paragraph (a) by any person is prohibited unless that person is licensed under section 148.5185 or 148.5186.

EFFECTIVE DATE. This section is effective January 1, 2019.

Sec. 65. Minnesota Statutes 2016, section 148.515, subdivision 1, is amended to read:

Subdivision 1. **Applicability.** Except as provided in section 148.516 or 148.517, an applicant for licensure as a speech-language pathologist or audiologist must meet the requirements in this section.

EFFECTIVE DATE. This section is effective January 1, 2019.

Sec. 66. Minnesota Statutes 2016, section 148.516, is amended to read:

148.516 LICENSURE BY EQUIVALENCY.

An applicant who applies for licensure by equivalency as a speech-language pathologist or audiologist must show evidence of possessing a current certificate of clinical competence issued by the American Speech-Language-Hearing Association or board certification by the American Board of Audiology and must meet the requirements of section 148.514.

EFFECTIVE DATE. This section is effective January 1, 2019.

Sec. 67. **[148.5185] RESTRICTED LICENSURE; SPEECH-LANGUAGE PATHOLOGY ASSISTANTS.**

Subdivision 1. **Qualifications for a restricted license.** To be eligible for restricted licensure as a speech-language pathology assistant, an applicant must satisfy the requirements in subdivision 2, 3, or 4.

Subd. 2. **Person practicing as a speech-language pathology assistant before January 1, 2019.** (a) A person who is practicing as a speech-language pathology assistant before January 1, 2019, and who does not meet the qualifications for a license under section 148.5186 may apply for a restricted speech-language pathology assistant license from the commissioner. An applicant under this paragraph must submit to the commissioner:

(1) proof of current employment as a speech-language pathology assistant; and

(2) a signed affidavit affirming supervision, from the licensed speech-language pathologist currently supervising the applicant.

(b) In order to be licensed as a speech-language pathology assistant under section 148.5186, a licensee with a restricted license under this subdivision must obtain an associate degree from a speech-language pathology assistant program that is accredited by the Higher Learning Commission of the North Central Association of Colleges or its equivalent, as approved by the commissioner, and that includes (1) coursework on an introduction to communication disorders, phonetics, language development, articulation disorders, language disorders, anatomy of speech/language hearing, stuttering, adult communication disorders, and clinical documentations and materials management; and (2) at least 100 hours of supervised field work experience in speech-language pathology assisting. Upon completion of the requirements in this paragraph prior to January 1, 2025, a licensee with a restricted license under this subdivision is eligible to apply for licensure under section 148.5186.

Subd. 3. **Person with a bachelor's degree in communication sciences or disorders and practicing as a speech-language pathology assistant before January 1, 2019.** (a) A person with a bachelor's degree in the discipline of communication sciences or disorders and who is practicing as a speech-language pathology assistant before January 1, 2019, but who does not meet the qualifications for a license under section 148.5186, may apply for a restricted speech-language pathology assistant license from the commissioner. An applicant under this paragraph must submit to the commissioner:

(1) a transcript from an educational institution documenting satisfactory completion of a bachelor's degree in the discipline of communication sciences or disorders;

(2) proof of current employment as a speech-language pathology assistant; and

(3) a signed affidavit affirming supervision, from the licensed speech-language pathologist currently supervising the applicant.

(b) In order to be licensed as a speech-language pathology assistant under section 148.5186, a licensee with a restricted license under this subdivision must complete (1) coursework from a speech-language pathology assistant program in articulation disorders, language disorders, adult communication disorders, and stuttering; and (2) at least 100 hours of supervised field work experience in speech-language pathology assisting. Upon completion of the requirements in this paragraph prior to January 1, 2025, a licensee with a restricted license under this subdivision is eligible to apply for licensure under section 148.5186.

Subd. 4. **Person with an associate degree from a program that does not meet requirements in section 148.5186.** (a) A person with an associate degree from a

speech-language pathology assistant program that does not meet the requirements in section 148.5186, subdivision 1, clause (1), may apply for a restricted speech-language pathology assistant license from the commissioner. An applicant under this paragraph must submit to the commissioner a transcript from an educational institution documenting satisfactory completion of an associate degree from a speech-language pathology assistant program. If the commissioner determines that the applicant's speech-language pathology assistant program does not include coursework or supervised field work experience that is equivalent to a program under section 148.5186, subdivision 1, clause (1), the commissioner may issue a restricted license to the applicant.

(b) In order to be licensed as a speech-language pathology assistant under section 148.5186, a licensee with a restricted license under this subdivision must complete any missing coursework or supervised field work experience, as determined by the commissioner, in a speech-language pathology assisting program. Upon completion of the requirements in this paragraph prior to January 1, 2025, a licensee with a restricted license under this subdivision is eligible to apply for licensure under section 148.5186.

Subd. 5. **Additional requirements; restricted license.** (a) A restricted license issued under subdivision 2, 3, or 4 may be renewed biennially until January 1, 2025.

(b) A licensee with a restricted license under subdivision 2 or 3 may only practice speech-language pathology assisting for the employer with whom the licensee was employed when the licensee applied for licensure.

Subd. 6. **Continuing education.** In order to renew a restricted license, a licensee must comply with the continuing education requirements in section 148.5193, subdivision 1a.

Subd. 7. **Scope of practice.** Scope of practice for a speech-language pathology assistant licensed under this section is governed by section 148.5192, subdivision 2.

EFFECTIVE DATE. This section is effective January 1, 2019.

Sec. 68. **[148.5186] LICENSURE; SPEECH-LANGUAGE PATHOLOGY ASSISTANTS.**

Subdivision 1. **Requirements for licensure.** To be eligible for licensure as a speech-language pathology assistant, an applicant must submit to the commissioner a transcript from an educational institution documenting satisfactory completion of either:

(1) an associate degree from a speech-language pathology assistant program that is accredited by the Higher Learning Commission of the North Central Association of Colleges

or its equivalent as approved by the commissioner, which includes at least 100 hours of supervised field work experience in speech-language pathology assisting; or

(2) a bachelor's degree in the discipline of communication sciences or disorders and a speech-language pathology assistant certificate program that includes (i) coursework in an introduction to speech-language pathology assisting, stuttering, articulation disorders, and language disorders; and (ii) at least 100 hours of supervised field work experience in speech-language pathology assisting.

Subd. 2. **Licensure by equivalency.** An applicant who applies for licensure by equivalency as a speech-language pathology assistant must provide evidence to the commissioner of satisfying the requirements in subdivision 1.

Subd. 3. **Scope of practice.** Scope of practice for a speech-language pathology assistant licensed under this section is governed by section 148.5192, subdivision 2.

EFFECTIVE DATE. This section is effective January 1, 2019.

Sec. 69. Minnesota Statutes 2017 Supplement, section 148.519, subdivision 1, is amended to read:

Subdivision 1. **Applications for licensure; speech-language pathologists and audiologists.** (a) An applicant for licensure as a speech-language pathologist or audiologist must:

(1) submit a completed application for licensure on forms provided by the commissioner. The application must include the applicant's name, certification number under chapter 153A, if applicable, business address and telephone number, or home address and telephone number if the applicant practices speech-language pathology or audiology out of the home, and a description of the applicant's education, training, and experience, including previous work history for the five years immediately preceding the date of application. The commissioner may ask the applicant to provide additional information necessary to clarify information submitted in the application; and

(2) submit documentation of the certificate of clinical competence issued by the American Speech-Language-Hearing Association, board certification by the American Board of Audiology, or satisfy the following requirements:

(i) submit a transcript showing the completion of a master's or doctoral degree or its equivalent meeting the requirements of section 148.515, subdivision 2;

(ii) submit documentation of the required hours of supervised clinical training;

(iii) submit documentation of the postgraduate clinical or doctoral clinical experience meeting the requirements of section 148.515, subdivision 4; and

(iv) submit documentation of receiving a qualifying score on an examination meeting the requirements of section 148.515, subdivision 6.

(b) In addition, an applicant must:

(1) sign a statement that the information in the application is true and correct to the best of the applicant's knowledge and belief;

(2) submit with the application all fees required by section 148.5194;

(3) sign a waiver authorizing the commissioner to obtain access to the applicant's records in this or any other state in which the applicant has engaged in the practice of speech-language pathology or audiology; and

(4) consent to a fingerprint-based criminal history background check as required under section 144.0572, pay all required fees, and cooperate with all requests for information. An applicant must complete a new criminal history background check if more than one year has elapsed since the applicant last applied for a license.

EFFECTIVE DATE. This section is effective January 1, 2019.

Sec. 70. Minnesota Statutes 2016, section 148.519, is amended by adding a subdivision to read:

Subd. 1a. **Applications for licensure; speech-language pathology assistants.** An applicant for licensure as a speech-language pathology assistant must submit to the commissioner:

(1) a completed application on forms provided by the commissioner. The application must include the applicant's name, business address and telephone number, home address and telephone number, and a description of the applicant's education, training, and experience, including previous work history for the five years immediately preceding the application date. The commissioner may ask the applicant to provide additional information needed to clarify information submitted in the application;

(2) documentation that the applicant satisfied one of the qualifications listed in section 148.5185 or 148.5186;

(3) a signed statement that the information in the application is true and correct to the best of the applicant's knowledge and belief;

(4) all fees required under section 148.5194; and

(5) a signed waiver authorizing the commissioner to obtain access to the applicant's records in this or any other state in which the applicant has worked as a speech-language pathology assistant.

EFFECTIVE DATE. This section is effective January 1, 2019.

Sec. 71. Minnesota Statutes 2016, section 148.5192, subdivision 1, is amended to read:

Subdivision 1. **Delegation requirements.** A licensed speech-language pathologist may delegate duties to a speech-language pathology assistant in accordance with this section. Duties may only be delegated to an individual who ~~has documented with a transcript from an educational institution satisfactory completion of either:~~

~~(1) an associate degree from a speech-language pathology assistant program that is accredited by the Higher Learning Commission of the North Central Association of Colleges or its equivalent as approved by the commissioner; or~~

~~(2) a bachelor's degree in the discipline of communication sciences or disorders with additional transcript credit in the area of instruction in assistant-level service delivery practices and completion of at least 100 hours of supervised field work experience as a speech-language pathology assistant student~~ is licensed under section 148.5185 or 148.5186.

EFFECTIVE DATE. This section is effective January 1, 2019.

Sec. 72. Minnesota Statutes 2017 Supplement, section 148.5193, subdivision 1, is amended to read:

Subdivision 1. **Number of contact hours required.** (a) An applicant for licensure renewal as a speech-language pathologist or audiologist must meet the requirements for continuing education stipulated by the American Speech-Language-Hearing Association or the American Board of Audiology, or satisfy the requirements described in paragraphs (b) to (e).

(b) Within one month following expiration of a license, an applicant for licensure renewal as either a speech-language pathologist or an audiologist must provide evidence to the commissioner of a minimum of 30 contact hours of continuing education obtained within the two years immediately preceding licensure expiration. A minimum of 20 contact hours of continuing education must be directly related to the licensee's area of licensure. Ten contact hours of continuing education may be in areas generally related to the licensee's area of licensure. Licensees who are issued licenses for a period of less than two years shall

prorate the number of contact hours required for licensure renewal based on the number of months licensed during the biennial licensure period. Licensees shall receive contact hours for continuing education activities only for the biennial licensure period in which the continuing education activity was performed.

(c) An applicant for licensure renewal as both a speech-language pathologist and an audiologist must attest to and document completion of a minimum of 36 contact hours of continuing education offered by a continuing education sponsor within the two years immediately preceding licensure renewal. A minimum of 15 contact hours must be received in the area of speech-language pathology and a minimum of 15 contact hours must be received in the area of audiology. Six contact hours of continuing education may be in areas generally related to the licensee's areas of licensure. Licensees who are issued licenses for a period of less than two years shall prorate the number of contact hours required for licensure renewal based on the number of months licensed during the biennial licensure period. Licensees shall receive contact hours for continuing education activities only for the biennial licensure period in which the continuing education activity was performed.

(d) If the licensee is licensed by the Professional Educator Licensing and Standards Board:

(1) activities that are approved in the categories of Minnesota Rules, part 8710.7200, subpart 3, items A and B, and that relate to speech-language pathology, shall be considered:

(i) offered by a sponsor of continuing education; and

(ii) directly related to speech-language pathology;

(2) activities that are approved in the categories of Minnesota Rules, part 8710.7200, subpart 3, shall be considered:

(i) offered by a sponsor of continuing education; and

(ii) generally related to speech-language pathology; and

(3) one clock hour as defined in Minnesota Rules, part 8710.7200, subpart 1, is equivalent to 1.0 contact hours of continuing education.

(e) Contact hours may not be accumulated in advance and transferred to a future continuing education period.

EFFECTIVE DATE. This section is effective January 1, 2019.

Sec. 73. Minnesota Statutes 2016, section 148.5193, is amended by adding a subdivision to read:

Subd. 1a. **Continuing education; speech-language pathology assistants.** An applicant for licensure renewal as a speech-language pathology assistant must meet the requirements for continuing education established by the commissioner.

EFFECTIVE DATE. This section is effective January 1, 2019.

Sec. 74. Minnesota Statutes 2016, section 148.5194, is amended by adding a subdivision to read:

Subd. 3b. **Speech-language pathology assistant initial licensure and renewal fees.** The fee for initial speech-language pathology assistant licensure under section 148.5185 or 148.5186 is $130. The fee for licensure renewal is $120.

EFFECTIVE DATE. This section is effective January 1, 2019.

Sec. 75. Minnesota Statutes 2016, section 148.5194, subdivision 8, is amended to read:

Subd. 8. **Penalty fees.** (a) The penalty fee for practicing speech-language pathology or audiology or using protected titles without a current license after the credential has expired and before it is renewed is the amount of the license renewal fee for any part of the first month, plus the license renewal fee for any part of any subsequent month up to 36 months. The penalty fee for a speech-language pathology assistant who practices speech-language pathology assisting or uses protected titles without a current license after a license has expired and before it is renewed is the amount of the license renewal fee for any part of the first month, plus the license renewal fee for any part of any subsequent month up to 36 months.

(b) The penalty fee for applicants who engage in the unauthorized practice of speech-language pathology or audiology or using protected titles before being issued a license is the amount of the license application fee for any part of the first month, plus the license application fee for any part of any subsequent month up to 36 months. The penalty fee for a speech-language pathology assistant who engages in the unauthorized practice of speech-language pathology assisting or uses protected titles without being issued a license is the amount of the license application fee for any part of the first month, plus the license application fee for any part of any subsequent month up to 36 months. This paragraph does not apply to applicants not qualifying for a license who engage in the unauthorized practice of speech language pathology or audiology.

(c) The penalty fee for practicing speech-language pathology or audiology and failing to submit a continuing education report by the due date with the correct number or type of hours in the correct time period is $100 plus $20 for each missing clock hour. The penalty fee for a licensed speech-language pathology assistant who fails to submit a continuing education report by the due date with the correct number or type of hours in the correct time period is $100 plus $20 for each missing clock hour. "Missing" means not obtained between the effective and expiration dates of the certificate, the one-month period following the certificate expiration date, or the 30 days following notice of a penalty fee for failing to report all continuing education hours. The licensee must obtain the missing number of continuing education hours by the next reporting due date.

(d) Civil penalties and discipline incurred by licensees prior to August 1, 2005, for conduct described in paragraph (a), (b), or (c) shall be recorded as nondisciplinary penalty fees. For conduct described in paragraph (a) or (b) occurring after August 1, 2005, and exceeding six months, payment of a penalty fee does not preclude any disciplinary action reasonably justified by the individual case.

EFFECTIVE DATE. This section is effective January 1, 2019.

Sec. 76. Minnesota Statutes 2016, section 148.5195, subdivision 3, is amended to read:

Subd. 3. **Grounds for disciplinary action by commissioner.** The commissioner may take any of the disciplinary actions listed in subdivision 4 on proof that the individual has:

(1) intentionally submitted false or misleading information to the commissioner or the advisory council;

(2) failed, within 30 days, to provide information in response to a written request by the commissioner or advisory council;

(3) performed services of a speech-language pathologist ~~or~~, audiologist, or speech-language pathology assistant in an incompetent or negligent manner;

(4) violated sections 148.511 to 148.5198;

(5) failed to perform services with reasonable judgment, skill, or safety due to the use of alcohol or drugs, or other physical or mental impairment;

(6) violated any state or federal law, rule, or regulation, and the violation is a felony or misdemeanor, an essential element of which is dishonesty, or which relates directly or indirectly to the practice of speech-language pathology ~~or~~, audiology, or speech-language pathology assisting. Conviction for violating any state or federal law which relates to

speech-language pathology ~~or~~, audiology, or speech-language pathology assisting is necessarily considered to constitute a violation, except as provided in chapter 364;

(7) aided or abetted another person in violating any provision of sections 148.511 to 148.5198;

(8) been or is being disciplined by another jurisdiction, if any of the grounds for the discipline is the same or substantially equivalent to those under sections 148.511 to 148.5198;

(9) not cooperated with the commissioner or advisory council in an investigation conducted according to subdivision 1;

(10) advertised in a manner that is false or misleading;

(11) engaged in conduct likely to deceive, defraud, or harm the public; or demonstrated a willful or careless disregard for the health, welfare, or safety of a client;

(12) failed to disclose to the consumer any fee splitting or any promise to pay a portion of a fee to any other professional other than a fee for services rendered by the other professional to the client;

(13) engaged in abusive or fraudulent billing practices, including violations of federal Medicare and Medicaid laws, Food and Drug Administration regulations, or state medical assistance laws;

(14) obtained money, property, or services from a consumer through the use of undue influence, high pressure sales tactics, harassment, duress, deception, or fraud;

(15) performed services for a client who had no possibility of benefiting from the services;

(16) failed to refer a client for medical evaluation or to other health care professionals when appropriate or when a client indicated symptoms associated with diseases that could be medically or surgically treated;

(17) had the certification required by chapter 153A denied, suspended, or revoked according to chapter 153A;

(18) used the term doctor of audiology, doctor of speech-language pathology, AuD, or SLPD without having obtained the degree from an institution accredited by the North Central Association of Colleges and Secondary Schools, the Council on Academic Accreditation in Audiology and Speech-Language Pathology, the United States Department of Education, or an equivalent;

(19) failed to comply with the requirements of section 148.5192 regarding supervision of speech-language pathology assistants; or

(20) if the individual is an audiologist or certified hearing instrument dispenser:

(i) prescribed or otherwise recommended to a consumer or potential consumer the use of a hearing instrument, unless the prescription from a physician or recommendation from an audiologist or certified dispenser is in writing, is based on an audiogram that is delivered to the consumer or potential consumer when the prescription or recommendation is made, and bears the following information in all capital letters of 12-point or larger boldface type: "THIS PRESCRIPTION OR RECOMMENDATION MAY BE FILLED BY, AND HEARING INSTRUMENTS MAY BE PURCHASED FROM, THE LICENSED AUDIOLOGIST OR CERTIFIED DISPENSER OF YOUR CHOICE";

(ii) failed to give a copy of the audiogram, upon which the prescription or recommendation is based, to the consumer when the consumer requests a copy;

(iii) failed to provide the consumer rights brochure required by section 148.5197, subdivision 3;

(iv) failed to comply with restrictions on sales of hearing instruments in sections 148.5197, subdivision 3, and 148.5198;

(v) failed to return a consumer's hearing instrument used as a trade-in or for a discount in the price of a new hearing instrument when requested by the consumer upon cancellation of the purchase agreement;

(vi) failed to follow Food and Drug Administration or Federal Trade Commission regulations relating to dispensing hearing instruments;

(vii) failed to dispense a hearing instrument in a competent manner or without appropriate training;

(viii) delegated hearing instrument dispensing authority to a person not authorized to dispense a hearing instrument under this chapter or chapter 153A;

(ix) failed to comply with the requirements of an employer or supervisor of a hearing instrument dispenser trainee;

(x) violated a state or federal court order or judgment, including a conciliation court judgment, relating to the activities of the individual's hearing instrument dispensing; or

(xi) failed to include on the audiogram the practitioner's printed name, credential type, credential number, signature, and date.

EFFECTIVE DATE. This section is effective January 1, 2019.

Sec. 77. Minnesota Statutes 2017 Supplement, section 148.5196, subdivision 1, is amended to read:

Subdivision 1. **Membership.** The commissioner shall appoint ~~12~~ 13 persons to a Speech-Language Pathologist and Audiologist Advisory Council. The ~~12~~ 13 persons must include:

(1) three public members, as defined in section 214.02. Two of the public members shall be either persons receiving services of a speech-language pathologist or audiologist, or family members of or caregivers to such persons, and at least one of the public members shall be either a hearing instrument user or an advocate of one;

(2) three speech-language pathologists licensed under sections 148.511 to 148.5198, one of whom is currently and has been, for the five years immediately preceding the appointment, engaged in the practice of speech-language pathology in Minnesota and each of whom is employed in a different employment setting including, but not limited to, private practice, hospitals, rehabilitation settings, educational settings, and government agencies;

(3) one speech-language pathologist licensed under sections 148.511 to 148.5198, who is currently and has been, for the five years immediately preceding the appointment, employed by a Minnesota public school district or a Minnesota public school district consortium that is authorized by Minnesota Statutes and who is licensed in speech-language pathology by the Professional Educator Licensing and Standards Board;

(4) three audiologists licensed under sections 148.511 to 148.5198, two of whom are currently and have been, for the five years immediately preceding the appointment, engaged in the practice of audiology and the dispensing of hearing instruments in Minnesota and each of whom is employed in a different employment setting including, but not limited to, private practice, hospitals, rehabilitation settings, educational settings, industry, and government agencies;

(5) one nonaudiologist hearing instrument dispenser recommended by a professional association representing hearing instrument dispensers; ~~and~~

(6) one physician licensed under chapter 147 and certified by the American Board of Otolaryngology, Head and Neck Surgery; and

(7) one speech-language pathology assistant licensed under section 148.5186.

EFFECTIVE DATE. This section is effective January 1, 2019.

Sec. 78. Minnesota Statutes 2016, section 148.5196, subdivision 3, is amended to read:

Subd. 3. **Duties.** The advisory council shall:

(1) advise the commissioner regarding speech-language pathologist ~~and~~, audiologist, and speech-language pathology assistant licensure standards;

(2) advise the commissioner regarding the delegation of duties to and the training required for speech-language pathology assistants;

(3) advise the commissioner on enforcement of sections 148.511 to 148.5198;

(4) provide for distribution of information regarding speech-language pathologist ~~and~~, audiologist, and speech-language pathology assistant licensure standards;

(5) review applications and make recommendations to the commissioner on granting or denying licensure or licensure renewal;

(6) review reports of investigations relating to individuals and make recommendations to the commissioner as to whether licensure should be denied or disciplinary action taken against the individual;

(7) advise the commissioner regarding approval of continuing education activities provided by sponsors using the criteria in section 148.5193, subdivision 2; and

(8) perform other duties authorized for advisory councils under chapter 214, or as directed by the commissioner.

EFFECTIVE DATE. This section is effective January 1, 2019.

Sec. 79. Minnesota Statutes 2016, section 149A.40, subdivision 11, is amended to read:

Subd. 11. **Continuing education.** The commissioner shall require 15 continuing education hours for renewal of a license to practice mortuary science. Nine of the hours must be in the following areas: body preparation, care, ~~or~~ handling, and cremation, 3 CE hours; professional practices, 3 CE hours; and regulation and ethics, 3 CE hours. Continuing education hours shall be reported to the commissioner every other year based on the licensee's license number. Licensees whose license ends in an odd number must report CE hours at renewal time every odd year. If a licensee's license ends in an even number, the licensee must report the licensee's CE hours at renewal time every even year.

EFFECTIVE DATE. This section is effective January 1, 2019, and applies to mortuary science license renewals on or after that date.

Sec. 80. Minnesota Statutes 2016, section 149A.95, subdivision 3, is amended to read:

Subd. 3. **Unlicensed personnel.** (a) A licensed crematory may employ unlicensed personnel, provided that all applicable provisions of this chapter are followed. It is the duty of the licensed crematory to provide proper training ~~for~~ to all unlicensed personnel and ensure that unlicensed personnel performing cremations are in compliance with the requirements in paragraph (b). The licensed crematory shall be strictly accountable for compliance with this chapter and other applicable state and federal regulations regarding occupational and workplace health and safety.

(b) Unlicensed personnel performing cremations at a licensed crematory must:

(1) complete a certified crematory operator course that is approved by the commissioner and that covers at least the following subjects:

(i) cremation and incinerator terminology;

(ii) combustion principles;

(iii) maintenance of and troubleshooting for cremation devices;

(iv) how to operate cremation devices;

(v) identification, the use of proper forms, and the record-keeping process for documenting chain of custody of human remains;

(vi) guidelines for recycling, including but not limited to compliance, disclosure, recycling procedures, and compensation;

(vii) legal and regulatory requirements regarding environmental issues, including specific environmental regulations with which compliance is required; and

(viii) cremation ethics;

(2) obtain a crematory operator certification;

(3) publicly post the crematory operator certification at the licensed crematory where the unlicensed personnel performs cremations; and

(4) maintain crematory operator certification through:

(i) recertification, if such recertification is required by the program through which the unlicensed personnel is certified; or

(ii) if recertification is not required by the program, completion of at least seven hours of continuing education credits in crematory operation every five years.

EFFECTIVE DATE. This section is effective January 1, 2019, and applies to unlicensed personnel performing cremations on or after that date.

Sec. 81. **PHASE-IN OF LICENSURE OF PRESCRIBED PEDIATRIC EXTENDED CARE CENTERS.**

Subdivision 1. **2019-2020 licensure period.** The commissioner of health shall phase in the licensure of prescribed pediatric extended care centers (PPEC centers) under Minnesota Statutes, chapter 144H, by issuing licenses for no more than two PPEC centers for the licensure period January 1, 2019, through December 31, 2020. To be eligible for licensure for the licensure period January 1, 2019, through December 31, 2020, an entity must hold a current comprehensive home care license under Minnesota Statutes, sections 144A.43 to 144A.482, and must have experience providing home care services to medically complex or technologically dependent children, as defined in Minnesota Statutes, section 144H.01, subdivision 5. Beginning January 1, 2021, the commissioner shall license additional PPEC centers if the commissioner determines that the applicant and the center meet the licensing requirements of Minnesota Statutes, chapter 144H.

Subd. 2. **Quality measures; development and reporting.** The commissioner of health, in consultation with prescribed pediatric extended care centers licensed for the 2019-2020 licensure period, shall develop quality measures for PPEC centers, procedures for PPEC centers to report quality measures to the commissioner, and methods for the commissioner to make the results of the quality measures available to the public.

Sec. 82. **OLDER ADULT SOCIAL ISOLATION WORKING GROUP.**

Subdivision 1. **Establishment; members.** The commissioner of health or the commissioner's designee shall convene an older adult social isolation working group that consists of no more than 35 members including, but not limited to:

(1) one person diagnosed with Alzheimer's or dementia;

(2) one caregiver of a person diagnosed with Alzheimer's or dementia;

(3) the executive director of Giving Voice;

(4) one representative from the Mayo Clinic Alzheimer's Disease Research Center;

(5) one representative from AARP Minnesota;

(6) one representative from Little Brothers-Friends of the Elderly, Minneapolis/St. Paul;

(7) one representative from the Alzheimer's Association Minnesota-North Dakota Chapter;

(8) one representative from the American Heart Association Minnesota Chapter;

(9) one representative from the Minnesota HomeCare Association;

(10) two representatives from long-term care trade associations;

(11) one representative from the Minnesota Rural Health Association;

(12) the commissioner of health or the commissioner's designee;

(13) one representative from the Minnesota Board on Aging;

(14) one representative from the Commission of Deaf, Deafblind and Hard of Hearing Minnesotans;

(15) one representative from the Minnesota Nurses Association;

(16) one representative from the Minnesota Council of Churches;

(17) one representative from the Minnesota Leadership Council on Aging;

(18) one representative from the Minnesota Association of Senior Services;

(19) one representative from Metro Meals on Wheels;

(20) one rural Minnesota geriatrician or family physician;

(21) at least two representatives from the University of Minnesota;

(22) one representative from one of the Minnesota Area Agencies on Aging;

(23) at least two members representing Minnesota rural communities;

(24) additional members representing communities of color;

(25) one representative from the National Alliance on Mental Illness; and

(26) one representative from the Citizens League.

Subd. 2. **Duties; recommendations.** The older adult social isolation working group must assess the current and future impact of social isolation on the lives of Minnesotans over age 55. The working group shall consider and make recommendations to the governor and chairs and members of the health and human services committees in the house of representatives and senate on the following issues:

(1) the public health impact of social isolation in the older adult population of Minnesota;

(2) identify existing Minnesota resources, services, and capacity to respond to the issue of social isolation in older adults;

(3) needed policies or community responses, including but not limited to expanding current services or developing future services after identifying gaps in service for rural geographical areas;

(4) needed policies or community responses, including but not limited to the expansion of culturally appropriate current services or developing future services after identifying gaps in service for persons of color; and

(5) impact of social isolation on older adults with disabilities and needed policies or community responses.

Subd. 3. **Meetings.** The working group must hold at least four public meetings beginning August 10, 2018. To the extent possible, technology must be utilized to reach the greatest number of interested persons throughout the state. The working group must complete the required meeting schedule by December 10, 2018.

Subd. 4. **Report.** The commissioner of health must submit a report and the working group's recommendations to the governor and chairs and members of the health and human services committees in the house of representatives and senate no later than January 14, 2019.

Subd. 5. **Sunset.** The working group sunsets upon delivery of the required report to the governor and legislative committees.

Sec. 83. **RULEMAKING; WELL AND BORING RECORDS.**

(a) The commissioner of health shall amend Minnesota Rules, part 4725.1851, subpart 1, to require the licensee, registrant, or property owner or lessee to submit the record of well or boring construction or sealing within 60 days after completion of the work, rather than within 30 days after completion of the work.

(b) The commissioner may use the good cause exemption under Minnesota Statutes, section 14.388, subdivision 1, clause (3), to adopt rules under this section, and Minnesota Statutes, section 14.386, does not apply, except as provided under Minnesota Statutes, section 14.388.

Sec. 84. **RULEMAKING; SECURITY SCREENING SYSTEMS.**

The commissioner of health may adopt permanent rules to implement Minnesota Statutes, section 144.121, subdivision 9, by December 31, 2020. If the commissioner of health does not adopt rules by December 31, 2020, rulemaking authority under this section is repealed. Rulemaking authority under this section is not continuing authority to amend or repeal the

rule. Any additional action on rules once adopted must be pursuant to specific statutory authority to take the additional action.

Sec. 85. **ADVISORY COUNCIL ON PANDAS AND PANS; INITIAL APPOINTMENTS AND FIRST MEETING.**

The appointing authorities shall appoint the first members of the advisory council on PANDAS and PANS under Minnesota Statutes, section 144.131, no later than October 1, 2018. The commissioner of health shall convene the first meeting by November 1, 2018, and the commissioner or the commissioner's designee shall act as chair until the advisory council elects a chair at its first meeting. Notwithstanding the length of terms specified in Minnesota Statutes, section 144.131, subdivision 3, at the first meeting of the advisory council, the chair elected by the members shall determine by lot one-third of the advisory council members whose terms shall expire on September 30 of the calendar year following the year of first appointment, one-third of the advisory council members whose terms shall expire on September 30 of the second calendar year following the year of first appointment, and the remaining advisory council members whose terms shall expire on September 30 of the third calendar year following the year of first appointment.

Sec. 86. **VARIANCE TO REQUIREMENT FOR SANITARY DUMPING STATION.**

Notwithstanding any law or rule to the contrary, the commissioner of health shall provide a variance to the requirement to provide a sanitary dumping station under Minnesota Rules, part 4630.0900, for a resort in Hubbard County that is located on an island and is landlocked, making it impractical to build a sanitary dumping station for use by recreational camping vehicles and recreational camping on the resort property. There must be an alternative dumping station available within a 15-mile radius of the resort or a vendor that is available to pump any self-contained liquid waste system that is located on the resort property.

Sec. 87. **REVISOR'S INSTRUCTIONS.**

(a) The revisor of statutes shall change the terms "service plan or service agreement" and "service agreement or service plan" to "service agreement" in the following sections of Minnesota Statutes: sections 144A.442; 144D.045; 144G.03, subdivision 4, paragraph (c); and 144G.04.

(b) The revisor of statutes shall change the term "service plan" to "service agreement" and the term "service plans" to "service agreements" in the following sections of Minnesota

Statutes: sections 144A.44; 144A.45; 144A.475; 144A.4791; 144A.4792; 144A.4793; 144A.4794; 144D.04; and 144G.03, subdivision 4, paragraph (a).

Sec. 88. **REPEALER.**

(a) Minnesota Statutes 2016, sections 144A.45, subdivision 6; and 144A.481, are repealed.

(b) Minnesota Statutes 2017 Supplement, section 146B.02, subdivision 7a, is repealed.

ARTICLE 2

HEALTH CARE

Section 1. Minnesota Statutes 2017 Supplement, section 13.69, subdivision 1, is amended to read:

Subdivision 1. **Classifications.** (a) The following government data of the Department of Public Safety are private data:

(1) medical data on driving instructors, licensed drivers, and applicants for parking certificates and special license plates issued to physically disabled persons;

(2) other data on holders of a disability certificate under section 169.345, except that (i) data that are not medical data may be released to law enforcement agencies, and (ii) data necessary for enforcement of sections 169.345 and 169.346 may be released to parking enforcement employees or parking enforcement agents of statutory or home rule charter cities and towns;

(3) Social Security numbers in driver's license and motor vehicle registration records, except that Social Security numbers must be provided to the Department of Revenue for purposes of tax administration, the Department of Labor and Industry for purposes of workers' compensation administration and enforcement, the judicial branch for purposes of debt collection, and the Department of Natural Resources for purposes of license application administration, and except that the last four digits of the Social Security number must be provided to the Department of Human Services for purposes of recovery of Minnesota health care program benefits paid; and

(4) data on persons listed as standby or temporary custodians under section 171.07, subdivision 11, except that the data must be released to:

(i) law enforcement agencies for the purpose of verifying that an individual is a designated caregiver; or

(ii) law enforcement agencies who state that the license holder is unable to communicate at that time and that the information is necessary for notifying the designated caregiver of the need to care for a child of the license holder.

The department may release the Social Security number only as provided in clause (3) and must not sell or otherwise provide individual Social Security numbers or lists of Social Security numbers for any other purpose.

(b) The following government data of the Department of Public Safety are confidential data: data concerning an individual's driving ability when that data is received from a member of the individual's family.

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

Sec. 2. Minnesota Statutes 2016, section 62A.30, is amended by adding a subdivision to read:

Subd. 4. **Mammograms.** (a) For purposes of subdivision 2, coverage for a preventive mammogram screening shall include digital breast tomosynthesis for enrollees at risk for breast cancer, and shall be covered as a preventive item or service, as described under section 62Q.46.

(b) For purposes of this subdivision, "digital breast tomosynthesis" means a radiologic procedure that involves the acquisition of projection images over the stationary breast to produce cross-sectional digital three-dimensional images of the breast. "At risk for breast cancer" means:

(1) having a family history with one or more first or second degree relatives with breast cancer;

(2) testing positive for BRCA1 or BRCA2 mutations;

(3) having heterogeneously dense breasts or extremely dense breasts based on the Breast Imaging Reporting and Data System established by the American College of Radiology; or

(4) having a previous diagnosis of breast cancer.

(c) This subdivision does not apply to coverage provided through a public health care program under chapter 256B or 256L.

(d) Nothing in this subdivision limits the coverage of digital breast tomosynthesis in a policy, plan, certificate, or contract referred to in subdivision 1 that is in effect prior to January 1, 2019.

(e) Nothing in this subdivision prohibits a policy, plan, certificate, or contract referred to in subdivision 1 from covering digital breast tomosynthesis for an enrollee who is not at risk for breast cancer.

EFFECTIVE DATE. This section is effective January 1, 2019, and applies to health plans issued, sold, or renewed on or after that date.

Sec. 3. Minnesota Statutes 2016, section 62A.65, subdivision 7, is amended to read:

Subd. 7. **Short-term coverage.** (a) For purposes of this section, "short-term coverage" means an individual health plan that:

(1) is issued to provide coverage for a period of ~~185 days or~~ less~~, except that the health plan may permit coverage to continue until the end of a period of hospitalization for a condition for which the covered person was hospitalized on the day that coverage would otherwise have ended~~ than 12 months;

(2) ~~is nonrenewable, provided that the health carrier may provide coverage for one or more subsequent periods that satisfy clause (1), if the total of the periods of coverage do not exceed a total of 365 days out of any 555-day period, plus any additional days covered as a result of hospitalization on the day that a period of coverage would otherwise have ended~~ may be renewed for only one additional period meeting the requirements of clause (1); and

(3) does not cover any preexisting conditions for the first six months of coverage, including ones that originated during a previous identical policy or contract with the same health carrier where coverage was continuous between the previous and the current policy or contract~~; and~~.

~~(4) is available with an immediate effective date without underwriting upon receipt of a completed application indicating eligibility under the health carrier's eligibility requirements, provided that coverage that includes optional benefits may be offered on a basis that does not meet this requirement.~~

(b) Short-term coverage is not subject to subdivisions 2 and 5. Short-term coverage may exclude as a preexisting condition any injury, illness, or condition for which the covered person had medical treatment, symptoms, or any manifestations before the effective date of the coverage, but dependent children born or placed for adoption during the policy period must not be subject to this provision.

~~(c) Notwithstanding subdivision 3, and section 62A.021, a health carrier may combine short-term coverage with its most commonly sold individual qualified plan, as defined in~~

~~section 62E.02, other than short-term coverage, for purposes of complying with the loss ratio requirement.~~

~~(d) The 365-day coverage limitation provided in paragraph (a) applies to the total number of days of short-term coverage that covers a person, regardless of the number of policies, contracts, or health carriers that provide the coverage. A written application for short-term coverage must ask the applicant whether the applicant has been covered by short-term coverage by any health carrier within the 555 days immediately preceding the effective date of the coverage being applied for. Short-term coverage issued in violation of the 365-day limitation is valid until the end of its term and does not lose its status as short-term coverage, in spite of the violation. A health carrier that knowingly issues short-term coverage in violation of the 365-day limitation is subject to the administrative penalties otherwise available to the commissioner of commerce or the commissioner of health, as appropriate.~~

Sec. 4. Minnesota Statutes 2016, section 62Q.55, subdivision 5, is amended to read:

Subd. 5. **Coverage restrictions or limitations.** (a) If emergency services are provided by a nonparticipating provider, with or without prior authorization, the health plan company shall not impose coverage restrictions or limitations that are more restrictive than apply to emergency services received from a participating provider. Cost-sharing requirements that apply to emergency services received out-of-network must be the same as the cost-sharing requirements that apply to services received in-network.

(b) If emergency services are provided by a nonparticipating provider:

(1) the nonparticipating provider shall not request payment from the enrollee in addition to the applicable cost-sharing requirements authorized under paragraph (a); and

(2) the enrollee shall be held harmless and not liable for payment to the nonparticipating provider that are in addition to the applicable cost-sharing requirements under paragraph (a).

(c) A health plan company must attempt to negotiate the reimbursement, less any applicable cost sharing requirements under paragraph (a), for the emergency services from the nonparticipating provider. If a health plan company's and nonparticipating provider's attempts to negotiate reimbursement for the emergency services do not result in a resolution, the health plan company or provider may elect to refer the matter for binding arbitration. The arbitrator must be chosen from the list created under section 62Q.556, subdivision 2, paragraph (c). The arbitrator must consider the information described in section 62Q.556, subdivision 2, paragraph (d), when reaching a decision. A nondisclosure agreement must

be executed by both parties prior to engaging an arbitrator in accordance with this subdivision. The cost of arbitration must be shared equally between the parties.

EFFECTIVE DATE. This section is effective January 1, 2019, and applies to emergency services provided on or after that date.

Sec. 5. **[256.0113] ELIGIBILITY VERIFICATION.**

Subdivision 1. **Verification required; vendor contract.** (a) The commissioner shall ensure that medical assistance, MinnesotaCare, and Supplemental Nutrition Assistance Program (SNAP) eligibility determinations through the MNsure information technology system and through other agency eligibility determination systems include the computerized verification of income, residency, identity, and when applicable, assets and compliance with SNAP work requirements.

(b) The commissioner shall contract with a vendor to verify the eligibility of all persons enrolled in medical assistance, MinnesotaCare, and SNAP during a specified audit period. This contract shall be exempt from sections 16C.08, subdivision 2, clause (1); 16C.09, paragraph (a), clause (1); 43A.047, paragraph (a), and any other law to the contrary.

(c) The contract must require the vendor to comply with enrollee data privacy requirements and to use encryption to safeguard enrollee identity. The contract must also provide penalties for vendor noncompliance.

(d) The contract must include a revenue sharing agreement, under which vendor compensation is limited to a portion of any savings to the state resulting from the vendor's implementation of eligibility verification initiatives under this section.

(e) The commissioner shall use existing resources to fund any agency administrative and technology-related costs incurred as a result of implementing this section.

(f) All state savings resulting from implementation of the vendor contract under this section, minus any payments to the vendor made under the terms of the revenue sharing agreement, shall be deposited into the health care access fund.

Subd. 2. **Verification process; vendor duties.** (a) The verification process implemented by the vendor must include but is not limited to data matches of the name, date of birth, address, and Social Security number of each medical assistance, MinnesotaCare, and SNAP enrollee against relevant information in federal and state data sources, including the federal data hub established under the Affordable Care Act. In designing the verification process, the vendor, to the extent feasible, shall incorporate procedures that are compatible and

coordinated with, and build upon or improve, existing procedures used by the MNsure information technology system and other agency eligibility determination systems.

(b) The vendor, upon preliminary determination that an enrollee is eligible or ineligible, shall notify the commissioner. Within 20 business days of notification, the commissioner shall accept the preliminary determination or reject the preliminary determination with a stated reason. The commissioner shall retain final authority over eligibility determinations. The vendor shall keep a record of all preliminary determinations of ineligibility submitted to the commissioner.

(c) The vendor shall recommend to the commissioner an eligibility verification process that allows ongoing verification of enrollee eligibility under the MNsure information technology system and other agency eligibility determination systems.

(d) The commissioner and the vendor, following the conclusion of the initial contract period, shall jointly submit an eligibility verification audit report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance. The report shall include but is not limited to information in the form of unidentified summary data on preliminary determinations of eligibility or ineligibility communicated by the vendor, the actions taken on those preliminary determinations by the commissioner, and the commissioner's reasons for rejecting preliminary determinations by the vendor. The report must also include the recommendations for ongoing verification of enrollee eligibility required under paragraph (c).

(e) An eligibility verification vendor contract shall be awarded for an initial one-year period, beginning January 1, 2019. The commissioner shall renew the contract for up to three additional one-year periods and require additional eligibility verification audits, if the commissioner or the legislative auditor determines that the MNsure information technology system and other agency eligibility determination systems cannot effectively verify the eligibility of medical assistance, MinnesotaCare, and SNAP enrollees.

Sec. 6. Minnesota Statutes 2016, section 256.014, subdivision 2, is amended to read:

Subd. 2. **State systems account created.** (a) A state systems account is created in the state treasury. Money collected by the commissioner of human services for the programs in subdivision 1 must be deposited in the account. Money in the state systems account and federal matching money is appropriated to the commissioner of human services for purposes of this section. Any unexpended balance in the appropriations for information systems projects for MAXIS, PRISM, MMIS, ISDS, METS, or SSIS does not cancel and is available

for ongoing development and operations, subject to review by the Legislative Advisory Commission under paragraphs (b) and (c).

(b) No unexpended balance under paragraph (a) may be expended by the commissioner of human services until the commissioner of management and budget has submitted the proposed expenditure to the members of the Legislative Advisory Commission for review and recommendation. If the commission makes a positive recommendation or no recommendation, or if the commission has not reviewed the request within 20 days after the date the proposed expenditure was submitted, the commissioner of management and budget may approve the proposed expenditure. If the commission recommends further review of the proposed expenditure, the commissioner shall provide additional information to the commission. If the commission makes a negative recommendation on the proposed expenditure within ten days of receiving further information, the commissioner shall not approve the proposed expenditure. If the commission makes a positive recommendation or no recommendation within ten days of receiving further information, the commissioner may approve the proposed expenditure.

(c) A recommendation of the commission must be made at a meeting of the commission unless a written recommendation is signed by all members entitled to vote on the item as specified in section 3.30, subdivision 2. A recommendation of the commission must be made by a majority of the commission.

Sec. 7. Minnesota Statutes 2017 Supplement, section 256B.0625, subdivision 3b, is amended to read:

Subd. 3b. **Telemedicine services.** (a) Medical assistance covers medically necessary services and consultations delivered by a licensed health care provider via telemedicine in the same manner as if the service or consultation was delivered in person. Coverage is limited to three telemedicine services per enrollee per calendar week, except as provided in paragraph (f). Telemedicine services shall be paid at the full allowable rate.

(b) The commissioner shall establish criteria that a health care provider must attest to in order to demonstrate the safety or efficacy of delivering a particular service via telemedicine. The attestation may include that the health care provider:

(1) has identified the categories or types of services the health care provider will provide via telemedicine;

(2) has written policies and procedures specific to telemedicine services that are regularly reviewed and updated;

(3) has policies and procedures that adequately address patient safety before, during, and after the telemedicine service is rendered;

(4) has established protocols addressing how and when to discontinue telemedicine services; and

(5) has an established quality assurance process related to telemedicine services.

(c) As a condition of payment, a licensed health care provider must document each occurrence of a health service provided by telemedicine to a medical assistance enrollee. Health care service records for services provided by telemedicine must meet the requirements set forth in Minnesota Rules, part 9505.2175, subparts 1 and 2, and must document:

(1) the type of service provided by telemedicine;

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

(3) the licensed health care provider's basis for determining that telemedicine is an appropriate and effective means for delivering the service to the enrollee;

(4) the mode of transmission of the telemedicine service and records evidencing that a particular mode of transmission was utilized;

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

(6) if the claim for payment is based on a physician's telemedicine consultation with another physician, the written opinion from the consulting physician providing the telemedicine consultation; and

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

(d) For purposes of this subdivision, unless otherwise covered under this chapter, "telemedicine" is defined as the delivery of health care services or consultations while the patient is at an originating site and the licensed health care provider is at a distant site. A communication between licensed health care providers, or a licensed health care provider and a patient that consists solely of a telephone conversation, e-mail, or facsimile transmission does not constitute telemedicine consultations or services. Telemedicine may be provided by means of real-time two-way, interactive audio and visual communications, including the application of secure video conferencing or store-and-forward technology to provide or support health care delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care.

(e) For purposes of this section, "licensed health care provider" means a licensed health care provider under section 62A.671, subdivision 6, a community paramedic as defined under section 144E.001, subdivision 5f, and a mental health practitioner defined under section 245.462, subdivision 17, or 245.4871, subdivision 26, working under the general supervision of a mental health professional; "health care provider" is defined under section 62A.671, subdivision 3; and "originating site" is defined under section 62A.671, subdivision 7.

(f) The limit on coverage of three telemedicine services per enrollee per calendar week does not apply if:

(1) the telemedicine services provided by the licensed health care provider are for the treatment and control of tuberculosis; and

(2) the services are provided in a manner consistent with the recommendations and best practices specified by the Centers for Disease Control and Prevention and the commissioner of health.

Sec. 8. Minnesota Statutes 2016, section 256B.0625, is amended by adding a subdivision to read:

Subd. 17d. **Transportation services oversight.** The commissioner shall contract with a vendor or dedicate staff for oversight of providers of nonemergency medical transportation services pursuant to the commissioner's authority in section 256B.04 and Minnesota Rules, parts 9505.2160 to 9505.2245.

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

Sec. 9. Minnesota Statutes 2016, section 256B.0625, is amended by adding a subdivision to read:

Subd. 17e. **Transportation provider termination.** (a) A terminated nonemergency medical transportation provider, including all named individuals on the current enrollment disclosure form and known or discovered affiliates of the nonemergency medical transportation provider, is not eligible to enroll as a nonemergency medical transportation provider for five years following the termination.

(b) After the five-year period in paragraph (a), if a provider seeks to reenroll as a nonemergency medical transportation provider, the nonemergency medical transportation provider must be placed on a one-year probation period. During a provider's probation

period the commissioner shall complete unannounced site visits and request documentation to review compliance with program requirements.

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

Sec. 10. Minnesota Statutes 2016, section 256B.0625, subdivision 18d, is amended to read:

Subd. 18d. **Advisory committee members.** (a) The Nonemergency Medical Transportation Advisory Committee consists of:

(1) four voting members who represent counties, utilizing the rural urban commuting area classification system. As defined in subdivision 17, these members shall be designated as follows:

(i) two counties within the 11-county metropolitan area;

(ii) one county representing the rural area of the state; and

(iii) one county representing the super rural area of the state.

The Association of Minnesota Counties shall appoint one county within the 11-county metropolitan area and one county representing the super rural area of the state. The Minnesota Inter-County Association shall appoint one county within the 11-county metropolitan area and one county representing the rural area of the state;

(2) three voting members who represent medical assistance recipients, including persons with physical and developmental disabilities, persons with mental illness, seniors, children, and low-income individuals;

(3) ~~four~~ five voting members who represent providers that deliver nonemergency medical transportation services to medical assistance enrollees, one of whom is a taxicab owner or operator;

(4) two voting members of the house of representatives, one from the majority party and one from the minority party, appointed by the speaker of the house, and two voting members from the senate, one from the majority party and one from the minority party, appointed by the Subcommittee on Committees of the Committee on Rules and Administration;

(5) one voting member who represents demonstration providers as defined in section 256B.69, subdivision 2;

(6) one voting member who represents an organization that contracts with state or local governments to coordinate transportation services for medical assistance enrollees;

(7) one voting member who represents the Minnesota State Council on Disability;

(8) the commissioner of transportation or the commissioner's designee, who shall serve as a voting member;

(9) one voting member appointed by the Minnesota Ambulance Association; and

(10) one voting member appointed by the Minnesota Hospital Association.

(b) Members of the advisory committee shall not be employed by the Department of Human Services. Members of the advisory committee shall receive no compensation.

Sec. 11. Minnesota Statutes 2016, section 256B.0625, subdivision 30, is amended to read:

Subd. 30. **Other clinic services.** (a) Medical assistance covers rural health clinic services, federally qualified health center services, nonprofit community health clinic services, and public health clinic services. Rural health clinic services and federally qualified health center services mean services defined in United States Code, title 42, section 1396d(a)(2)(B) and (C). Payment for rural health clinic and federally qualified health center services shall be made according to applicable federal law and regulation.

(b) A federally qualified health center that is beginning initial operation shall submit an estimate of budgeted costs and visits for the initial reporting period in the form and detail required by the commissioner. A federally qualified health center that is already in operation shall submit an initial report using actual costs and visits for the initial reporting period. Within 90 days of the end of its reporting period, a federally qualified health center shall submit, in the form and detail required by the commissioner, a report of its operations, including allowable costs actually incurred for the period and the actual number of visits for services furnished during the period, and other information required by the commissioner. Federally qualified health centers that file Medicare cost reports shall provide the commissioner with a copy of the most recent Medicare cost report filed with the Medicare program intermediary for the reporting year which support the costs claimed on their cost report to the state.

(c) In order to continue cost-based payment under the medical assistance program according to paragraphs (a) and (b), a federally qualified health center or rural health clinic must apply for designation as an essential community provider within six months of final adoption of rules by the Department of Health according to section 62Q.19, subdivision 7. For those federally qualified health centers and rural health clinics that have applied for essential community provider status within the six-month time prescribed, medical assistance payments will continue to be made according to paragraphs (a) and (b) for the first three

years after application. For federally qualified health centers and rural health clinics that either do not apply within the time specified above or who have had essential community provider status for three years, medical assistance payments for health services provided by these entities shall be according to the same rates and conditions applicable to the same service provided by health care providers that are not federally qualified health centers or rural health clinics.

(d) Effective July 1, 1999, the provisions of paragraph (c) requiring a federally qualified health center or a rural health clinic to make application for an essential community provider designation in order to have cost-based payments made according to paragraphs (a) and (b) no longer apply.

(e) Effective January 1, 2000, payments made according to paragraphs (a) and (b) shall be limited to the cost phase-out schedule of the Balanced Budget Act of 1997.

(f) Effective January 1, 2001, each federally qualified health center and rural health clinic may elect to be paid either under the prospective payment system established in United States Code, title 42, section 1396a(aa), or under an alternative payment methodology consistent with the requirements of United States Code, title 42, section 1396a(aa), and approved by the Centers for Medicare and Medicaid Services. The alternative payment methodology shall be 100 percent of cost as determined according to Medicare cost principles.

(g) For purposes of this section, "nonprofit community clinic" is a clinic that:

(1) has nonprofit status as specified in chapter 317A;

(2) has tax exempt status as provided in Internal Revenue Code, section 501(c)(3);

(3) is established to provide health services to low-income population groups, uninsured, high-risk and special needs populations, underserved and other special needs populations;

(4) employs professional staff at least one-half of which are familiar with the cultural background of their clients;

(5) charges for services on a sliding fee scale designed to provide assistance to low-income clients based on current poverty income guidelines and family size; and

(6) does not restrict access or services because of a client's financial limitations or public assistance status and provides no-cost care as needed.

~~(h) Effective for services provided on or after January 1, 2015, all claims for payment of clinic services provided by federally qualified health centers and rural health clinics shall~~

~~be paid by the commissioner. the commissioner shall determine the most feasible method for paying claims from the following options:~~

~~(1) federally qualified health centers and rural health clinics submit claims directly to the commissioner for payment, and the commissioner provides claims information for recipients enrolled in a managed care or county-based purchasing plan to the plan, on a regular basis; or~~

~~(2) federally qualified health centers and rural health clinics submit claims for recipients enrolled in a managed care or county-based purchasing plan to the plan, and those claims are submitted by the plan to the commissioner for payment to the clinic.~~

(h) Federally qualified health centers and rural health clinics shall submit claims directly to the commissioner for payment, and the commissioner shall provide claims information for recipients enrolled in a managed care plan or county-based purchasing plan to the plan on a regular basis as determined by the commissioner.

(i) For clinic services provided prior to January 1, 2015, the commissioner shall calculate and pay monthly the proposed managed care supplemental payments to clinics, and clinics shall conduct a timely review of the payment calculation data in order to finalize all supplemental payments in accordance with federal law. Any issues arising from a clinic's review must be reported to the commissioner by January 1, 2017. Upon final agreement between the commissioner and a clinic on issues identified under this subdivision, and in accordance with United States Code, title 42, section 1396a(bb), no supplemental payments for managed care plan or county-based purchasing plan claims for services provided prior to January 1, 2015, shall be made after June 30, 2017. If the commissioner and clinics are unable to resolve issues under this subdivision, the parties shall submit the dispute to the arbitration process under section 14.57.

(j) The commissioner shall seek a federal waiver, authorized under section 1115 of the Social Security Act, to obtain federal financial participation at the 100 percent federal matching percentage available to facilities of the Indian Health Service or tribal organization in accordance with section 1905(b) of the Social Security Act for expenditures made to organizations dually certified under Title V of the Indian Health Care Improvement Act, Public Law 94-437, and as a federally qualified health center under paragraph (a) that provides services to American Indian and Alaskan Native individuals eligible for services under this subdivision.

EFFECTIVE DATE. This section is effective January 1, 2019, and applies to services provided on or after that date.

Sec. 12. **[256B.0759] DIRECT CONTRACTING PILOT PROGRAM.**

Subdivision 1. **Establishment.** The commissioner shall establish a direct contracting pilot program to test alternative and innovative methods of delivering care through community-based collaborative care networks to medical assistance and MinnesotaCare enrollees. The pilot program shall be designed to coordinate care delivery to enrollees who demonstrate a combination of medical, economic, behavioral health, cultural, and geographic risk factors, including persons determined to be at risk of substance abuse and opioid addiction. The commissioner shall issue a request for proposals to select care networks to deliver care through the pilot program for a three-year period beginning January 1, 2020.

Subd. 2. **Eligible individuals.** (a) The pilot program shall serve individuals who:

(1) are eligible for medical assistance under section 256B.055 or MinnesotaCare under chapter 256L;

(2) reside in the service area of the care network;

(3) have a combination of multiple risk factors identified by the care network and approved by the commissioner;

(4) have elected to participate in the pilot project as an alternative to receiving services under fee-for-service or through a managed care or county-based purchasing plan or integrated health partnership; and

(5) agree to participate in risk mitigation strategies as provided in subdivision 4, clause (4), if the individual is determined to be at risk of opioid addiction or substance abuse.

(b) The commissioner may identify individuals who are potentially eligible to be enrolled with a care network based on zip code or other geographic designation, utilization history, or other factors indicating whether an individual resides in the service area of a care network. The commissioner shall coordinate pilot program enrollment with the enrollment and procurement process for managed care and county-based purchasing plans and integrated health partnerships.

Subd. 3. **Selection of care networks.** Participation in the pilot program is limited to no more than six care networks. The commissioner shall ensure that the care networks selected serve different geographic areas of the state. The commissioner shall consider the following criteria when selecting care networks to participate in the program:

(1) the ability of the care network to provide or arrange for the full range of health care services required to be provided under section 256B.69, including but not limited to primary

care, inpatient hospital care, specialty care, behavioral health services, and chemical dependency and substance abuse treatment services;

(2) at least 25,000 individuals reside in the service area of the care network;

(3) the care network serves a high percentage of patients who are enrolled in Minnesota health care programs or are uninsured compared to the overall Minnesota population; and

(4) the care network can demonstrate the capacity to improve health outcomes and reduce total cost of care for the population in its service area through better patient engagement, coordination of care, and the provision of specialized services to address risk factors related to opioid addiction and substance abuse, and address nonclinical risk factors and barriers to access.

Subd. 4. **Requirements for participating care networks.** (a) A care network selected to participate in the pilot program must:

(1) accept a capitation rate for enrollees equal to the capitation rate that would otherwise apply to the enrollees under section 256B.69;

(2) comply with all requirements in section 256B.69 related to performance targets, capitation rate withholds, and administrative expenses;

(3) maintain adequate reserves and demonstrate the ability to bear risk, based upon criteria established by the commissioner under the request for proposals, or demonstrate to the commissioner that this requirement has been met through a contract with a health plan company, third-party administrator, stop-loss insurer, or other entity; and

(4) assess all enrollees for risk factors related to opioid addiction and substance abuse and, based upon the professional judgment of the health care provider, require enrollees determined to be at risk to enter into a patient provider agreement, submit to urine drug screening, and participate in other risk mitigation strategies; and

(5) participate in quality of care and financial reporting initiatives, in the form and manner specified by the commissioner.

(b) An existing integrated health partnership that meets the criteria in this section is eligible to participate in the pilot program while continuing as an integrated health partnership.

Subd. 5. **Requirements for the commissioner.** (a) The commissioner shall provide all participating care networks with enrollee utilization and cost information similar to that provided by the commissioner to integrated health partnerships.

(b) The commissioner, in consultation with the commissioner of health and care networks, shall design and administer the pilot program in a manner that allows the testing of new care coordination models and quality-of-care measures to determine the extent to which the care delivered by the pilot program, relative to the care delivered under fee-for-service and by managed care and county-based purchasing plans and integrated health partnerships:

(1) improves outcomes and reduces the total cost of care for the population served; and

(2) reduces administrative burdens and costs for health care providers and state agencies.

(c) The commissioner, based on the analysis under paragraph (b), shall evaluate the pilot program and present recommendations as to whether the pilot program should be continued or expanded to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by February 15, 2022.

Sec. 13. Minnesota Statutes 2016, section 256B.69, subdivision 5a, is amended to read:

Subd. 5a. **Managed care contracts.** (a) Managed care contracts under this section and section 256L.12 shall be entered into or renewed on a calendar year basis. The commissioner may issue separate contracts with requirements specific to services to medical assistance recipients age 65 and older.

(b) A prepaid health plan providing covered health services for eligible persons pursuant to chapters 256B and 256L is responsible for complying with the terms of its contract with the commissioner. Requirements applicable to managed care programs under chapters 256B and 256L established after the effective date of a contract with the commissioner take effect when the contract is next issued or renewed.

(c) The commissioner shall withhold five percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program pending completion of performance targets. Each performance target must be quantifiable, objective, measurable, and reasonably attainable, except in the case of a performance target based on a federal or state law or rule. Criteria for assessment of each performance target must be outlined in writing prior to the contract effective date. Clinical or utilization performance targets and their related criteria must consider evidence-based research and reasonable interventions when available or applicable to the populations served, and must be developed with input from external clinical experts and stakeholders, including managed care plans, county-based purchasing plans, and providers. The managed care or county-based purchasing plan must demonstrate, to the commissioner's satisfaction, that the data submitted regarding attainment of the performance

target is accurate. The commissioner shall periodically change the administrative measures used as performance targets in order to improve plan performance across a broader range of administrative services. The performance targets must include measurement of plan efforts to contain spending on health care services and administrative activities. The commissioner may adopt plan-specific performance targets that take into account factors affecting only one plan, including characteristics of the plan's enrollee population. The withheld funds must be returned no sooner than July of the following year if performance targets in the contract are achieved. The commissioner may exclude special demonstration projects under subdivision 23.

(d) The commissioner shall require that managed care plans use the assessment and authorization processes, forms, timelines, standards, documentation, and data reporting requirements, protocols, billing processes, and policies consistent with medical assistance fee-for-service or the Department of Human Services contract requirements consistent with medical assistance fee-for-service or the Department of Human Services contract requirements for all personal care assistance services under section 256B.0659.

(e) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the health plan's emergency department utilization rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. For 2012, the reduction shall be based on the health plan's utilization in 2009. To earn the return of the withhold each subsequent year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than ten percent of the plan's emergency department utilization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, compared to the previous measurement year until the final performance target is reached. When measuring performance, the commissioner must consider the difference in health risk in a managed care or county-based purchasing plan's membership in the baseline year compared to the measurement year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a reduction in the utilization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph shall continue for each consecutive contract period until the plan's emergency room utilization rate for state health care program enrollees is reduced by 25 percent of the plan's emergency room utilization rate for medical assistance and MinnesotaCare enrollees for calendar year 2009. Hospitals shall cooperate with the health plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved.

(f) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the plan's hospitalization admission rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than five percent of the plan's hospital admission rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, compared to the previous calendar year until the final performance target is reached. When measuring performance, the commissioner must consider the difference in health risk in a managed care or county-based purchasing plan's membership in the baseline year compared to the measurement year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that this reduction in the hospitalization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph shall continue until there is a 25 percent reduction in the hospital admission rate compared to the hospital admission rates in calendar year 2011, as determined by the commissioner. The hospital admissions in this performance target do not include the admissions applicable to the subsequent hospital admission performance target under paragraph (g). Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved.

(g) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the plan's hospitalization admission rates for subsequent hospitalizations within 30 days of a previous hospitalization of a patient regardless of the reason, for medical assistance and MinnesotaCare

enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of the subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, of no less than five percent compared to the previous calendar year until the final performance target is reached.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a qualifying reduction in the subsequent hospitalization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph must continue for each consecutive contract period until the plan's subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, is reduced by 25 percent of the plan's subsequent hospitalization rate for calendar year 2011. Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that must be returned to the hospitals if the performance target is achieved.

(h) Effective for services rendered on or after January 1, 2013, through December 31, 2013, the commissioner shall withhold 4.5 percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

(i) Effective for services rendered on or after January 1, 2014, the commissioner shall withhold three percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

(j) A managed care plan or a county-based purchasing plan under section 256B.692 may include as admitted assets under section 62D.044 any amount withheld under this section that is reasonably expected to be returned.

(k) Contracts between the commissioner and a prepaid health plan are exempt from the set-aside and preference provisions of section 16C.16, subdivisions 6, paragraph (a), and 7.

(l) The return of the withhold under paragraphs (h) and (i) is not subject to the requirements of paragraph (c).

(m) Managed care plans and county-based purchasing plans shall maintain current and fully executed agreements for all subcontractors, including bargaining groups, for administrative services that are expensed to the state's public health care programs. Subcontractor agreements determined to be material, as defined by the commissioner after taking into account state contracting and relevant statutory requirements, must be in the form of a written instrument or electronic document containing the elements of offer, acceptance, consideration, payment terms, scope, duration of the contract, and how the subcontractor services relate to state public health care programs. Upon request, the commissioner shall have access to all subcontractor documentation under this paragraph. Nothing in this paragraph shall allow release of information that is nonpublic data pursuant to section 13.02.

(n) Effective for services provided on or after January 1, 2019, through December 31, 2019, the commissioner shall withhold two percent of the capitation payment provided to managed care plans under this section, and county-based purchasing plans under section 256B.692, for each medical assistance enrollee. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year, for capitation payments for enrollees for whom the plan has submitted to the commissioner a verification of coverage form completed and signed by the enrollee. The verification of coverage form must be developed by the commissioner and made available to managed care and county-based purchasing plans. The form must require the enrollee to provide the enrollee's name and street address and the name of the managed care or county-based purchasing plan selected by or assigned to the enrollee and must include a signature block that allows the enrollee to attest that the information provided is accurate. A plan shall request that all enrollees complete the verification of coverage form and shall submit all completed forms to the commissioner by February 28, 2019. If a completed form for an enrollee is not received by the commissioner by that date:

(1) the commissioner shall not return to the plan funds withheld for that enrollee;

(2) the commissioner shall cease making capitation payments to the plan for that enrollee, effective with the April 2019 coverage month; and

(3) the commissioner shall disenroll the enrollee from medical assistance, subject to any enrollee appeal.

(o) The commissioner may establish and administer a single preferred drug list for medical assistance and MinnesotaCare enrollees receiving services through fee-for-service, integrated health partnerships, managed care, or county-based purchasing, only if the commissioner first studies this change and then obtains legislative approval in the form of enacted legislation authorizing the change. In conducting the study, the commissioner shall consult with interested and affected stakeholders including but not limited to managed care organizations, county-based purchasers, integrated health partnerships, health care providers, and enrollees. The commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance on the anticipated impact of the proposed change on: the state budget, access to services, quality of both outcomes and enrollee experience, and administrative efficiency. The report must also include an assessment of possible unintended consequences of the use of a single preferred drug list.

Sec. 14. **ENCOUNTER REPORTING OF 340B ELIGIBLE DRUGS.**

(a) The commissioner of human services, in consultation with federally qualified health centers, managed care organizations, and contract pharmacies, shall develop recommendations for a process to identify and report at point of sale the 340B drugs that are dispensed to enrollees of managed care organizations who are patients of a federally qualified health center, and to exclude these claims from the Medicaid Drug Rebate Program and ensure that duplicate discounts for drugs do not occur. In developing this process, the commissioner shall assess the impact of allowing federally qualified health centers to utilize the 340B Drug Pricing Program drug discounts if a federally qualified health center utilizes a contract pharmacy for a patient enrolled in the prepaid medical assistance program.

(b) By March 1, 2019, the commissioner shall report the recommendations to the chairs and ranking minority members of the house of representatives and senate committees with jurisdiction over medical assistance.

Sec. 15. **RECONCILIATION OF MINNESOTACARE PREMIUMS.**

Subdivision 1. **Reconciliation required.** (a) The commissioner of human services shall reconcile all MinnesotaCare premiums paid or due for health coverage provided during the period January 1, 2014, through December 31, 2017, by July 1, 2018. Based on this reconciliation, the commissioner shall notify each MinnesotaCare enrollee or former enrollee

of any amount owed as premiums, refund to the enrollee or former enrollee any premium overpayment, and enter into a payment arrangement with the enrollee or former enrollee as necessary.

(b) The commissioner of human services is prohibited from using agency staff and resources to plan, develop, or promote any proposal that would offer a health insurance product on the individual market that would offer consumers similar benefits and networks as the standard MinnesotaCare program, until the commissioner of management and budget has determined under subdivision 2 that the commissioner is in compliance with the requirements of this section.

Subd. 2. **Determination of compliance; contingent transfer.** The commissioner of management and budget shall determine whether the commissioner of human services has complied with the requirements of subdivision 1. If the commissioner of management and budget determines that the commissioner of human services is not in compliance with subdivision 1, the commissioner of management and budget shall transfer $10,000 from the central office operations account of the Department of Human Services to the premium security plan account established under Minnesota Statutes, section 62E.25, for each business day of noncompliance.

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

Sec. 16. **CONTRACT TO RECOVER THIRD-PARTY LIABILITY.**

The commissioner shall contract with a vendor to implement a third-party liability recovery program for medical assistance and MinnesotaCare. Under the terms of the contract, the vendor shall be reimbursed using a percentage of the money recovered through the third-party liability recovery program. All money recovered that remains after reimbursement of the vendor is available for operation of the medical assistance and MinnesotaCare programs. The use of this money must be authorized in law by the legislature.

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

Sec. 17. **STUDY AND REPORT ON DISPARITIES BETWEEN GEOGRAPHIC RATING AREAS IN INDIVIDUAL AND SMALL GROUP MARKET HEALTH INSURANCE RATES.**

Subdivision 1. **Study and recommendations.** (a) As permitted by the availability of resources, the legislative auditor is requested to study disparities between Minnesota's nine geographic rating areas in individual and small group market health insurance rates and

recommend ways to reduce or eliminate rate disparities between the geographic rating areas and provide for stability of the individual and small group health insurance markets in the state. In the study, if conducted, the legislative auditor shall:

(1) identify the factors that cause higher individual and small group market health insurance rates in certain geographic rating areas, and determine the extent to which each identified factor contributes to the higher rates;

(2) identify the impact of referral centers on individual and small group market health insurance rates in southeastern Minnesota, and identify ways to reduce the rate disparity between southeastern Minnesota and the metropolitan area, taking into consideration the patterns of referral center usage by patients in those regions;

(3) determine the extent to which individuals and small employers located in a geographic rating area with higher health insurance rates than surrounding geographic rating areas have obtained health insurance in a lower-cost geographic rating area, identify the strategies that individuals and small employers use to obtain health insurance in a lower-cost geographic rating area, and measure the effects of this practice on the rates of the individuals and small employers remaining in the geographic rating area with higher health insurance rates; and

(4) develop proposals to redraw the boundaries of Minnesota's geographic rating areas, and calculate the effect each proposal would have on rates in each of the proposed rating areas. The legislative auditor shall examine at least three options for redrawing the boundaries of Minnesota's geographic rating areas, at least one of which must reduce the number of geographic rating areas. All options for redrawing Minnesota's geographic rating areas considered by the legislative auditor must be designed:

(i) with the purposes of reducing or eliminating rate disparities between geographic rating areas and providing for stability of the individual and small group health insurance markets in the state;

(ii) with consideration of the composition of existing provider networks and referral patterns in regions of the state; and

(iii) in compliance with the requirements for geographic rating areas in Code of Federal Regulations, title 45, section 147.102(b), and other applicable federal law and guidance.

(b) Health carriers that cover Minnesota residents, health systems that provide care to Minnesota residents, and the commissioner of health shall cooperate with any requests for information from the legislative auditor that the legislative auditor determines is necessary to conduct the study.

(c) The legislative auditor may recommend one or more proposals for redrawing Minnesota's geographic rating areas if the legislative auditor determines that the proposal would reduce or eliminate individual and small group market health insurance rate disparities between the geographic rating areas and provide for stability of the individual and small group health insurance markets in the state.

Subd. 2. **Contract.** The legislative auditor may contract with another entity for technical assistance in conducting the study and developing recommendations according to subdivision 1.

Subd. 3. **Report.** The legislative auditor is requested to complete the study and recommendations by January 1, 2019, and to submit a report on the study and recommendations by that date to the chairs and ranking minority members of the legislative committees with jurisdiction over health care and health insurance.

Sec. 18. **TESTIMONY ON USE OF DIGITAL BREAST TOMOSYNTHESIS BY MEMBERS OF THE STATE EMPLOYEE GROUP INSURANCE PROGRAM.**

The director of the state employee group insurance program must prepare and submit written testimony to the house of representatives and senate committees with jurisdiction over health and human services and state government finance regarding the impact of Minnesota Statutes, section 62A.30, subdivision 4. The director must provide data on actual utilization of the coverage under Minnesota Statutes, section 62A.30, subdivision 4 by members of the state employee group insurance program from January 1, 2019, to June 30, 2019. The director may make recommendations for legislation addressing any issues relating to the coverage required by Minnesota Statutes, section 62A.30, subdivision 4. The testimony required under this section is due by December 31, 2019.

Sec. 19. **MENTAL HEALTH AND SUBSTANCE USE DISORDER PARITY WORK GROUP.**

Subdivision 1. **Establishment; membership.** (a) A mental health and substance use disorder parity work group is established and shall include the following members:

(1) two members representing health plan companies that offer health plans in the individual market, appointed by the commissioner of commerce;

(2) two members representing health plan companies that offer health plans in the group markets, appointed by the commissioner of commerce;

(3) the commissioner of health or a designee;

(4) the commissioner of commerce or a designee;

(5) the commissioner of management and budget or a designee;

(6) two members representing employers, appointed by the commissioner of commerce;

(7) two members who are providers representing the mental health and substance use disorder community, appointed by the commissioner of commerce; and

(8) two members who are advocates representing the mental health and substance use disorder community, appointed by the commissioner of commerce.

(b) Members of the work group must have expertise in standards for evidence-based care, benefit design, or knowledge relating to the analysis of mental health and substance use disorder parity under federal and state law, including nonquantitative treatment limitations.

Subd. 2. **First appointments; first meeting; chair.** Appointing authorities shall appoint members to the work group by July 1, 2018. The commissioner of commerce or a designee shall convene the first meeting of the work group on or before August 1, 2018. The commissioner of commerce or the commissioner's designee shall act as chair.

Subd. 3. **Duties.** The mental health and substance use disorder parity work group shall:

(1) develop recommendations on the most effective approach to determine and demonstrate mental health and substance use disorder parity, in accordance with state and federal law for individual and group health plans offered in Minnesota; and

(2) report recommendations to the legislature.

Subd. 4. **Report.** (a) By February 15, 2019, the work group shall submit a report with recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance.

(b) The report must include the following:

(1) a summary of completed state enforcement actions relating to individual and group health plans offered in Minnesota during the preceding 12-month period regarding compliance with parity in mental health and substance use disorders benefits in accordance with state and federal law and a summary of the results of completed state enforcement actions. Data that is protected under state or federal law as nonpublic, private, or confidential shall remain nonpublic, private, or confidential. This summary must include:

(i) the number of formal enforcement actions taken;

(ii) the benefit classifications examined in each enforcement action; and

(iii) the subject matter of each enforcement action, including quantitative and nonquantitative treatment limitations;

(2) detailed information about any regulatory actions the commissioner of health or commissioner of commerce has taken as a result of a completed state enforcement action pertaining to health plan compliance with Minnesota Statutes, sections 62Q.47 and 62Q.53, and United States Code, title 42, section 18031(j);

(3) a description of the work group's recommendations on educating the public about alcoholism, mental health, or chemical dependency parity protections under state and federal law; and

(4) recommendations on the most effective approach to determine and demonstrate mental health and substance use disorder parity, in accordance with state and federal law for individual and group health plans offered in Minnesota.

(c) In developing the report and recommendations, the work group may consult with the Substance Abuse and Mental Health Services Agency and the National Association of Insurance Commissioners for the latest developments on evaluation of mental health and substance use disorder parity.

(d) The report must be written in plain language and must be made available to the public by being posted on the Web sites of the Department of Health and Department of Commerce. The work group may make the report publicly available in additional ways, at its discretion.

(e) The report must include any draft legislation necessary to implement the recommendations of the work group.

Subd. 5. **Expiration.** The mental health and substance use disorder parity work group expires February 16, 2019, or the day after submitting the report required in this section, whichever is earlier.

Sec. 20. **REPEALER.**

Minnesota Statutes 2016, section 62A.65, subdivision 7a, is repealed.

ARTICLE 3

CHEMICAL AND MENTAL HEALTH

Section 1. Minnesota Statutes 2016, section 13.851, is amended by adding a subdivision to read:

Subd. 11. **Mental health screening.** The treatment of data collected by a sheriff or local corrections agency related to individuals who may have a mental illness is governed by section 641.15, subdivision 3a.

Sec. 2. Minnesota Statutes 2016, section 245A.04, subdivision 7, is amended to read:

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

(1) the name of the license holder;

(2) the address of the program;

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

(4) the type of license;

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

(6) any special conditions of licensure.

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

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

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

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

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

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

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

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

(2) been denied a license within the past two years;

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

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

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

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

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

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

~~(h)~~ (g) Notwithstanding paragraph ~~(g)~~ (f), when a revocation is based on the disqualification of a controlling individual or license holder, and the controlling individual or license holder is ordered under section 245C.17 to be immediately removed from direct contact with persons receiving services or is ordered to be under continuous, direct supervision when providing direct contact services, the program may continue to operate only if the program complies with the order and submits documentation demonstrating compliance with the order. If the disqualified individual fails to submit a timely request for reconsideration, or if the disqualification is not set aside and no variance is granted, the order to immediately remove the individual from direct contact or to be under continuous, direct supervision remains in effect pending the outcome of a hearing and final order from the commissioner.

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

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

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

Sec. 3. Minnesota Statutes 2016, section 245A.04, is amended by adding a subdivision to read:

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

(b) At least 30 days before the effective date of a change, the license holder must notify the commissioner in writing of any change:

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

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

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

(4) in the federal or state tax identification number associated with the license holder.

(c) When a license holder notifies the commissioner of a change to the business structure governing the licensed program or services but is not selling the business, the license holder must provide amended articles of incorporation and other documentation of the change and any other information requested by the commissioner.

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

Sec. 4. **[245A.043] LICENSE APPLICATION AFTER CHANGE OF OWNERSHIP.**

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

Subd. 2. **Change of ownership.** If the commissioner determines that there will be a change of ownership, the commissioner shall require submission of a new license application. A change of ownership occurs when:

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

(2) the license holder merges with another organization;

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

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

(5) there is a turnover of each controlling individual associated with the license within a 12-month period. A change to the license holder's controlling individuals, including a change due to a transfer of stock, is not a change of ownership if at least one controlling individual who was listed on the license for at least 12 consecutive months continues to be a controlling individual after the reported change.

Subd. 3. **Change of ownership requirements.** (a) A license holder who intends to change the ownership of the program or service under subdivision 2 to a party that intends to assume operation without an interruption in service longer than 60 days after acquiring the program or service must provide the commissioner with written notice of the proposed sale or change, on a form provided by the commissioner, at least 60 days before the anticipated date of the change in ownership. For purposes of this subdivision and subdivision 4, "party" means the party that intends to operate the service or program.

(b) The party must submit a license application under this chapter on a form and in the manner prescribed by the commissioner at least 30 days before the change of ownership is complete and must include documentation to support the upcoming change. The form and manner of the application prescribed by the commissioner shall require only information which is specifically required by statute or rule. The party must comply with background study requirements under chapter 245C and shall pay the application fee required in section 245A.10. A party that intends to assume operation without an interruption in service longer

than 60 days after acquiring the program or service is exempt from the requirements of Minnesota Rules, part 9530.6800.

(c) The commissioner may develop streamlined application procedures when the party is an existing license holder under this chapter and is acquiring a program licensed under this chapter or service in the same service class as one or more licensed programs or services the party operates and those licenses are in substantial compliance according to the licensing standards in this chapter and applicable rules. For purposes of this subdivision, "substantial compliance" means within the past 12 months the commissioner did not: (i) issue a sanction under section 245A.07 against a license held by the party or (ii) make a license held by the party conditional according to section 245A.06.

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

(e) If a licensing inspection of the program or service was conducted within the previous 12 months and the existing license holder's license record demonstrates substantial compliance with the applicable licensing requirements, the commissioner may waive the party's inspection required by section 245A.04, subdivision 4. The party must submit to the commissioner proof that the premises was inspected by a fire marshal or that the fire marshal deemed that an inspection was not warranted and proof that the premises was inspected for compliance with the building code or that no inspection was deemed warranted.

(f) If the party is seeking a license for a program or service that has an outstanding correction order, the party must submit a letter with the license application identifying how and within what length of time the party shall resolve the outstanding correction order and come into full compliance with the licensing requirements.

(g) Any action taken under section 245A.06 or 245A.07 against the existing license holder's license at the time the party is applying for a license, including when the existing license holder is operating under a conditional license or is subject to a revocation, shall remain in effect until the commissioner determines that the grounds for the action are corrected or no longer exist.

(h) The commissioner shall evaluate the application of the party according to section 245A.04, subdivision 6. Pursuant to section 245A.04, subdivision 7, if the commissioner determines that the party complies with applicable laws and rules, the commissioner may issue a license or a temporary change of ownership license.

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

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

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

(b) The commissioner may establish criteria to issue a temporary change of ownership license, if a license holder's death, divorce, or other event affects the ownership of the program, when an applicant seeks to assume operation of the program or service to ensure continuity of the program or service while a license application is evaluated. This subdivision applies to any program or service licensed under this chapter.

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

Sec. 5. Minnesota Statutes 2016, section 245C.22, subdivision 4, is amended to read:

Subd. 4. **Risk of harm; set aside.** (a) The commissioner may set aside the disqualification if the commissioner finds that the individual has submitted sufficient information to demonstrate that the individual does not pose a risk of harm to any person served by the applicant, license holder, or other entities as provided in this chapter.

(b) In determining whether the individual has met the burden of proof by demonstrating the individual does not pose a risk of harm, the commissioner shall consider:

(1) the nature, severity, and consequences of the event or events that led to the disqualification;

(2) whether there is more than one disqualifying event;

(3) the age and vulnerability of the victim at the time of the event;

(4) the harm suffered by the victim;

(5) vulnerability of persons served by the program;

(6) the similarity between the victim and persons served by the program;

(7) the time elapsed without a repeat of the same or similar event;

(8) documentation of successful completion by the individual studied of training or rehabilitation pertinent to the event; and

(9) any other information relevant to reconsideration.

(c) If the individual requested reconsideration on the basis that the information relied upon to disqualify the individual was incorrect or inaccurate and the commissioner determines that the information relied upon to disqualify the individual is correct, the commissioner must also determine if the individual poses a risk of harm to persons receiving services in accordance with paragraph (b).

(d) For an individual in the chemical dependency field, the commissioner must set aside the disqualification if the following criteria are met:

(1) the individual submits sufficient documentation to demonstrate that the individual is a nonviolent controlled substance offender under section 244.0513, subdivision 2, clauses (1), (2), and (6);

(2) the individual is disqualified exclusively for one or more offenses listed under section 152.021, subdivision 2 or 2a; 152.022, subdivision 2; 152.023, subdivision 2; 152.024; or 152.025;

(3) the individual provided documentation of successful completion of treatment, at least one year prior to the date of the request for reconsideration, at a program licensed under chapter 245G;

(4) the individual provided documentation demonstrating abstinence from controlled substances, as defined in section 152.01, subdivision 4, for the period one year prior to the date of the request for reconsideration; and

(5) the individual is seeking employment in the chemical dependency field.

Sec. 6. Minnesota Statutes 2017 Supplement, section 245C.22, subdivision 5, is amended to read:

Subd. 5. **Scope of set-aside.** (a) If the commissioner sets aside a disqualification under this section, the disqualified individual remains disqualified, but may hold a license and have direct contact with or access to persons receiving services. Except as provided in paragraph (b), the commissioner's set-aside of a disqualification is limited solely to the licensed program, applicant, or agency specified in the set aside notice under section 245C.23.

For personal care provider organizations, the commissioner's set-aside may further be limited to a specific individual who is receiving services. For new background studies required under section 245C.04, subdivision 1, paragraph (h), if an individual's disqualification was previously set aside for the license holder's program and the new background study results in no new information that indicates the individual may pose a risk of harm to persons receiving services from the license holder, the previous set-aside shall remain in effect.

(b) If the commissioner has previously set aside an individual's disqualification for one or more programs or agencies, and the individual is the subject of a subsequent background study for a different program or agency, the commissioner shall determine whether the disqualification is set aside for the program or agency that initiated the subsequent background study. A notice of a set-aside under paragraph (c) shall be issued within 15 working days if all of the following criteria are met:

(1) the subsequent background study was initiated in connection with a program licensed or regulated under the same provisions of law and rule for at least one program for which the individual's disqualification was previously set aside by the commissioner;

(2) the individual is not disqualified for an offense specified in section 245C.15, subdivision 1 ~~or 2~~;

(3) the individual is not disqualified for an offense specified in section 245C.15, subdivision 2, unless the individual is employed in the chemical dependency field;

(4) the commissioner has received no new information to indicate that the individual may pose a risk of harm to any person served by the program; and

~~(4)~~ (5) the previous set-aside was not limited to a specific person receiving services.

(c) When a disqualification is set aside under paragraph (b), the notice of background study results issued under section 245C.17, in addition to the requirements under section 245C.17, shall state that the disqualification is set aside for the program or agency that initiated the subsequent background study. The notice must inform the individual that the individual may request reconsideration of the disqualification under section 245C.21 on the basis that the information used to disqualify the individual is incorrect.

Sec. 7. Minnesota Statutes 2017 Supplement, section 245G.03, subdivision 1, is amended to read:

Subdivision 1. **License requirements.** (a) An applicant for a license to provide substance use disorder treatment must comply with the general requirements in chapters 245A and 245C, sections 626.556 and 626.557, and Minnesota Rules, chapter 9544.

(b) The assessment of need process under Minnesota Rules, parts 9530.6800 and 9530.6810, is not applicable to programs licensed under this chapter. However, the commissioner may deny issuance of a license to an applicant if the commissioner determines that the services currently available in the local area are sufficient to meet local need and the addition of new services would be detrimental to individuals seeking these services.

(c) The commissioner may grant variances to the requirements in this chapter that do not affect the client's health or safety if the conditions in section 245A.04, subdivision 9, are met.

Sec. 8. Minnesota Statutes 2017 Supplement, section 254A.03, subdivision 3, is amended to read:

Subd. 3. **Rules for substance use disorder care.** (a) The commissioner of human services shall establish by rule criteria to be used in determining the appropriate level of chemical dependency care for each recipient of public assistance seeking treatment for substance misuse or substance use disorder. Upon federal approval of a comprehensive assessment as a Medicaid benefit, or on July 1, 2018, whichever is later, and notwithstanding the criteria in Minnesota Rules, parts 9530.6600 to 9530.6655, an eligible vendor of comprehensive assessments under section 254B.05 may determine and approve the appropriate level of substance use disorder treatment for a recipient of public assistance. The process for determining an individual's financial eligibility for the consolidated chemical dependency treatment fund or determining an individual's enrollment in or eligibility for a publicly subsidized health plan is not affected by the individual's choice to access a comprehensive assessment for placement.

(b) The commissioner shall develop and implement a utilization review process for publicly funded treatment placements to monitor and review the clinical appropriateness and timeliness of all publicly funded placements in treatment.

(c) A structured assessment for alcohol or substance use disorder that is provided to a recipient of public assistance by a primary care clinic, hospital, or other medical setting establishes medical necessity and approval for an initial set of substance use disorder services identified in section 254B.05, subdivision 5, when the screen result is positive for alcohol or substance misuse. The initial set of services approved for a recipient whose screen result is positive shall include four hours of individual or group substance use disorder treatment, two hours of substance use disorder care coordination, and two hours of substance use disorder peer support services. A recipient must obtain an assessment pursuant to paragraph (a) to be approved for additional treatment services.

EFFECTIVE DATE. This section is effective July 1, 2018, contingent on federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained or denied.

Sec. 9. Minnesota Statutes 2016, section 254B.02, subdivision 1, is amended to read:

Subdivision 1. **Chemical dependency treatment allocation.** The chemical dependency treatment appropriation shall be placed in a special revenue account. ~~The commissioner shall annually transfer funds from the chemical dependency fund to pay for operation of the drug and alcohol abuse normative evaluation system and to pay for all costs incurred by adding two positions for licensing of chemical dependency treatment and rehabilitation programs located in hospitals for which funds are not otherwise appropriated.~~ The ~~remainder of the~~ money in the special revenue account must be used according to the requirements in this chapter.

Sec. 10. Minnesota Statutes 2017 Supplement, section 254B.03, subdivision 2, is amended to read:

Subd. 2. **Chemical dependency fund payment.** (a) Payment from the chemical dependency fund is limited to payments for services other than detoxification licensed under Minnesota Rules, parts 9530.6510 to 9530.6590, that, if located outside of federally recognized tribal lands, would be required to be licensed by the commissioner as a chemical dependency treatment or rehabilitation program under sections 245A.01 to 245A.16, and services other than detoxification provided in another state that would be required to be licensed as a chemical dependency program if the program were in the state. Out of state vendors must also provide the commissioner with assurances that the program complies substantially with state licensing requirements and possesses all licenses and certifications required by the host state to provide chemical dependency treatment. Vendors receiving payments from the chemical dependency fund must not require co-payment from a recipient of benefits for services provided under this subdivision. The vendor is prohibited from using the client's public benefits to offset the cost of services paid under this section. The vendor shall not require the client to use public benefits for room or board costs. This includes but is not limited to cash assistance benefits under chapters 119B, 256D, and 256J, or SNAP benefits. Retention of SNAP benefits is a right of a client receiving services through the consolidated chemical dependency treatment fund or through state contracted managed care entities. Payment from the chemical dependency fund shall be made for necessary room and board costs provided by vendors certified according to section 254B.05, or in a

community hospital licensed by the commissioner of health according to sections 144.50 to 144.56 to a client who is:

(1) determined to meet the criteria for placement in a residential chemical dependency treatment program according to rules adopted under section 254A.03, subdivision 3; and

(2) concurrently receiving a chemical dependency treatment service in a program licensed by the commissioner and reimbursed by the chemical dependency fund.

(b) A county may, from its own resources, provide chemical dependency services for which state payments are not made. A county may elect to use the same invoice procedures and obtain the same state payment services as are used for chemical dependency services for which state payments are made under this section if county payments are made to the state in advance of state payments to vendors. When a county uses the state system for payment, the commissioner shall make monthly billings to the county using the most recent available information to determine the anticipated services for which payments will be made in the coming month. Adjustment of any overestimate or underestimate based on actual expenditures shall be made by the state agency by adjusting the estimate for any succeeding month.

(c) The commissioner shall coordinate chemical dependency services and determine whether there is a need for any proposed expansion of chemical dependency treatment services. ~~The commissioner shall deny vendor certification to any provider that has not received prior approval from the commissioner for the creation of new programs or the expansion of existing program capacity. The commissioner shall consider the provider's capacity to obtain clients from outside the state based on plans, agreements, and previous utilization history, when determining the need for new treatment services~~ The commissioner may deny vendor certification to a provider if the commissioner determines that the services currently available in the local area are sufficient to meet local need and that the addition of new services would be detrimental to individuals seeking these services.

Sec. 11. Minnesota Statutes 2017 Supplement, section 256.045, subdivision 3, is amended to read:

Subd. 3. **State agency hearings.** (a) State agency hearings are available for the following:

(1) any person applying for, receiving or having received public assistance, medical care, or a program of social services granted by the state agency or a county agency or the federal Food Stamp Act whose application for assistance is denied, not acted upon with

reasonable promptness, or whose assistance is suspended, reduced, terminated, or claimed to have been incorrectly paid;

(2) any patient or relative aggrieved by an order of the commissioner under section 252.27;

(3) a party aggrieved by a ruling of a prepaid health plan;

(4) except as provided under chapter 245C, any individual or facility determined by a lead investigative agency to have maltreated a vulnerable adult under section 626.557 after they have exercised their right to administrative reconsideration under section 626.557;

(5) any person whose claim for foster care payment according to a placement of the child resulting from a child protection assessment under section 626.556 is denied or not acted upon with reasonable promptness, regardless of funding source;

(6) any person to whom a right of appeal according to this section is given by other provision of law;

(7) an applicant aggrieved by an adverse decision to an application for a hardship waiver under section 256B.15;

(8) an applicant aggrieved by an adverse decision to an application or redetermination for a Medicare Part D prescription drug subsidy under section 256B.04, subdivision 4a;

(9) except as provided under chapter 245A, an individual or facility determined to have maltreated a minor under section 626.556, after the individual or facility has exercised the right to administrative reconsideration under section 626.556;

(10) except as provided under chapter 245C, an individual disqualified under sections 245C.14 and 245C.15, following a reconsideration decision issued under section 245C.23, on the basis of serious or recurring maltreatment; a preponderance of the evidence that the individual has committed an act or acts that meet the definition of any of the crimes listed in section 245C.15, subdivisions 1 to 4; or for failing to make reports required under section 626.556, subdivision 3, or 626.557, subdivision 3. Hearings regarding a maltreatment determination under clause (4) or (9) and a disqualification under this clause in which the basis for a disqualification is serious or recurring maltreatment, shall be consolidated into a single fair hearing. In such cases, the scope of review by the human services judge shall include both the maltreatment determination and the disqualification. The failure to exercise the right to an administrative reconsideration shall not be a bar to a hearing under this section if federal law provides an individual the right to a hearing to dispute a finding of maltreatment;

(11) any person with an outstanding debt resulting from receipt of public assistance, medical care, or the federal Food Stamp Act who is contesting a setoff claim by the Department of Human Services or a county agency. The scope of the appeal is the validity of the claimant agency's intention to request a setoff of a refund under chapter 270A against the debt;

(12) a person issued a notice of service termination under section 245D.10, subdivision 3a, from residential supports and services as defined in section 245D.03, subdivision 1, paragraph (c), clause (3), that is not otherwise subject to appeal under subdivision 4a;

(13) an individual disability waiver recipient based on a denial of a request for a rate exception under section 256B.4914; ~~or~~

(14) a person issued a notice of service termination under section 245A.11, subdivision 11, that is not otherwise subject to appeal under subdivision 4a~~.~~; or

(15) a county disputes cost of care under section 246.54 based on administrative or other delay of a client's discharge from a state-operated facility after notification to a county that the client no longer meets medical criteria for the state-operated facility, when the county has developed a viable discharge plan.

(b) The hearing for an individual or facility under paragraph (a), clause (4), (9), or (10), is the only administrative appeal to the final agency determination specifically, including a challenge to the accuracy and completeness of data under section 13.04. Hearings requested under paragraph (a), clause (4), apply only to incidents of maltreatment that occur on or after October 1, 1995. Hearings requested by nursing assistants in nursing homes alleged to have maltreated a resident prior to October 1, 1995, shall be held as a contested case proceeding under the provisions of chapter 14. Hearings requested under paragraph (a), clause (9), apply only to incidents of maltreatment that occur on or after July 1, 1997. A hearing for an individual or facility under paragraph (a), clauses (4), (9), and (10), is only available when there is no district court action pending. If such action is filed in district court while an administrative review is pending that arises out of some or all of the events or circumstances on which the appeal is based, the administrative review must be suspended until the judicial actions are completed. If the district court proceedings are completed, dismissed, or overturned, the matter may be considered in an administrative hearing.

(c) For purposes of this section, bargaining unit grievance procedures are not an administrative appeal.

(d) The scope of hearings involving claims to foster care payments under paragraph (a), clause (5), shall be limited to the issue of whether the county is legally responsible for a

child's placement under court order or voluntary placement agreement and, if so, the correct amount of foster care payment to be made on the child's behalf and shall not include review of the propriety of the county's child protection determination or child placement decision.

(e) The scope of hearings under paragraph (a), clauses (12) and (14), shall be limited to whether the proposed termination of services is authorized under section 245D.10, subdivision 3a, paragraph (b), or 245A.11, subdivision 11, and whether the requirements of section 245D.10, subdivision 3a, paragraphs (c) to (e), or 245A.11, subdivision 2a, paragraphs (d) to (f), were met. If the appeal includes a request for a temporary stay of termination of services, the scope of the hearing shall also include whether the case management provider has finalized arrangements for a residential facility, a program, or services that will meet the assessed needs of the recipient by the effective date of the service termination.

(f) A vendor of medical care as defined in section 256B.02, subdivision 7, or a vendor under contract with a county agency to provide social services is not a party and may not request a hearing under this section, except if assisting a recipient as provided in subdivision 4.

(g) An applicant or recipient is not entitled to receive social services beyond the services prescribed under chapter 256M or other social services the person is eligible for under state law.

(h) The commissioner may summarily affirm the county or state agency's proposed action without a hearing when the sole issue is an automatic change due to a change in state or federal law.

(i) Unless federal or Minnesota law specifies a different time frame in which to file an appeal, an individual or organization specified in this section may contest the specified action, decision, or final disposition before the state agency by submitting a written request for a hearing to the state agency within 30 days after receiving written notice of the action, decision, or final disposition, or within 90 days of such written notice if the applicant, recipient, patient, or relative shows good cause, as defined in section 256.0451, subdivision 13, why the request was not submitted within the 30-day time limit. The individual filing the appeal has the burden of proving good cause by a preponderance of the evidence.

Sec. 12. Minnesota Statutes 2017 Supplement, section 256B.0625, subdivision 56a, is amended to read:

Subd. 56a. **~~Post-arrest~~ Officer-involved community-based ~~service~~ care coordination.** (a) Medical assistance covers ~~post-arrest~~ officer-involved community-based ~~service~~ care coordination for an individual who:

(1) has ~~been identified as having~~ screened positive for benefiting from treatment for a mental illness or substance use disorder using a ~~screening~~ tool approved by the commissioner;

(2) does not require the security of a public detention facility and is not considered an inmate of a public institution as defined in Code of Federal Regulations, title 42, section 435.1010;

(3) meets the eligibility requirements in section 256B.056; and

(4) has agreed to participate in ~~post-arrest~~ officer-involved community-based ~~service~~ care coordination ~~through a diversion contract in lieu of incarceration~~.

(b) ~~Post-arrest~~ Officer-involved community-based ~~service~~ care coordination means navigating services to address a client's mental health, chemical health, social, economic, and housing needs, or any other activity targeted at reducing the incidence of jail utilization and connecting individuals with existing covered services available to them, including, but not limited to, targeted case management, waiver case management, or care coordination.

(c) ~~Post-arrest~~ Officer-involved community-based ~~service~~ care coordination must be provided by an individual who is an employee of ~~a county~~ or is under contract with a county, or is an employee of or under contract with an Indian health service facility or facility owned and operated by a tribe or a tribal organization operating under Public Law 93-638 as a 638 facility to provide ~~post-arrest~~ officer-involved community-based care coordination and is qualified under one of the following criteria:

(1) a licensed mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (6);

(2) a mental health practitioner as defined in section 245.462, subdivision 17, working under the clinical supervision of a mental health professional; ~~or~~

(3) a certified peer specialist under section 256B.0615, working under the clinical supervision of a mental health professional;

(4) an individual qualified as an alcohol and drug counselor under section 254G.11, subdivision 5; or

(5) a recovery peer qualified under section 245G.11, subdivision 8, working under the supervision of an individual qualified as an alcohol and drug counselor under section 245G.11, subdivision 5.

(d) Reimbursement is allowed for up to 60 days following the initial determination of eligibility.

(e) Providers of ~~post-arrest~~ officer-involved community-based ~~service~~ care coordination shall annually report to the commissioner on the number of individuals served, and number of the community-based services that were accessed by recipients. The commissioner shall ensure that services and payments provided under ~~post-arrest~~ officer-involved community-based ~~service~~ care coordination do not duplicate services or payments provided under section 256B.0625, subdivision 20, 256B.0753, 256B.0755, or 256B.0757.

(f) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of cost for post-arrest community-based service coordination services shall be provided by the county providing the services, from sources other than federal funds or funds used to match other federal funds.

EFFECTIVE DATE. Paragraphs (a) to (e) are effective retroactively from March 1, 2018.

Sec. 13. Minnesota Statutes 2016, section 641.15, subdivision 3a, is amended to read:

Subd. 3a. **Intake procedure; approved mental health screening.** As part of its intake procedure for new ~~prisoners~~ inmates, the sheriff or local corrections shall use a mental health screening tool approved by the commissioner of corrections in consultation with the commissioner of human services and local corrections staff to identify persons who may have mental illness. Names of persons who have screened positive or may have a mental illness may be shared with the local county social services agency. The jail may refer an offender to county personnel of the welfare system, as defined in section 13.46, subdivision 1, paragraph (c), in order to arrange for services upon discharge and may share private data as necessary to carry out the following:

(1) providing assistance in filling out an application for medical assistance or MinnesotaCare;

(2) making a referral for case management as outlined under section 245.467, subdivision 4;

(3) providing assistance in obtaining a state photo identification;

(4) securing a timely appointment with a psychiatrist or other appropriate community mental health provider;

(5) providing prescriptions for a 30-day supply of all necessary medications; or

(6) behavioral health service coordination.

Sec. 14. Laws 2017, First Special Session chapter 6, article 8, section 71, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective for services provided on July 1, 2017, through ~~April 30, 2019, and expires May 1, 2019~~ June 30, 2019, and expires July 1, 2019.

Sec. 15. Laws 2017, First Special Session chapter 6, article 8, section 72, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective for services provided on July 1, 2017, through ~~April 30, 2019, and expires May 1, 2019~~ June 30, 2019, and expires July 1, 2019.

Sec. 16. Laws 2017, First Special Session chapter 6, article 8, section 74, is amended to read:

Sec. 74. **CHILDREN'S MENTAL HEALTH REPORT AND RECOMMENDATIONS.**

The commissioner of human services shall conduct a comprehensive analysis of Minnesota's continuum of intensive mental health services and shall develop recommendations for a sustainable and community-driven continuum of care for children with serious mental health needs, including children currently being served in residential treatment. The commissioner's analysis shall include, but not be limited to:

(1) data related to access, utilization, efficacy, and outcomes for Minnesota's current system of residential mental health treatment for a child with a severe emotional disturbance;

(2) potential expansion of the state's psychiatric residential treatment facility (PRTF) capacity, including increasing the number of PRTF beds and conversion of existing children's mental health residential treatment programs into PRTFs;

(3) the capacity need for PRTF and other group settings within the state if adequate community-based alternatives are accessible, equitable, and effective statewide;

(4) recommendations for expanding alternative community-based service models to meet the needs of a child with a serious mental health disorder who would otherwise require

residential treatment and potential service models that could be utilized, including data related to access, utilization, efficacy, and outcomes;

(5) models of care used in other states; and

(6) analysis and specific recommendations for the design and implementation of new service models, including analysis to inform rate setting as necessary.

The analysis shall be supported and informed by extensive stakeholder engagement. Stakeholders include individuals who receive services, family members of individuals who receive services, providers, counties, health plans, advocates, and others. Stakeholder engagement shall include interviews with key stakeholders, intentional outreach to individuals who receive services and the individual's family members, and regional listening sessions.

The commissioner shall provide a report with specific recommendations and timelines for implementation to the legislative committees with jurisdiction over children's mental health policy and finance by ~~November 15, 2018~~ January 15, 2019.

ARTICLE 4

OPIOIDS AND PRESCRIPTION DRUGS

Section 1. **[62Q.184] STEP THERAPY OVERRIDE.**

Subdivision 1. **Definitions.** (a) For the purposes of this section, the terms in this subdivision have the meanings given them.

(b) "Clinical practice guideline" means a systematically developed statement to assist health care providers and enrollees in making decisions about appropriate health care services for specific clinical circumstances and conditions developed independently of a health plan company, pharmaceutical manufacturer, or any entity with a conflict of interest.

(c) "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols, and clinical practice guidelines used by a health plan company to determine the medical necessity and appropriateness of health care services.

(d) "Health plan company" has the meaning given in section 62Q.01, subdivision 4, but does not include a managed care organization or county-based purchasing plan participating in a public program under chapters 256B or 256L, or an integrated health partnership under section 256B.0755.

(e) "Step therapy protocol" means a protocol or program that establishes the specific sequence in which prescription drugs for a specified medical condition, including

self-administered and physician-administered drugs, are medically appropriate for a particular enrollee and are covered under a health plan.

(f) "Step therapy override" means that the step therapy protocol is overridden in favor of coverage of the selected prescription drug of the prescribing health care provider because at least one of the conditions of subdivision 3, paragraph (a), exists.

Subd. 2. **Establishment of a step therapy protocol.** A health plan company shall consider available recognized evidence-based and peer-reviewed clinical practice guidelines when establishing a step therapy protocol. Upon written request of an enrollee, a health plan company shall provide any clinical review criteria applicable to a specific prescription drug covered by the health plan.

Subd. 3. **Step therapy override process; transparency.** (a) When coverage of a prescription drug for the treatment of a medical condition is restricted for use by a health plan company through the use of a step therapy protocol, enrollees and prescribing health care providers shall have access to a clear, readily accessible, and convenient process to request a step therapy override. The process shall be made easily accessible on the health plan company's Web site. A health plan company may use its existing medical exceptions process to satisfy this requirement. A health plan company shall grant an override to the step therapy protocol if at least one of the following conditions exist:

(1) the prescription drug required under the step therapy protocol is contraindicated pursuant to the pharmaceutical manufacturer's prescribing information for the drug or, due to a documented adverse event with a previous use or a documented medical condition, including a comorbid condition, is likely to do any of the following:

(i) cause an adverse reaction to the enrollee;

(ii) decrease the ability of the enrollee to achieve or maintain reasonable functional ability in performing daily activities; or

(iii) cause physical or mental harm to the enrollee;

(2) the enrollee has had a trial of the required prescription drug covered by their current or previous health plan, or another prescription drug in the same pharmacologic class or with the same mechanism of action, and was adherent during such trial for a period of time sufficient to allow for a positive treatment outcome, and the prescription drug was discontinued by the enrollee's health care provider due to lack of effectiveness, or an adverse event. This clause does not prohibit a health plan company from requiring an enrollee to try another drug in the same pharmacologic class or with the same mechanism of action if

that therapy sequence is supported by the evidence-based and peer-reviewed clinical practice guideline, Food and Drug Administration label, or pharmaceutical manufacturer's prescribing information; or

(3) the enrollee is currently receiving a positive therapeutic outcome on a prescription drug for the medical condition under consideration if, while on their current health plan or the immediately preceding health plan, the enrollee received coverage for the prescription drug and the enrollee's prescribing health care provider gives documentation to the health plan company that the change in prescription drug required by the step therapy protocol is expected to be ineffective or cause harm to the enrollee based on the known characteristics of the specific enrollee and the known characteristics of the required prescription drug.

(b) Upon granting a step therapy override, a health plan company shall authorize coverage for the prescription drug if the prescription drug is a covered prescription drug under the enrollee's health plan.

(c) The enrollee, or the prescribing health care provider if designated by the enrollee, may appeal the denial of a step therapy override by a health plan company using the complaint procedure under sections 62Q.68 to 62Q.73.

(d) In a denial of an override request and any subsequent appeal, a health plan company's decision must specifically state why the step therapy override request did not meet the condition under paragraph (a) cited by the prescribing health care provider in requesting the step therapy override and information regarding the procedure to request external review of the denial pursuant to section 62Q.73. A denial of a request for a step therapy override that is upheld on appeal is a final adverse determination for purposes of section 62Q.73 and is eligible for a request for external review by an enrollee pursuant to section 62Q.73.

(e) A health plan company shall respond to a step therapy override request or an appeal within five days of receipt of a complete request. In cases where exigent circumstances exist, a health plan company shall respond within 72 hours of receipt of a complete request. If a health plan company does not send a response to the enrollee or prescribing health care provider if designated by the enrollee within the time allotted, the override request or appeal is granted and binding on the health plan company.

(f) Step therapy override requests must be accessible to and submitted by health care providers, and accepted by group purchasers electronically through secure electronic transmission, as described under section 62J.497, subdivision 5.

(g) Nothing in this section prohibits a health plan company from:

(1) requesting relevant documentation from an enrollee's medical record in support of a step therapy override request; or

(2) requiring an enrollee to try a generic equivalent drug pursuant to section 151.21, or a biosimilar, as defined under United States Code, title 42, section 262(i)(2), prior to providing coverage for the equivalent branded prescription drug.

(h) This section shall not be construed to allow the use of a pharmaceutical sample for the primary purpose of meeting the requirements for a step therapy override.

EFFECTIVE DATE. This section is effective January 1, 2019, and applies to health plans offered, issued, or sold on or after that date.

Sec. 2. Minnesota Statutes 2016, section 151.214, subdivision 2, is amended to read:

Subd. 2. **No prohibition on disclosure.** No contracting agreement between an employer-sponsored health plan or health plan company, or its contracted pharmacy benefit manager, and a resident or nonresident pharmacy ~~registered~~ licensed under this chapter, may prohibit ~~the~~:

(1) a pharmacy from disclosing to patients information a pharmacy is required or given the option to provide under subdivision 1; or

(2) a pharmacist from informing a patient when the amount the patient is required to pay under the patient's health plan for a particular drug is greater than the amount the patient would be required to pay for the same drug if purchased out-of-pocket at the pharmacy's usual and customary price.

Sec. 3. **[151.555] PRESCRIPTION DRUG REPOSITORY PROGRAM.**

Subdivision 1. **Definitions.** (a) For the purposes of this section, the terms defined in this subdivision have the meanings given.

(b) "Central repository" means a wholesale distributor that meets the requirements under subdivision 3 and enters into a contract with the Board of Pharmacy in accordance with this section.

(c) "Distribute" means to deliver, other than by administering or dispensing.

(d) "Donor" means:

(1) a health care facility as defined in this subdivision;

(2) a skilled nursing facility licensed under chapter 144A;

(3) an assisted living facility registered under chapter 144D where there is centralized storage of drugs and 24-hour on-site licensed nursing coverage provided seven days a week;

(4) a pharmacy licensed under section 151.19, and located either in the state or outside the state;

(5) a drug wholesaler licensed under section 151.47; or

(6) a drug manufacturer licensed under section 151.252.

(e) "Drug" means any prescription drug that has been approved for medical use in the United States, is listed in the United States Pharmacopoeia or National Formulary, and meets the criteria established under this section for donation. This definition includes cancer drugs and antirejection drugs, but does not include controlled substances, as defined in section 152.01, subdivision 4, or a prescription drug that can only be dispensed to a patient registered with the drug's manufacturer in accordance with federal Food and Drug Administration requirements.

(f) "Health care facility" means:

(1) a physician's office or health care clinic where licensed practitioners provide health care to patients;

(2) a hospital licensed under section 144.50;

(3) a pharmacy licensed under section 151.19 and located in Minnesota; or

(4) a nonprofit community clinic, including a federally qualified health center; a rural health clinic; public health clinic; or other community clinic that provides health care utilizing a sliding fee scale to patients who are low-income, uninsured, or underinsured.

(g) "Local repository" means a health care facility that elects to accept donated drugs and medical supplies and meets the requirements of subdivision 4.

(h) "Medical supplies" or "supplies" means any prescription and nonprescription medical supply needed to administer a prescription drug.

(i) "Original, sealed, unopened, tamper-evident packaging" means packaging that is sealed, unopened, and tamper-evident, including a manufacturer's original unit dose or unit-of-use container, a repackager's original unit dose or unit-of-use container, or unit-dose packaging prepared by a licensed pharmacy according to the standards of Minnesota Rules, part 6800.3750.

(j) "Practitioner" has the meaning given in section 151.01, subdivision 23, except that it does not include a veterinarian.

Subd. 2. **Establishment.** By January 1, 2019, the Board of Pharmacy shall establish a drug repository program, through which donors may donate a drug or medical supply for use by an individual who meets the eligibility criteria specified under subdivision 5. The board shall contract with a central repository that meets the requirements of subdivision 3 to implement and administer the prescription drug repository program.

Subd. 3. **Central repository requirements.** (a) The board shall publish a request for proposal for participants who meet the requirements of this subdivision and are interested in acting as the central repository for the drug repository program. The board shall follow all applicable state procurement procedures in the selection process.

(b) To be eligible to act as the central repository, the participant must be a wholesale drug distributor located in Minnesota, licensed pursuant to section 151.47, and in compliance with all applicable federal and state statutes, rules, and regulations.

(c) The central repository shall be subject to inspection by the board pursuant to section 151.06, subdivision 1.

Subd. 4. **Local repository requirements.** (a) To be eligible for participation in the drug repository program, a health care facility must agree to comply with all applicable federal and state laws, rules, and regulations pertaining to the drug repository program, drug storage, and dispensing. The facility must also agree to maintain in good standing any required state license or registration that may apply to the facility.

(b) A local repository may elect to participate in the program by submitting the following information to the central repository on a form developed by the board and made available on the board's Web site:

(1) the name, street address, and telephone number of the health care facility and any state-issued license or registration number issued to the facility, including the issuing state agency;

(2) the name and telephone number of a responsible pharmacist or practitioner who is employed by or under contract with the health care facility; and

(3) a statement signed and dated by the responsible pharmacist or practitioner indicating that the health care facility meets the eligibility requirements under this section and agrees to comply with this section.

(c) Participation in the drug repository program is voluntary. A local repository may withdraw from participation in the drug repository program at any time by providing written notice to the central repository on a form developed by the board and made available on

the board's Web site. The central repository shall provide the board with a copy of the withdrawal notice within ten business days from the date of receipt of the withdrawal notice.

Subd. 5. **Individual eligibility and application requirements.** (a) To be eligible for the drug repository program, an individual must submit to a local repository an intake application form that is signed by the individual and attests that the individual:

(1) is a resident of Minnesota;

(2) is uninsured, has no prescription drug coverage, or is underinsured;

(3) acknowledges that the drugs or medical supplies to be received through the program may have been donated; and

(4) consents to a waiver of the child-resistant packaging requirements of the federal Poison Prevention Packaging Act.

(b) Upon determining that an individual is eligible for the program, the local repository shall furnish the individual with an identification card. The card shall be valid for one year from the date of issuance and may be used at any local repository. A new identification card may be issued upon expiration once the individual submits a new application form.

(c) The local repository shall send a copy of the intake application form to the central repository by regular mail, facsimile, or secured e-mail within ten days from the date the application is approved by the local repository.

(d) The board shall develop and make available on the board's Web site an application form and the format for the identification card.

Subd. 6. **Standards and procedures for accepting donations of drugs and supplies.** (a) A donor may donate prescription drugs or medical supplies to the central repository or a local repository if the drug or supply meets the requirements of this section as determined by a pharmacist or practitioner who is employed by or under contract with the central repository or a local repository.

(b) A prescription drug is eligible for donation under the drug repository program if the following requirements are met:

(1) the donation is accompanied by a drug repository donor form described under paragraph (d) that is signed by an individual who is authorized by the donor to attest to the donor's knowledge in accordance with paragraph (d);

(2) the drug's expiration date is at least six months after the date the drug was donated. If a donated drug bears an expiration date that is less than six months from the donation

date, the drug may be accepted and distributed if the drug is in high demand and can be dispensed for use by a patient before the drug's expiration date;

(3) the drug is in its original, sealed, unopened, tamper-evident packaging that includes the expiration date. Single-unit-dose drugs may be accepted if the single-unit-dose packaging is unopened;

(4) the drug or the packaging does not have any physical signs of tampering, misbranding, deterioration, compromised integrity, or adulteration;

(5) the drug does not require storage temperatures other than normal room temperature as specified by the manufacturer or United States Pharmacopoeia, unless the drug is being donated directly by its manufacturer, a wholesale drug distributor, or a pharmacy located in Minnesota; and

(6) the prescription drug is not a controlled substance.

(c) A medical supply is eligible for donation under the drug repository program if the following requirements are met:

(1) the supply has no physical signs of tampering, misbranding, or alteration and there is no reason to believe it has been adulterated, tampered with, or misbranded;

(2) the supply is in its original, unopened, sealed packaging;

(3) the donation is accompanied by a drug repository donor form described under paragraph (d) that is signed by an individual who is authorized by the donor to attest to the donor's knowledge in accordance with paragraph (d); and

(4) if the supply bears an expiration date, the date is at least six months later than the date the supply was donated. If the donated supply bears an expiration date that is less than six months from the date the supply was donated, the supply may be accepted and distributed if the supply is in high demand and can be dispensed for use by a patient before the supply's expiration date.

(d) The board shall develop the drug repository donor form and make it available on the board's Web site. The form must state that to the best of the donor's knowledge the donated drug or supply has been properly stored and that the drug or supply has never been opened, used, tampered with, adulterated, or misbranded.

(e) Donated drugs and supplies may be shipped or delivered to the premises of the central repository or a local repository, and shall be inspected by a pharmacist or an authorized practitioner who is employed by or under contract with the repository and who has been

designated by the repository to accept donations. A drop box must not be used to deliver or accept donations.

(f) The central repository and local repository shall inventory all drugs and supplies donated to the repository. For each drug, the inventory must include the drug's name, strength, quantity, manufacturer, expiration date, and the date the drug was donated. For each medical supply, the inventory must include a description of the supply, its manufacturer, the date the supply was donated, and, if applicable, the supply's brand name and expiration date.

Subd. 7. **Standards and procedures for inspecting and storing donated prescription drugs and supplies.** (a) A pharmacist or authorized practitioner who is employed by or under contract with the central repository or a local repository shall inspect all donated prescription drugs and supplies to determine, to the extent reasonably possible in the professional judgment of the pharmacist or practitioner, that the drug or supply is not adulterated or misbranded, has not been tampered with, is safe and suitable for dispensing, and meets the requirements for donation. The pharmacist or practitioner who inspects the drugs or supplies shall sign an inspection record stating that the requirements for donation have been met. If a local repository receives drugs and supplies from the central repository, the local repository does not need to reinspect the drugs and supplies.

(b) The central repository and local repositories shall store donated drugs and supplies in a secure storage area under environmental conditions appropriate for the drug or supply being stored. Donated drugs and supplies may not be stored with nondonated inventory. If donated drugs or supplies are not inspected immediately upon receipt, a repository must quarantine the donated drugs or supplies separately from all dispensing stock until the donated drugs or supplies have been inspected and approved for dispensing under the program.

(c) The central repository and local repositories shall dispose of all prescription drugs and medical supplies that are not suitable for donation in compliance with applicable federal and state statutes, regulations, and rules concerning hazardous waste.

(d) In the event that controlled substances or prescription drugs that can only be dispensed to a patient registered with the drug's manufacturer are shipped or delivered to a central or local repository for donation, the shipment delivery must be documented by the repository and returned immediately to the donor or the donor's representative that provided the drugs.

(e) Each repository must develop drug and medical supply recall policies and procedures. If a repository receives a recall notification, the repository shall destroy all of the drug or medical supply in its inventory that is the subject of the recall and complete a record of

destruction form in accordance with paragraph (f). If a drug or medical supply that is the subject of a Class I or Class II recall has been dispensed, the repository shall immediately notify the recipient of the recalled drug or medical supply. A drug that potentially is subject to a recall need not be destroyed if its packaging bears a lot number and that lot of the drug is not subject to the recall. If no lot number is on the drug's packaging, it must be destroyed.

(f) A record of destruction of donated drugs and supplies that are not dispensed under subdivision 8, are subject to a recall under paragraph (e), or are not suitable for donation shall be maintained by the repository for at least five years. For each drug or supply destroyed, the record shall include the following information:

(1) the date of destruction;

(2) the name, strength, and quantity of the drug destroyed; and

(3) the name of the person or firm that destroyed the drug.

Subd. 8. **Dispensing requirements.** (a) Donated drugs and supplies may be dispensed if the drugs or supplies are prescribed by a practitioner for use by an eligible individual and are dispensed by a pharmacist or practitioner. A repository shall dispense drugs and supplies to eligible individuals in the following priority order: (1) individuals who are uninsured; (2) individuals with no prescription drug coverage; and (3) individuals who are underinsured. A repository shall dispense donated prescription drugs in compliance with applicable federal and state laws and regulations for dispensing prescription drugs, including all requirements relating to packaging, labeling, record keeping, drug utilization review, and patient counseling.

(b) Before dispensing or administering a drug or supply, the pharmacist or practitioner shall visually inspect the drug or supply for adulteration, misbranding, tampering, and date of expiration. Drugs or supplies that have expired or appear upon visual inspection to be adulterated, misbranded, or tampered with in any way must not be dispensed or administered.

(c) Before a drug or supply is dispensed or administered to an individual, the individual must sign a drug repository recipient form acknowledging that the individual understands the information stated on the form. The board shall develop the form and make it available on the board's Web site. The form must include the following information:

(1) that the drug or supply being dispensed or administered has been donated and may have been previously dispensed;

(2) that a visual inspection has been conducted by the pharmacist or practitioner to ensure that the drug or supply has not expired, has not been adulterated or misbranded, and is in its original, unopened packaging; and

(3) that the dispensing pharmacist, the dispensing or administering practitioner, the central repository or local repository, the Board of Pharmacy, and any other participant of the drug repository program cannot guarantee the safety of the drug or medical supply being dispensed or administered and that the pharmacist or practitioner has determined that the drug or supply is safe to dispense or administer based on the accuracy of the donor's form submitted with the donated drug or medical supply and the visual inspection required to be performed by the pharmacist or practitioner before dispensing or administering.

Subd. 9. **Handling fees.** (a) The central or local repository may charge the individual receiving a drug or supply a handling fee of no more than 250 percent of the medical assistance program dispensing fee for each drug or medical supply dispensed or administered by that repository.

(b) A repository that dispenses or administers a drug or medical supply through the drug repository program shall not receive reimbursement under the medical assistance program or the MinnesotaCare program for that dispensed or administered drug or supply.

Subd. 10. **Distribution of donated drugs and supplies.** (a) The central repository and local repositories may distribute drugs and supplies donated under the drug repository program to other participating repositories for use pursuant to this program.

(b) A local repository that elects not to dispense donated drugs or supplies must transfer all donated drugs and supplies to the central repository. A copy of the donor form that was completed by the original donor under subdivision 6 must be provided to the central repository at the time of transfer.

Subd. 11. **Forms and record-keeping requirements.** (a) The following forms developed for the administration of this program shall be utilized by the participants of the program and shall be available on the board's Web site:

(1) intake application form described under subdivision 5;

(2) local repository participation form described under subdivision 4;

(3) local repository withdrawal form described under subdivision 4;

(4) drug repository donor form described under subdivision 6;

(5) record of destruction form described under subdivision 7; and

(6) drug repository recipient form described under subdivision 8.

(b) All records, including drug inventory, inspection, and disposal of donated prescription drugs and medical supplies must be maintained by a repository for a minimum of five years. Records required as part of this program must be maintained pursuant to all applicable practice acts.

(c) Data collected by the drug repository program from all local repositories shall be submitted quarterly or upon request to the central repository. Data collected may consist of the information, records, and forms required to be collected under this section.

(d) The central repository shall submit reports to the board as required by the contract or upon request of the board.

Subd. 12. **Liability.** (a) The manufacturer of a drug or supply is not subject to criminal or civil liability for injury, death, or loss to a person or to property for causes of action described in clauses (1) and (2). A manufacturer is not liable for:

(1) the intentional or unintentional alteration of the drug or supply by a party not under the control of the manufacturer; or

(2) the failure of a party not under the control of the manufacturer to transfer or communicate product or consumer information or the expiration date of the donated drug or supply.

(b) A health care facility participating in the program, a pharmacist dispensing a drug or supply pursuant to the program, a practitioner dispensing or administering a drug or supply pursuant to the program, or a donor of a drug or medical supply is immune from civil liability for an act or omission that causes injury to or the death of an individual to whom the drug or supply is dispensed and no disciplinary action by a health-related licensing board shall be taken against a pharmacist or practitioner so long as the drug or supply is donated, accepted, distributed, and dispensed according to the requirements of this section. This immunity does not apply if the act or omission involves reckless, wanton, or intentional misconduct, or malpractice unrelated to the quality of the drug or medical supply.

Sec. 4. Minnesota Statutes 2016, section 151.71, is amended by adding a subdivision to read:

Subd. 3. **Lowest cost to consumers.** (a) A health plan company or pharmacy benefits manager shall not require an individual to make a payment at the point of sale for a covered prescription medication in an amount greater than the allowable cost to consumers, as defined in paragraph (b).

(b) For purposes of paragraph (a), "allowable cost to consumers" means the lowest of: (1) the applicable co-payment for the prescription medication; or (2) the amount an individual would pay for the prescription medication if the individual purchased the prescription medication without using a health plan benefit.

Sec. 5. Minnesota Statutes 2017 Supplement, section 152.105, subdivision 2, is amended to read:

Subd. 2. **Sheriff to maintain collection receptacle.** The sheriff of each county shall maintain or contract for the maintenance of at least one collection receptacle for the disposal of noncontrolled substances, pharmaceutical controlled substances, and other legend drugs, as permitted by federal law. For purposes of this section, "legend drug" has the meaning given in section 151.01, subdivision 17. The collection receptacle must comply with federal law. In maintaining and operating the collection receptacle, the sheriff shall follow all applicable provisions of Code of Federal Regulations, title 21, parts 1300, 1301, 1304, 1305, 1307, and 1317, as amended through May 1, 2017. The sheriff of each county may meet the requirements of this subdivision though the use of an alternative method for the disposal of noncontrolled substances, pharmaceutical controlled substances, and other legend drugs that has been approved by the Board of Pharmacy. This may include making available to the public, without charge, at-home prescription drug deactivation and disposal products that render drugs and medications inert and irretrievable.

Sec. 6. Minnesota Statutes 2016, section 152.11, is amended by adding a subdivision to read:

Subd. 5. **Limitations on the dispensing of opioid prescription drug orders.** (a) No prescription drug order for an opioid drug listed in Schedule II may be dispensed by a pharmacist or other dispenser more than 30 days after the date on which the prescription drug order was issued.

(b) No prescription drug order for an opioid drug listed in Schedules III through V may be initially dispensed by a pharmacist or other dispenser more than 30 days after the date on which the prescription drug order was issued. No prescription drug order for an opioid drug listed in Schedules III through V may be refilled by a pharmacist or other dispenser more than 45 days after the previous date on which it was dispensed.

(c) For purposes of this section, "dispenser" has the meaning given in section 152.126, subdivision 1.

Sec. 7. **STUDENT HEALTH INITIATIVE TO LIMIT OPIOID HARM.**

Subdivision 1. **Grant awards.** The commissioner of human services, in consultation with the commissioner of education, the Board of Trustees of the Minnesota State Colleges and Universities, the Board of Directors of the Minnesota Private College Council, and the regents of the University of Minnesota, shall develop and administer a program to award grants to secondary school students in grades 7 through 12 and undergraduate students attending a Minnesota postsecondary educational institution, and their community partner or partners, to conduct opioid awareness and opioid abuse prevention activities. If a grant proposal includes more than one community partner, the proposal must designate a primary community partner. Grant applications must be submitted by the primary community partner and any grant award must be managed by the primary community partner on behalf of secondary school and undergraduate student applicants and grantees. Grants shall be awarded for a fiscal year and are onetime.

Subd. 2. **Grant criteria.** (a) Grant dollars may be used for opioid awareness campaigns and events, education related to opioid addiction and abuse prevention, initiatives to limit inappropriate opioid prescriptions, peer education programs targeted to students at high risk of opioid addiction and abuse, and other related initiatives as approved by the commissioner. Grant projects must include one or more of the following components as they relate to opioid abuse and prevention and the role of the community partner: high-risk populations, law enforcement, education, clinical services, or social services.

(b) The commissioner of human services shall seek to provide grant funding for at least one proposal that addresses opioid abuse in the American Indian community.

Subd. 3. **Community partners.** For purposes of the grant program, community partners may include but are not limited to public health agencies; local law enforcement; community health centers; medical clinics; emergency medical service professionals; schools and postsecondary educational institutions; opioid addiction, advocacy, and recovery organizations; tribal governments; local chambers of commerce; and city councils and county boards.

Subd. 4. **Report.** The commissioner of human services shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance, K-12 education policy and finance, and higher education policy and finance by September 1, 2019, on the implementation of the grant program and the grants awarded under this section.

Subd. 5. **Federal grants.** (a) The commissioner of human services shall apply for any federal grant funding that aligns with the purposes of this section. The commissioner shall submit to the legislature any changes to the program established under this section that are necessary to comply with the terms of the federal grant.

(b) The commissioner shall notify the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance, K-12 education policy and finance, and higher education policy and finance of any grant applications submitted and any federal actions taken related to the grant applications.

Sec. 8. **OPIOID OVERDOSE REDUCTION PILOT PROGRAM.**

Subdivision 1. **Establishment.** The commissioner of health shall provide grants to ambulance services to fund activities by community paramedic teams to reduce opioid overdoses in the state. Under this pilot program, ambulance services shall develop and implement projects in which community paramedics connect with patients who are discharged from a hospital or emergency department following an opioid overdose episode, develop personalized care plans for those patients in consultation with the ambulance service medical director, and provide follow-up services to those patients.

Subd. 2. **Priority areas; services.** (a) In a project developed under this section, an ambulance service must target community paramedic team services to portions of the service area with high levels of opioid use, high death rates from opioid overdoses, and urgent needs for interventions.

(b) In a project developed under this section, a community paramedic team shall:

(1) provide services to patients released from a hospital following an opioid overdose episode and place priority on serving patients who were administered the opiate antagonist naloxone hydrochloride by emergency medical services personnel in response to a 911 call during the opioid overdose episode;

(2) provide the following evaluations during an initial home visit: a home safety assessment including whether there is a need to dispose of prescription drugs that are expired or no longer needed; medication reconciliation; an HIV risk assessment; instruction on the use of naloxone hydrochloride; and a basic needs assessment;

(3) provide patients with health assessments, medication management, chronic disease monitoring and education, and assistance in following hospital discharge orders; and

(4) work with a multidisciplinary team to address the overall physical and mental health needs of patients and health needs related to substance use disorder treatment.

Subd. 3. **Evaluation.** An ambulance service that receives a grant under this section must evaluate the extent to which the project was successful in reducing the number of opioid overdoses and opioid overdose deaths among patients who received services and in reducing the inappropriate use of opioids by patients who received services. The commissioner of health shall develop specific evaluation measures and reporting timelines for ambulance services receiving grants. Ambulance services must submit the information required by the commissioner to the commissioner and the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services by December 1, 2019.

Sec. 9. **REPEALER.**

Minnesota Statutes 2016, section 151.55, is repealed.

ARTICLE 5

COMMUNITY SUPPORTS AND CONTINUING CARE

Section 1. Minnesota Statutes 2017 Supplement, section 245A.03, subdivision 7, is amended to read:

Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an initial license for child foster care licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or adult foster care licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, under this chapter for a physical location that will not be the primary residence of the license holder for the entire period of licensure. If a license is issued during this moratorium, and the license holder changes the license holder's primary residence away from the physical location of the foster care license, the commissioner shall revoke the license according to section 245A.07. The commissioner shall not issue an initial license for a community residential setting licensed under chapter 245D. When approving an exception under this paragraph, the commissioner shall consider the resource need determination process in paragraph (h), the availability of foster care licensed beds in the geographic area in which the licensee seeks to operate, the results of a person's choices during their annual assessment and service plan review, and the recommendation of the local county board. The determination by the commissioner is final and not subject to appeal. Exceptions to the moratorium include:

(1) foster care settings that are required to be registered under chapter 144D;

(2) foster care licenses replacing foster care licenses in existence on May 15, 2009, or community residential setting licenses replacing adult foster care licenses in existence on

December 31, 2013, and determined to be needed by the commissioner under paragraph (b);

(3) new foster care licenses or community residential setting licenses determined to be needed by the commissioner under paragraph (b) for the closure of a nursing facility, ICF/DD, or regional treatment center; restructuring of state-operated services that limits the capacity of state-operated facilities; or allowing movement to the community for people who no longer require the level of care provided in state-operated facilities as provided under section 256B.092, subdivision 13, or 256B.49, subdivision 24;

(4) new foster care licenses or community residential setting licenses determined to be needed by the commissioner under paragraph (b) for persons requiring hospital level care;

(5) new foster care licenses or community residential setting licenses determined to be needed by the commissioner for the transition of people from personal care assistance to the home and community-based services;

(6) new foster care licenses or community residential setting licenses determined to be needed by the commissioner for the transition of people from the residential care waiver services to foster care services. This exception applies only when:

(i) the person's case manager provided the person with information about the choice of service, service provider, and location of service to help the person make an informed choice; and

(ii) the person's foster care services are less than or equal to the cost of the person's services delivered in the residential care waiver service setting as determined by the lead agency; ~~or~~

(7) new foster care licenses or community residential setting licenses for people receiving services under chapter 245D and residing in an unlicensed setting before May 1, 2017, and for which a license is required. This exception does not apply to people living in their own home. For purposes of this clause, there is a presumption that a foster care or community residential setting license is required for services provided to three or more people in a dwelling unit when the setting is controlled by the provider. A license holder subject to this exception may rebut the presumption that a license is required by seeking a reconsideration of the commissioner's determination. The commissioner's disposition of a request for reconsideration is final and not subject to appeal under chapter 14. The exception is available until June 30, ~~2018~~ 2019. This exception is available when:

(i) the person's case manager provided the person with information about the choice of service, service provider, and location of service, including in the person's home, to help the person make an informed choice; and

(ii) the person's services provided in the licensed foster care or community residential setting are less than or equal to the cost of the person's services delivered in the unlicensed setting as determined by the lead agency~~.~~; or

(8) a vacancy in a setting granted an exception under clause (7) may receive an exception created by a person receiving services under chapter 245D and residing in the unlicensed setting between January 1, 2017, and May 1, 2017, for which a vacancy occurs between January 1, 2017, and the date of the exception request. This exception is available when the lead agency provides documentation to the commissioner on the eligibility criteria being met. This exception is available until June 30, 2019.

(b) The commissioner shall determine the need for newly licensed foster care homes or community residential settings as defined under this subdivision. As part of the determination, the commissioner shall consider the availability of foster care capacity in the area in which the licensee seeks to operate, and the recommendation of the local county board. The determination by the commissioner must be final. A determination of need is not required for a change in ownership at the same address.

(c) When an adult resident served by the program moves out of a foster home that is not the primary residence of the license holder according to section 256B.49, subdivision 15, paragraph (f), or the adult community residential setting, the county shall immediately inform the Department of Human Services Licensing Division. The department may decrease the statewide licensed capacity for adult foster care settings.

(d) Residential settings that would otherwise be subject to the decreased license capacity established in paragraph (c) shall be exempt if the license holder's beds are occupied by residents whose primary diagnosis is mental illness and the license holder is certified under the requirements in subdivision 6a or section 245D.33.

(e) A resource need determination process, managed at the state level, using the available reports required by section 144A.351, and other data and information shall be used to determine where the reduced capacity determined under section 256B.493 will be implemented. The commissioner shall consult with the stakeholders described in section 144A.351, and employ a variety of methods to improve the state's capacity to meet the informed decisions of those people who want to move out of corporate foster care or community residential settings, long-term service needs within budgetary limits, including

seeking proposals from service providers or lead agencies to change service type, capacity, or location to improve services, increase the independence of residents, and better meet needs identified by the long-term services and supports reports and statewide data and information.

(f) At the time of application and reapplication for licensure, the applicant and the license holder that are subject to the moratorium or an exclusion established in paragraph (a) are required to inform the commissioner whether the physical location where the foster care will be provided is or will be the primary residence of the license holder for the entire period of licensure. If the primary residence of the applicant or license holder changes, the applicant or license holder must notify the commissioner immediately. The commissioner shall print on the foster care license certificate whether or not the physical location is the primary residence of the license holder.

(g) License holders of foster care homes identified under paragraph (f) that are not the primary residence of the license holder and that also provide services in the foster care home that are covered by a federally approved home and community-based services waiver, as authorized under section 256B.0915, 256B.092, or 256B.49, must inform the human services licensing division that the license holder provides or intends to provide these waiver-funded services.

(h) The commissioner may adjust capacity to address needs identified in section 144A.351. Under this authority, the commissioner may approve new licensed settings or delicense existing settings. Delicensing of settings will be accomplished through a process identified in section 256B.493. Annually, by August 1, the commissioner shall provide information and data on capacity of licensed long-term services and supports, actions taken under the subdivision to manage statewide long-term services and supports resources, and any recommendations for change to the legislative committees with jurisdiction over the health and human services budget.

(i) The commissioner must notify a license holder when its corporate foster care or community residential setting licensed beds are reduced under this section. The notice of reduction of licensed beds must be in writing and delivered to the license holder by certified mail or personal service. The notice must state why the licensed beds are reduced and must inform the license holder of its right to request reconsideration by the commissioner. The license holder's request for reconsideration must be in writing. If mailed, the request for reconsideration must be postmarked and sent to the commissioner within 20 calendar days after the license holder's receipt of the notice of reduction of licensed beds. If a request for

reconsideration is made by personal service, it must be received by the commissioner within 20 calendar days after the license holder's receipt of the notice of reduction of licensed beds.

(j) The commissioner shall not issue an initial license for children's residential treatment services licensed under Minnesota Rules, parts 2960.0580 to 2960.0700, under this chapter for a program that Centers for Medicare and Medicaid Services would consider an institution for mental diseases. Facilities that serve only private pay clients are exempt from the moratorium described in this paragraph. The commissioner has the authority to manage existing statewide capacity for children's residential treatment services subject to the moratorium under this paragraph and may issue an initial license for such facilities if the initial license would not increase the statewide capacity for children's residential treatment services subject to the moratorium under this paragraph.

Sec. 2. Minnesota Statutes 2017 Supplement, section 245A.11, subdivision 2a, is amended to read:

Subd. 2a. **Adult foster care and community residential setting license capacity.** (a) The commissioner shall issue adult foster care and community residential setting licenses with a maximum licensed capacity of four beds, including nonstaff roomers and boarders, except that the commissioner may issue a license with a capacity of five beds, including roomers and boarders, according to paragraphs (b) to (g).

(b) The license holder may have a maximum license capacity of five if all persons in care are age 55 or over and do not have a serious and persistent mental illness or a developmental disability.

(c) The commissioner may grant variances to paragraph (b) to allow a facility with a licensed capacity of up to five persons to admit an individual under the age of 55 if the variance complies with section 245A.04, subdivision 9, and approval of the variance is recommended by the county in which the licensed facility is located.

(d) The commissioner may grant variances to paragraph (a) to allow the use of an additional bed, up to five, for emergency crisis services for a person with serious and persistent mental illness or a developmental disability, regardless of age, if the variance complies with section 245A.04, subdivision 9, and approval of the variance is recommended by the county in which the licensed facility is located.

(e) The commissioner may grant a variance to paragraph (b) to allow for the use of an additional bed, up to five, for respite services, as defined in section 245A.02, for persons with disabilities, regardless of age, if the variance complies with sections 245A.03,

subdivision 7, and 245A.04, subdivision 9, and approval of the variance is recommended by the county in which the licensed facility is located. Respite care may be provided under the following conditions:

(1) staffing ratios cannot be reduced below the approved level for the individuals being served in the home on a permanent basis;

(2) no more than two different individuals can be accepted for respite services in any calendar month and the total respite days may not exceed 120 days per program in any calendar year;

(3) the person receiving respite services must have his or her own bedroom, which could be used for alternative purposes when not used as a respite bedroom, and cannot be the room of another person who lives in the facility; and

(4) individuals living in the facility must be notified when the variance is approved. The provider must give 60 days' notice in writing to the residents and their legal representatives prior to accepting the first respite placement. Notice must be given to residents at least two days prior to service initiation, or as soon as the license holder is able if they receive notice of the need for respite less than two days prior to initiation, each time a respite client will be served, unless the requirement for this notice is waived by the resident or legal guardian.

(f) The commissioner may issue an adult foster care or community residential setting license with a capacity of five adults if the fifth bed does not increase the overall statewide capacity of licensed adult foster care or community residential setting beds in homes that are not the primary residence of the license holder, as identified in a plan submitted to the commissioner by the county, when the capacity is recommended by the county licensing agency of the county in which the facility is located and if the recommendation verifies that:

(1) the facility meets the physical environment requirements in the adult foster care licensing rule;

(2) the five-bed living arrangement is specified for each resident in the resident's:

(i) individualized plan of care;

(ii) individual service plan under section 256B.092, subdivision 1b, if required; or

(iii) individual resident placement agreement under Minnesota Rules, part 9555.5105, subpart 19, if required;

(3) the license holder obtains written and signed informed consent from each resident or resident's legal representative documenting the resident's informed choice to remain living in the home and that the resident's refusal to consent would not have resulted in service termination; and

(4) the facility was licensed for adult foster care before ~~March 1, 2011~~ June 30, 2016.

(g) The commissioner shall not issue a new adult foster care license under paragraph (f) after June 30, ~~2019~~ 2021. The commissioner shall allow a facility with an adult foster care license issued under paragraph (f) before June 30, ~~2019~~ 2021, to continue with a capacity of five adults if the license holder continues to comply with the requirements in paragraph (f).

Sec. 3. Minnesota Statutes 2017 Supplement, section 245D.03, subdivision 1, is amended to read:

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

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

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

(2) adult companion services as defined under the brain injury, community access for disability inclusion, community alternative care, and elderly waiver plans, excluding adult companion services provided under the Corporation for National and Community Services

Senior Companion Program established under the Domestic Volunteer Service Act of 1973, Public Law 98-288;

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

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

(5) night supervision services as defined under the brain injury, community access for disability inclusion, community alternative care, and developmental disability waiver ~~plan~~ plans;

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

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

(c) Intensive support services provide assistance, supervision, and care that is necessary to ensure the health and welfare of the person and services specifically directed toward the training, habilitation, or rehabilitation of the person. Intensive support services include:

(1) intervention services, including:

(i) ~~behavioral~~ positive support services as defined under the brain injury ~~and~~, community access for disability inclusion, community alternative care, and developmental disability waiver plans;

(ii) in-home or out-of-home crisis respite services as defined under the brain injury, community access for disability inclusion, community alternative care, and developmental disability waiver ~~plan~~ plans; and

(iii) specialist services as defined under the current brain injury, community access for disability inclusion, community alternative care, and developmental disability waiver ~~plan~~ plans;

(2) in-home support services, including:

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

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

(iii) semi-independent living services; and

(iv) individualized home supports services as defined under the brain injury, community alternative care, and community access for disability inclusion waiver plans;

(3) residential supports and services, including:

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

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

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

(4) day services, including:

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

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

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

(5) employment exploration services as defined under the brain injury, community alternative care, community access for disability inclusion, and developmental disability waiver plans;

(6) employment development services as defined under the brain injury, community alternative care, community access for disability inclusion, and developmental disability waiver plans; and

(7) employment support services as defined under the brain injury, community alternative care, community access for disability inclusion, and developmental disability waiver plans.

Sec. 4. Minnesota Statutes 2016, section 245D.071, subdivision 5, is amended to read:

Subd. 5. **Service plan review and evaluation.** (a) The license holder must give the person or the person's legal representative and case manager an opportunity to participate in the ongoing review and development of the service plan and the methods used to support

the person and accomplish outcomes identified in subdivisions 3 and 4. At least once per year, or within 30 days of a written request by the person, the person's legal representative, or the case manager, the license holder, in coordination with the person's support team or expanded support team, must meet with the person, the person's legal representative, and the case manager, and participate in service plan review meetings following stated timelines established in the person's coordinated service and support plan or coordinated service and support plan addendum ~~or within 30 days of a written request by the person, the person's legal representative, or the case manager, at a minimum of once per year~~. The purpose of the service plan review is to determine whether changes are needed to the service plan based on the assessment information, the license holder's evaluation of progress towards accomplishing outcomes, or other information provided by the support team or expanded support team.

(b) At least once per year, the license holder, in coordination with the person's support team or expanded support team, must meet with the person, the person's legal representative, and the case manager to discuss how technology might be used to meet the person's desired outcomes. The coordinated service and support plan or support plan addendum must include a summary of this discussion. The summary must include a statement regarding any decision made related to the use of technology and a description of any further research that must be completed before a decision regarding the use of technology can be made. Nothing in this paragraph requires the coordinated service and support plan to include the use of technology for the provision of services.

~~(b)~~ (c) The license holder must summarize the person's status and progress toward achieving the identified outcomes and make recommendations and identify the rationale for changing, continuing, or discontinuing implementation of supports and methods identified in subdivision 4 in a report available at the time of the progress review meeting. The report must be sent at least five working days prior to the progress review meeting if requested by the team in the coordinated service and support plan or coordinated service and support plan addendum.

~~(c)~~ (d) The license holder must send the coordinated service and support plan addendum to the person, the person's legal representative, and the case manager by mail within ten working days of the progress review meeting. Within ten working days of the mailing of the coordinated service and support plan addendum, the license holder must obtain dated signatures from the person or the person's legal representative and the case manager to document approval of any changes to the coordinated service and support plan addendum.

~~(d)~~ (e) If, within ten working days of submitting changes to the coordinated service and support plan and coordinated service and support plan addendum, the person or the person's legal representative or case manager has not signed and returned to the license holder the coordinated service and support plan or coordinated service and support plan addendum or has not proposed written modifications to the license holder's submission, the submission is deemed approved and the coordinated service and support plan addendum becomes effective and remains in effect until the legal representative or case manager submits a written request to revise the coordinated service and support plan addendum.

Sec. 5. Minnesota Statutes 2016, section 245D.091, subdivision 2, is amended to read:

Subd. 2. **~~Behavior~~ Positive support professional qualifications.** A ~~behavior~~ positive support professional providing ~~behavioral~~ positive support services as identified in section 245D.03, subdivision 1, paragraph (c), clause (1), item (i), must have competencies in the following areas as required under the brain injury ~~and~~, community access for disability inclusion, community alternative care, and developmental disability waiver plans or successor plans:

(1) ethical considerations;

(2) functional assessment;

(3) functional analysis;

(4) measurement of behavior and interpretation of data;

(5) selecting intervention outcomes and strategies;

(6) behavior reduction and elimination strategies that promote least restrictive approved alternatives;

(7) data collection;

(8) staff and caregiver training;

(9) support plan monitoring;

(10) co-occurring mental disorders or neurocognitive disorder;

(11) demonstrated expertise with populations being served; and

(12) must be a:

(i) psychologist licensed under sections 148.88 to 148.98, who has stated to the Board of Psychology competencies in the above identified areas;

(ii) clinical social worker licensed as an independent clinical social worker under chapter 148D, or a person with a master's degree in social work from an accredited college or university, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the areas identified in clauses (1) to (11);

(iii) physician licensed under chapter 147 and certified by the American Board of Psychiatry and Neurology or eligible for board certification in psychiatry with competencies in the areas identified in clauses (1) to (11);

(iv) licensed professional clinical counselor licensed under sections 148B.29 to 148B.39 with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services who has demonstrated competencies in the areas identified in clauses (1) to (11);

(v) person with a master's degree from an accredited college or university in one of the behavioral sciences or related fields, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services with demonstrated competencies in the areas identified in clauses (1) to (11); ~~or~~

(vi) person with a master's degree or PhD in one of the behavioral sciences or related fields with demonstrated expertise in positive support services, as determined by the person's case manager based on the person's needs as outlined in the person's community support plan; or

(vii) registered nurse who is licensed under sections 148.171 to 148.285, and who is certified as a clinical specialist or as a nurse practitioner in adult or family psychiatric and mental health nursing by a national nurse certification organization, or who has a master's degree in nursing or one of the behavioral sciences or related fields from an accredited college or university or its equivalent, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services.

Sec. 6. Minnesota Statutes 2016, section 245D.091, subdivision 3, is amended to read:

Subd. 3. **~~Behavior~~ Positive support analyst qualifications.** (a) A ~~behavior~~ positive support analyst providing ~~behavioral~~ positive support services as identified in section 245D.03, subdivision 1, paragraph (c), clause (1), item (i), must have competencies in the following areas as required under the brain injury ~~and~~, community access for disability inclusion, community alternative care, and developmental disability waiver plans or successor plans:

(1) have obtained a baccalaureate degree, master's degree, or PhD in a social services discipline; ~~or~~

(2) meet the qualifications of a mental health practitioner as defined in section 245.462, subdivision 17.; or

(3) be a board certified behavior analyst or board certified assistant behavior analyst by the Behavior Analyst Certification Board, Incorporated.

(b) In addition, a ~~behavior~~ positive support analyst must:

(1) have four years of supervised experience ~~working with individuals who exhibit challenging behaviors as well as co-occurring mental disorders or neurocognitive disorder~~ conducting functional behavior assessments and designing, implementing, and evaluating effectiveness of positive practices behavior support strategies for people who exhibit challenging behaviors as well as co-occurring mental disorders and neurocognitive disorder;

(2) have received ~~ten hours of instruction in functional assessment and functional analysis;~~ training prior to hire or within 90 calendar days of hire that includes:

(i) ten hours of instruction in functional assessment and functional analysis;

(ii) 20 hours of instruction in the understanding of the function of behavior;

(iii) ten hours of instruction on design of positive practices behavior support strategies;

(iv) 20 hours of instruction preparing written intervention strategies, designing data collection protocols, training other staff to implement positive practice strategies, summarizing and reporting program evaluation data, analyzing program evaluation data to identify design flaws in behavioral interventions or failures in implementation fidelity, and recommending enhancements based on evaluation data; and

(v) eight hours of instruction on principles of person-centered thinking;

~~(3) have received 20 hours of instruction in the understanding of the function of behavior;~~

~~(4) have received ten hours of instruction on design of positive practices behavior support strategies;~~

~~(5) have received 20 hours of instruction on the use of behavior reduction approved strategies used only in combination with behavior positive practices strategies;~~

~~(6)~~ (3) be determined by a ~~behavior~~ positive support professional to have the training and prerequisite skills required to provide positive practice strategies as well as behavior reduction approved and permitted intervention to the person who receives ~~behavioral~~ positive support; and

~~(7)~~ (4) be under the direct supervision of a ~~behavior~~ positive support professional.

(c) Meeting the qualifications for a positive support professional under subdivision 2 shall substitute for meeting the qualifications listed in paragraph (b).

Sec. 7. Minnesota Statutes 2016, section 245D.091, subdivision 4, is amended to read:

Subd. 4. **~~Behavior~~ Positive support specialist qualifications.** (a) A ~~behavior~~ positive support specialist providing ~~behavioral~~ positive support services as identified in section 245D.03, subdivision 1, paragraph (c), clause (1), item (i), must have competencies in the following areas as required under the brain injury ~~and~~, community access for disability inclusion, community alternative care, and developmental disability waiver plans or successor plans:

(1) have an associate's degree in a social services discipline; or

(2) have two years of supervised experience working with individuals who exhibit challenging behaviors as well as co-occurring mental disorders or neurocognitive disorder.

(b) In addition, a behavior specialist must:

(1) have received training prior to hire or within 90 calendar days of hire that includes:

(i) a minimum of four hours of training in functional assessment;

~~(2) have received~~ (ii) 20 hours of instruction in the understanding of the function of behavior;

~~(3) have received~~ (iii) ten hours of instruction on design of positive practices behavioral support strategies; and

(iv) eight hours of instruction on principles of person-centered thinking;

~~(4)~~ (2) be determined by a ~~behavior~~ positive support professional to have the training and prerequisite skills required to provide positive practices strategies as well as behavior reduction approved intervention to the person who receives ~~behavioral~~ positive support; and

~~(5)~~ (3) be under the direct supervision of a ~~behavior~~ positive support professional.

(c) Meeting the qualifications for a positive support professional under subdivision 2 shall substitute for meeting the qualifications listed in paragraphs (a) and (b).

Sec. 8. Minnesota Statutes 2017 Supplement, section 252.41, subdivision 3, is amended to read:

Subd. 3. **Day training and habilitation services for adults with developmental disabilities.** (a) "Day training and habilitation services for adults with developmental disabilities" means services that:

(1) include supervision, training, assistance, center-based work-related activities, or other community-integrated activities designed and implemented in accordance with the individual service and individual habilitation plans required under Minnesota Rules, parts 9525.0004 to 9525.0036, to help an adult reach and maintain the highest possible level of independence, productivity, and integration into the community; and

(2) are provided by a vendor licensed under sections 245A.01 to 245A.16 and 252.28, subdivision 2, to provide day training and habilitation services.

(b) Day training and habilitation services reimbursable under this section do not include special education and related services as defined in the Education of the Individuals with Disabilities Act, United States Code, title 20, chapter 33, section 1401, clauses (6) and (17), or vocational services funded under section 110 of the Rehabilitation Act of 1973, United States Code, title 29, section 720, as amended.

(c) Except for specified service units authorized and provided in the transition period defined in section 256B.4913, subdivision 7, paragraph (b), day training and habilitation services do not include employment exploration, employment development, or employment support services as defined in the home and community-based services waivers for people with disabilities authorized under sections 256B.092 and 256B.49.

EFFECTIVE DATE. This section is effective retroactively from January 1, 2018.

Sec. 9. Minnesota Statutes 2016, section 256B.0625, is amended by adding a subdivision to read:

Subd. 65. **Prescribed pediatric extended care center services.** Medical assistance covers prescribed pediatric extended care center basic services as defined under section 144H.01, subdivision 2. The commissioner shall set two payment rates for basic services provided at prescribed pediatric extended care centers licensed under chapter 144H: (1) a $250 half-day rate per child attending a prescribed pediatric extended care center for less than four hours per day; and (2) a $500 full-day rate per child attending a prescribed pediatric extended care center for four hours or more per day. The rates established in this subdivision may be reevaluated by the commissioner two years after the effective date of this subdivision.

EFFECTIVE DATE. This section is effective January 1, 2019, or upon federal approval, whichever occurs later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 10. Minnesota Statutes 2016, section 256B.0659, subdivision 11, is amended to read:

Subd. 11. **Personal care assistant; requirements.** (a) A personal care assistant must meet the following requirements:

(1) be at least 18 years of age with the exception of persons who are 16 or 17 years of age with these additional requirements:

(i) supervision by a qualified professional every 60 days; and

(ii) employment by only one personal care assistance provider agency responsible for compliance with current labor laws;

(2) be employed by a personal care assistance provider agency;

(3) enroll with the department as a personal care assistant after clearing a background study. Except as provided in subdivision 11a, before a personal care assistant provides services, the personal care assistance provider agency must initiate a background study on the personal care assistant under chapter 245C, and the personal care assistance provider agency must have received a notice from the commissioner that the personal care assistant is:

(i) not disqualified under section 245C.14; or

(ii) is disqualified, but the personal care assistant has received a set aside of the disqualification under section 245C.22;

(4) be able to effectively communicate with the recipient and personal care assistance provider agency;

(5) be able to provide covered personal care assistance services according to the recipient's personal care assistance care plan, respond appropriately to recipient needs, and report changes in the recipient's condition to the supervising qualified professional or physician;

(6) not be a consumer of personal care assistance services;

(7) maintain daily written records including, but not limited to, time sheets under subdivision 12;

(8) effective January 1, 2010, complete standardized training as determined by the commissioner before completing enrollment. The training must be available in languages

other than English and to those who need accommodations due to disabilities. Personal care assistant training must include successful completion of the following training components: basic first aid, vulnerable adult, child maltreatment, OSHA universal precautions, basic roles and responsibilities of personal care assistants including information about assistance with lifting and transfers for recipients, emergency preparedness, orientation to positive behavioral practices, fraud issues, and completion of time sheets. Upon completion of the training components, the personal care assistant must demonstrate the competency to provide assistance to recipients;

(9) complete training and orientation on the needs of the recipient; and

(10) be limited to providing and being paid for up to 275 hours per month of personal care assistance services regardless of the number of recipients being served or the number of personal care assistance provider agencies enrolled with. The number of hours worked per day shall not be disallowed by the department unless in violation of the law.

(b) A legal guardian may be a personal care assistant if the guardian is not being paid for the guardian services and meets the criteria for personal care assistants in paragraph (a).

(c) Persons who do not qualify as a personal care assistant include parents, stepparents, and legal guardians of minors; spouses; paid legal guardians of adults; family foster care providers, except as otherwise allowed in section 256B.0625, subdivision 19a; and staff of a residential setting.

(d) Personal care services qualify for the enhanced rate described in subdivision 17a if the personal care assistant providing the services:

(1) provides services, according to the care plan in subdivision 7, to a recipient who qualifies for 12 or more hours per day of PCA services; and

(2) satisfies the current requirements of Medicare for training and competency or competency evaluation of home health aides or nursing assistants, as provided in the Code of Federal Regulations, title 42, section 483.151 or 484.36, or alternative state approved training or competency requirements.

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

Sec. 11. Minnesota Statutes 2016, section 256B.0659, is amended by adding a subdivision to read:

Subd. 17a. **Enhanced rate.** An enhanced rate of 105 percent of the rate paid for PCA services shall be paid for services provided to persons who qualify for 12 or more hours of

PCA service per day when provided by a PCA who meets the requirements of subdivision 11, paragraph (d). The enhanced rate for PCA services includes, and is not in addition to, any rate adjustments implemented by the commissioner on July 1, 2018, to comply with the terms of a collective bargaining agreement between the state of Minnesota and an exclusive representative of individual providers under section 179A.54 that provides for wage increases for individual providers who serve participants assessed to need 12 or more hours of PCA services per day.

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

Sec. 12. Minnesota Statutes 2016, section 256B.0659, subdivision 21, is amended to read:

Subd. 21. **Requirements for provider enrollment of personal care assistance provider agencies.** (a) All personal care assistance provider agencies must provide, at the time of enrollment, reenrollment, and revalidation as a personal care assistance provider agency in a format determined by the commissioner, information and documentation that includes, but is not limited to, the following:

(1) the personal care assistance provider agency's current contact information including address, telephone number, and e-mail address;

(2) proof of surety bond coverage. Upon new enrollment, or if the provider's Medicaid revenue in the previous calendar year is up to and including $300,000, the provider agency must purchase a surety bond of $50,000. If the Medicaid revenue in the previous year is over $300,000, the provider agency must purchase a surety bond of $100,000. The surety bond must be in a form approved by the commissioner, must be renewed annually, and must allow for recovery of costs and fees in pursuing a claim on the bond;

(3) proof of fidelity bond coverage in the amount of $20,000;

(4) proof of workers' compensation insurance coverage;

(5) proof of liability insurance;

(6) a description of the personal care assistance provider agency's organization identifying the names of all owners, managing employees, staff, board of directors, and the affiliations of the directors, owners, or staff to other service providers;

(7) a copy of the personal care assistance provider agency's written policies and procedures including: hiring of employees; training requirements; service delivery; and employee and consumer safety including process for notification and resolution of consumer

grievances, identification and prevention of communicable diseases, and employee misconduct;

(8) copies of all other forms the personal care assistance provider agency uses in the course of daily business including, but not limited to:

(i) a copy of the personal care assistance provider agency's time sheet if the time sheet varies from the standard time sheet for personal care assistance services approved by the commissioner, and a letter requesting approval of the personal care assistance provider agency's nonstandard time sheet;

(ii) the personal care assistance provider agency's template for the personal care assistance care plan; and

(iii) the personal care assistance provider agency's template for the written agreement in subdivision 20 for recipients using the personal care assistance choice option, if applicable;

(9) a list of all training and classes that the personal care assistance provider agency requires of its staff providing personal care assistance services;

(10) documentation that the personal care assistance provider agency and staff have successfully completed all the training required by this section, including the requirements under subdivision 11, paragraph (d), if enhanced PCA services are provided and submitted for an enhanced rate under subdivision 17a;

(11) documentation of the agency's marketing practices;

(12) disclosure of ownership, leasing, or management of all residential properties that is used or could be used for providing home care services;

(13) documentation that the agency will use the following percentages of revenue generated from the medical assistance rate paid for personal care assistance services for employee personal care assistant wages and benefits: 72.5 percent of revenue in the personal care assistance choice option and 72.5 percent of revenue from other personal care assistance providers. The revenue generated by the qualified professional and the reasonable costs associated with the qualified professional shall not be used in making this calculation; and

(14) effective May 15, 2010, documentation that the agency does not burden recipients' free exercise of their right to choose service providers by requiring personal care assistants to sign an agreement not to work with any particular personal care assistance recipient or for another personal care assistance provider agency after leaving the agency and that the agency is not taking action on any such agreements or requirements regardless of the date signed.

(b) Personal care assistance provider agencies shall provide the information specified in paragraph (a) to the commissioner at the time the personal care assistance provider agency enrolls as a vendor or upon request from the commissioner. The commissioner shall collect the information specified in paragraph (a) from all personal care assistance providers beginning July 1, 2009.

(c) All personal care assistance provider agencies shall require all employees in management and supervisory positions and owners of the agency who are active in the day-to-day management and operations of the agency to complete mandatory training as determined by the commissioner before enrollment of the agency as a provider. Employees in management and supervisory positions and owners who are active in the day-to-day operations of an agency who have completed the required training as an employee with a personal care assistance provider agency do not need to repeat the required training if they are hired by another agency, if they have completed the training within the past three years. By September 1, 2010, the required training must be available with meaningful access according to title VI of the Civil Rights Act and federal regulations adopted under that law or any guidance from the United States Health and Human Services Department. The required training must be available online or by electronic remote connection. The required training must provide for competency testing. Personal care assistance provider agency billing staff shall complete training about personal care assistance program financial management. This training is effective July 1, 2009. Any personal care assistance provider agency enrolled before that date shall, if it has not already, complete the provider training within 18 months of July 1, 2009. Any new owners or employees in management and supervisory positions involved in the day-to-day operations are required to complete mandatory training as a requisite of working for the agency. Personal care assistance provider agencies certified for participation in Medicare as home health agencies are exempt from the training required in this subdivision. When available, Medicare-certified home health agency owners, supervisors, or managers must successfully complete the competency test.

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

Sec. 13. Minnesota Statutes 2016, section 256B.0659, subdivision 24, is amended to read:

Subd. 24. **Personal care assistance provider agency; general duties.** A personal care assistance provider agency shall:

(1) enroll as a Medicaid provider meeting all provider standards, including completion of the required provider training;

(2) comply with general medical assistance coverage requirements;

(3) demonstrate compliance with law and policies of the personal care assistance program to be determined by the commissioner;

(4) comply with background study requirements;

(5) verify and keep records of hours worked by the personal care assistant and qualified professional;

(6) not engage in any agency-initiated direct contact or marketing in person, by phone, or other electronic means to potential recipients, guardians, or family members;

(7) pay the personal care assistant and qualified professional based on actual hours of services provided;

(8) withhold and pay all applicable federal and state taxes;

(9) ~~effective January 1, 2010,~~ document that the agency uses a minimum of 72.5 percent of the revenue generated by the medical assistance rate for personal care assistance services for employee personal care assistant wages and benefits. The revenue generated by the qualified professional and the reasonable costs associated with the qualified professional shall not be used in making this calculation;

(10) make the arrangements and pay unemployment insurance, taxes, workers' compensation, liability insurance, and other benefits, if any;

(11) enter into a written agreement under subdivision 20 before services are provided;

(12) report suspected neglect and abuse to the common entry point according to section 256B.0651;

(13) provide the recipient with a copy of the home care bill of rights at start of service; ~~and~~

(14) request reassessments at least 60 days prior to the end of the current authorization for personal care assistance services, on forms provided by the commissioner; and

(15) document that the agency uses the additional revenue due to the enhanced rate under subdivision 17a for the wages and benefits of the PCAs whose services meet the requirements under subdivision 11, paragraph (d).

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

Sec. 14. Minnesota Statutes 2016, section 256B.0659, subdivision 28, is amended to read:

Subd. 28. **Personal care assistance provider agency; required documentation.** (a) Required documentation must be completed and kept in the personal care assistance provider agency file or the recipient's home residence. The required documentation consists of:

(1) employee files, including:

(i) applications for employment;

(ii) background study requests and results;

(iii) orientation records about the agency policies;

(iv) trainings completed with demonstration of competence, including verification of the completion of training required under subdivision 11, paragraph (d), for any billing of the enhanced rate under subdivision 17a;

(v) supervisory visits;

(vi) evaluations of employment; and

(vii) signature on fraud statement;

(2) recipient files, including:

(i) demographics;

(ii) emergency contact information and emergency backup plan;

(iii) personal care assistance service plan;

(iv) personal care assistance care plan;

(v) month-to-month service use plan;

(vi) all communication records;

(vii) start of service information, including the written agreement with recipient; and

(viii) date the home care bill of rights was given to the recipient;

(3) agency policy manual, including:

(i) policies for employment and termination;

(ii) grievance policies with resolution of consumer grievances;

(iii) staff and consumer safety;

(iv) staff misconduct; and

(v) staff hiring, service delivery, staff and consumer safety, staff misconduct, and resolution of consumer grievances;

(4) time sheets for each personal care assistant along with completed activity sheets for each recipient served; and

(5) agency marketing and advertising materials and documentation of marketing activities and costs.

(b) The commissioner may assess a fine of up to $500 on provider agencies that do not consistently comply with the requirements of this subdivision.

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

Sec. 15. Minnesota Statutes 2017 Supplement, section 256B.0921, is amended to read:

256B.0921 HOME AND COMMUNITY-BASED SERVICES ~~INCENTIVE~~ INNOVATION POOL.

The commissioner of human services shall develop an initiative to provide incentives for innovation in: (1) achieving integrated competitive employment; (2) achieving integrated competitive employment for youth under age 25 upon their graduation from school; (3) living in the most integrated setting; and (4) other outcomes determined by the commissioner. The commissioner shall seek requests for proposals and shall contract with one or more entities to provide incentive payments for meeting identified outcomes.

Sec. 16. Minnesota Statutes 2017 Supplement, section 256B.4913, subdivision 7, is amended to read:

Subd. 7. **New services.** (a) A service added to section 256B.4914 after January 1, 2014, is not subject to rate stabilization adjustment in this section.

(b) The commissioner shall implement the new services in section 256B.4914, subdivision 3, clauses (23), (24), and (25). Transition to the new services shall occur as service agreements renew or service plans change, except that service authorizations of daily units of day training and habilitation services and prevocational services that have rates subject to rate stabilization under this section as of July 1, 2018, shall transition service unit authorizations that fall under the new services in section 256B.4914, subdivision 3, clauses (23), (24), and (25), on June 30, 2019.

(c) Service authorizations that include the delayed transition under paragraph (b) shall not also authorize and bill for the new services in section 256B.4914, subdivision 3, clauses

(23), (24), and (25), on the same day that a daily unit or partial day unit of day training and habilitation services or prevocational services is billed.

EFFECTIVE DATE. This section is effective July 1, 2018, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 17. Minnesota Statutes 2017 Supplement, section 256B.4914, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) For purposes of this section, the following terms have the meanings given them, unless the context clearly indicates otherwise.

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

(c) "Component value" means underlying factors that are part of the cost of providing services that are built into the waiver rates methodology to calculate service rates.

(d) "Customized living tool" means a methodology for setting service rates that delineates and documents the amount of each component service included in a recipient's customized living service plan.

(e) "Direct care staff" means employees providing direct service provision to people receiving services under this section. Direct care staff does not include executive, managerial, and administrative staff.

(f) "Disability waiver rates system" means a statewide system that establishes rates that are based on uniform processes and captures the individualized nature of waiver services and recipient needs.

~~(f)~~ (g) "Individual staffing" means the time spent as a one-to-one interaction specific to an individual recipient by staff to provide direct support and assistance with activities of daily living, instrumental activities of daily living, and training to participants, and is based on the requirements in each individual's coordinated service and support plan under section 245D.02, subdivision 4b; any coordinated service and support plan addendum under section 245D.02, subdivision 4c; and an assessment tool. Provider observation of an individual's needs must also be considered.

~~(g)~~ (h) "Lead agency" means a county, partnership of counties, or tribal agency charged with administering waivered services under sections 256B.092 and 256B.49.

~~(h)~~ (i) "Median" means the amount that divides distribution into two equal groups, one-half above the median and one-half below the median.

~~(i)~~ (j) "Payment or rate" means reimbursement to an eligible provider for services provided to a qualified individual based on an approved service authorization.

~~(j)~~ (k) "Rates management system" means a Web-based software application that uses a framework and component values, as determined by the commissioner, to establish service rates.

~~(k)~~ (l) "Recipient" means a person receiving home and community-based services funded under any of the disability waivers.

~~(l)~~ (m) "Shared staffing" means time spent by employees, not defined under paragraph ~~(f)~~ (g), providing or available to provide more than one individual with direct support and assistance with activities of daily living as defined under section 256B.0659, subdivision 1, paragraph (b); instrumental activities of daily living as defined under section 256B.0659, subdivision 1, paragraph (i); ancillary activities needed to support individual services; and training to participants, and is based on the requirements in each individual's coordinated service and support plan under section 245D.02, subdivision 4b; any coordinated service and support plan addendum under section 245D.02, subdivision 4c; an assessment tool; and provider observation of an individual's service need. Total shared staffing hours are divided proportionally by the number of individuals who receive the shared service provisions.

~~(m)~~ (n) "Staffing ratio" means the number of recipients a service provider employee supports during a unit of service based on a uniform assessment tool, provider observation, case history, and the recipient's services of choice, and not based on the staffing ratios under section 245D.31.

~~(n)~~ (o) "Unit of service" means the following:

(1) for residential support services under subdivision 6, a unit of service is a day. Any portion of any calendar day, within allowable Medicaid rules, where an individual spends time in a residential setting is billable as a day;

(2) for day services under subdivision 7:

(i) for day training and habilitation services, a unit of service is either:

(A) a day unit of service is defined as six or more hours of time spent providing direct services and transportation; or

(B) a partial day unit of service is defined as fewer than six hours of time spent providing direct services and transportation; and

(C) for new day service recipients after January 1, 2014, 15 minute units of service must be used for fewer than six hours of time spent providing direct services and transportation;

(ii) for adult day and structured day services, a unit of service is a day or 15 minutes. A day unit of service is six or more hours of time spent providing direct services;

(iii) for prevocational services, a unit of service is a day or an hour. A day unit of service is six or more hours of time spent providing direct service;

(3) for unit-based services with programming under subdivision 8:

(i) for supported living services, a unit of service is a day or 15 minutes. When a day rate is authorized, any portion of a calendar day where an individual receives services is billable as a day; and

(ii) for all other services, a unit of service is 15 minutes; and

(4) for unit-based services without programming under subdivision 9, a unit of service is 15 minutes.

Sec. 18. Minnesota Statutes 2017 Supplement, section 256B.4914, subdivision 3, is amended to read:

Subd. 3. **Applicable services.** Applicable services are those authorized under the state's home and community-based services waivers under sections 256B.092 and 256B.49, including the following, as defined in the federally approved home and community-based services plan:

(1) 24-hour customized living;

(2) adult day care;

(3) adult day care bath;

~~(4) behavioral programming;~~

~~(5)~~ (4) companion services;

~~(6)~~ (5) customized living;

~~(7)~~ (6) day training and habilitation;

(7) employment development services;

(8) employment exploration services;

(9) employment support services;

~~(8)~~ (10) housing access coordination;

~~(9)~~ (11) independent living skills;

(12) independent living skills specialist services;

(13) individualized home supports;

~~(10)~~ (14) in-home family support;

~~(11)~~ (15) night supervision;

~~(12)~~ (16) personal support;

(17) positive support service;

~~(13)~~ (18) prevocational services;

~~(14)~~ (19) residential care services;

~~(15)~~ (20) residential support services;

~~(16)~~ (21) respite services;

~~(17)~~ (22) structured day services;

~~(18)~~ (23) supported employment services;

~~(19)~~ (24) supported living services;

~~(20)~~ (25) transportation services;

~~(21) individualized home supports;~~

~~(22) independent living skills specialist services;~~

~~(23) employment exploration services;~~

~~(24) employment development services;~~

~~(25) employment support services;~~ and

(26) other services as approved by the federal government in the state home and community-based services plan.

Sec. 19. Minnesota Statutes 2016, section 256B.4914, subdivision 4, is amended to read:

Subd. 4. **Data collection for rate determination.** (a) Rates for applicable home and community-based waivered services, including rate exceptions under subdivision 12, are set by the rates management system.

(b) Data for services under section 256B.4913, subdivision 4a, shall be collected in a manner prescribed by the commissioner.

(c) Data and information in the rates management system may be used to calculate an individual's rate.

(d) Service providers, with information from the community support plan and oversight by lead agencies, shall provide values and information needed to calculate an individual's rate into the rates management system. The determination of service levels must be part of a discussion with members of the support team as defined in section 245D.02, subdivision 34. This discussion must occur prior to the final establishment of each individual's rate. The values and information include:

(1) shared staffing hours;

(2) individual staffing hours;

(3) direct registered nurse hours;

(4) direct licensed practical nurse hours;

(5) staffing ratios;

(6) information to document variable levels of service qualification for variable levels of reimbursement in each framework;

(7) shared or individualized arrangements for unit-based services, including the staffing ratio;

(8) number of trips and miles for transportation services; and

(9) service hours provided through monitoring technology.

(e) Updates to individual data must include:

(1) data for each individual that is updated annually when renewing service plans; and

(2) requests by individuals or lead agencies to update a rate whenever there is a change in an individual's service needs, with accompanying documentation.

(f) Lead agencies shall review and approve all services reflecting each individual's needs, and the values to calculate the final payment rate for services with variables under subdivisions 6, 7, 8, and 9 for each individual. Lead agencies must notify the individual and the service provider of the final agreed-upon values and rate, and provide information that is identical to what was entered into the rates management system. If a value used was mistakenly or erroneously entered and used to calculate a rate, a provider may petition lead

agencies to correct it. Lead agencies must respond to these requests. When responding to the request, the lead agency must consider:

(1) meeting the health and welfare needs of the individual or individuals receiving services by service site, identified in their coordinated service and support plan under section 245D.02, subdivision 4b, and any addendum under section 245D.02, subdivision 4c;

(2) meeting the requirements for staffing under subdivision 2, paragraphs ~~(f)~~ (g), ~~(i)~~ (m), and ~~(m)~~ (n); and meeting or exceeding the licensing standards for staffing required under section 245D.09, subdivision 1; and

(3) meeting the staffing ratio requirements under subdivision 2, paragraph (n), and meeting or exceeding the licensing standards for staffing required under section 245D.31.

(g) To aid in the transition required in section 256B.4913, subdivision 7, paragraph (b), discussion of transition to the new services in subdivision 3, clauses (23), (24), and (25), shall be a part of the service planning process. Lead agencies authorizing daily units of day training and habilitation services and prevocational services shall enter information into the rate management system indicating the average units of employment development services, employment exploration services, and employment support services that are expected to be provided within the transition period daily rate.

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

Sec. 20. Minnesota Statutes 2017 Supplement, section 256B.4914, subdivision 5, is amended to read:

Subd. 5. **Base wage index and standard component values.** (a) The base wage index is established to determine staffing costs associated with providing services to individuals receiving home and community-based services. For purposes of developing and calculating the proposed base wage, Minnesota-specific wages taken from job descriptions and standard occupational classification (SOC) codes from the Bureau of Labor Statistics as defined in the most recent edition of the Occupational Handbook must be used. The base wage index must be calculated as follows:

(1) for residential direct care staff, the sum of:

(i) 15 percent of the subtotal of 50 percent of the median wage for personal and home health aide (SOC code 39-9021); 30 percent of the median wage for nursing assistant (SOC code 31-1014); and 20 percent of the median wage for social and human services aide (SOC code 21-1093); and

(ii) 85 percent of the subtotal of 20 percent of the median wage for home health aide (SOC code 31-1011); 20 percent of the median wage for personal and home health aide (SOC code 39-9021); 20 percent of the median wage for nursing assistant (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

(2) for day services, 20 percent of the median wage for nursing assistant (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

(3) for residential asleep-overnight staff, the wage is the minimum wage in Minnesota for large employers, except in a family foster care setting, the wage is 36 percent of the minimum wage in Minnesota for large employers;

(4) for behavior program analyst staff, 100 percent of the median wage for mental health counselors (SOC code 21-1014);

(5) for behavior program professional staff, 100 percent of the median wage for clinical counseling and school psychologist (SOC code 19-3031);

(6) for behavior program specialist staff, 100 percent of the median wage for psychiatric technicians (SOC code 29-2053);

(7) for supportive living services staff, 20 percent of the median wage for nursing assistant (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

(8) for housing access coordination staff, 100 percent of the median wage for community and social services specialist (SOC code 21-1099);

(9) for in-home family support staff, 20 percent of the median wage for nursing aide (SOC code 31-1012); 30 percent of the median wage for community social service specialist (SOC code 21-1099); 40 percent of the median wage for social and human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric technician (SOC code 29-2053);

(10) for individualized home supports services staff, 40 percent of the median wage for community social service specialist (SOC code 21-1099); 50 percent of the median wage for social and human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric technician (SOC code 29-2053);

(11) for independent living skills staff, 40 percent of the median wage for community social service specialist (SOC code 21-1099); 50 percent of the median wage for social and human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric technician (SOC code 29-2053);

(12) for independent living skills specialist staff, 100 percent of mental health and substance abuse social worker (SOC code 21-1023);

(13) for supported employment staff, 20 percent of the median wage for nursing assistant (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

(14) for employment support services staff, 50 percent of the median wage for rehabilitation counselor (SOC code 21-1015); and 50 percent of the median wage for community and social services specialist (SOC code 21-1099);

(15) for employment exploration services staff, 50 percent of the median wage for rehabilitation counselor (SOC code 21-1015); and 50 percent of the median wage for community and social services specialist (SOC code 21-1099);

(16) for employment development services staff, 50 percent of the median wage for education, guidance, school, and vocational counselors (SOC code 21-1012); and 50 percent of the median wage for community and social services specialist (SOC code 21-1099);

(17) for adult companion staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing assistant (SOC code 31-1014);

(18) for night supervision staff, 20 percent of the median wage for home health aide (SOC code 31-1011); 20 percent of the median wage for personal and home health aide (SOC code 39-9021); 20 percent of the median wage for nursing assistant (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

(19) for respite staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing assistant (SOC code 31-1014);

(20) for personal support staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing assistant (SOC code 31-1014);

(21) for supervisory staff, 100 percent of the median wage for community and social services specialist (SOC code 21-1099), with the exception of the supervisor of behavior professional, behavior analyst, and behavior specialists, which is 100 percent of the median wage for clinical counseling and school psychologist (SOC code 19-3031);

(22) for registered nurse staff, 100 percent of the median wage for registered nurses (SOC code 29-1141); and

(23) for licensed practical nurse staff, 100 percent of the median wage for licensed practical nurses (SOC code 29-2061).

(b) Component values for residential support services are:

(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

(3) employee-related cost ratio: 23.6 percent;

(4) general administrative support ratio: 13.25 percent;

(5) program-related expense ratio: 1.3 percent; and

(6) absence and utilization factor ratio: 3.9 percent.

(c) Component values for family foster care are:

(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

(3) employee-related cost ratio: 23.6 percent;

(4) general administrative support ratio: 3.3 percent;

(5) program-related expense ratio: 1.3 percent; and

(6) absence factor: 1.7 percent.

(d) Component values for day services for all services are:

(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

(3) employee-related cost ratio: 23.6 percent;

(4) program plan support ratio: 5.6 percent;

(5) client programming and support ratio: ten percent;

(6) general administrative support ratio: 13.25 percent;

(7) program-related expense ratio: 1.8 percent; and

(8) absence and utilization factor ratio: 9.4 percent.

(e) Component values for unit-based services with programming are:

(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

(3) employee-related cost ratio: 23.6 percent;

(4) program plan supports ratio: 15.5 percent;

(5) client programming and supports ratio: 4.7 percent;

(6) general administrative support ratio: 13.25 percent;

(7) program-related expense ratio: 6.1 percent; and

(8) absence and utilization factor ratio: 3.9 percent.

(f) Component values for unit-based services without programming except respite are:

(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

(3) employee-related cost ratio: 23.6 percent;

(4) program plan support ratio: 7.0 percent;

(5) client programming and support ratio: 2.3 percent;

(6) general administrative support ratio: 13.25 percent;

(7) program-related expense ratio: 2.9 percent; and

(8) absence and utilization factor ratio: 3.9 percent.

(g) Component values for unit-based services without programming for respite are:

(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

(3) employee-related cost ratio: 23.6 percent;

(4) general administrative support ratio: 13.25 percent;

(5) program-related expense ratio: 2.9 percent; and

(6) absence and utilization factor ratio: 3.9 percent.

(h) On July 1, 2017, the commissioner shall update the base wage index in paragraph (a) based on the wage data by standard occupational code (SOC) from the Bureau of Labor Statistics available on December 31, 2016. The commissioner shall publish these updated values and load them into the rate management system. On ~~July~~ January 1, 2022, and every ~~five~~ two years thereafter, the commissioner shall update the base wage index in paragraph (a) based on the ~~most recently available~~ wage data by SOC from the Bureau of Labor Statistics available on December 31 of the year two years prior to the scheduled update. The commissioner shall publish these updated values and load them into the rate management system.

(i) On July 1, 2017, the commissioner shall update the framework components in paragraph (d), clause (5); paragraph (e), clause (5); and paragraph (f), clause (5); subdivision 6, clauses (8) and (9); and subdivision 7, clauses (10), (16), and (17), for changes in the Consumer Price Index. The commissioner will adjust these values higher or lower by the percentage change in the Consumer Price Index-All Items, United States city average (CPI-U) from January 1, 2014, to January 1, 2017. The commissioner shall publish these updated values and load them into the rate management system. On ~~July~~ January 1, 2022, and every ~~five~~ two years thereafter, the commissioner shall update the framework components in paragraph (d), clause (5); paragraph (e), clause (5); and paragraph (f), clause (5); subdivision 6, clauses (8) and (9); and subdivision 7, clauses (10), (16), and (17), for changes in the Consumer Price Index. The commissioner shall adjust these values higher or lower by the percentage change in the CPI-U from the date of the previous update to the ~~date of the~~ data ~~most recently~~ available on December 31 of the year two years prior to the scheduled update. The commissioner shall publish these updated values and load them into the rate management system.

(j) In this subdivision, if Bureau of Labor Statistics occupational codes or Consumer Price Index items are unavailable in the future, the commissioner shall recommend to the legislature codes or items to update and replace missing component values.

(k) The commissioner shall increase the updated base wage index in paragraph (h) with a competitive workforce factor of 8.35 percent.

EFFECTIVE DATE. (a) The amendments to paragraphs (h) and (i) are effective January 1, 2022, or upon federal approval, whichever is later. The commissioner shall inform the revisor of statutes when federal approval is obtained.

(b) Paragraph (k) is effective July 1, 2018, or upon federal approval, whichever is later. The commissioner shall inform the revisor of statutes when federal approval is obtained.

Sec. 21. Minnesota Statutes 2017 Supplement, section 256B.4914, subdivision 6, is amended to read:

Subd. 6. **Payments for residential support services.** (a) Payments for residential support services, as defined in sections 256B.092, subdivision 11, and 256B.49, subdivision 22, must be calculated as follows:

(1) determine the number of shared staffing and individual direct staff hours to meet a recipient's needs provided on site or through monitoring technology;

(2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5. This is defined as the direct-care rate;

(3) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (2). This is defined as the customized direct-care rate;

(4) multiply the number of shared and individual direct staff hours provided on site or through monitoring technology and nursing hours by the appropriate staff wages in subdivision 5, paragraph (a), or the customized direct-care rate;

(5) multiply the number of shared and individual direct staff hours provided on site or through monitoring technology and nursing hours by the product of the supervision span of control ratio in subdivision 5, paragraph (b), clause (1), and the appropriate supervision wage in subdivision 5, paragraph (a), clause (21);

(6) combine the results of clauses (4) and (5), excluding any shared and individual direct staff hours provided through monitoring technology, and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (b), clause (2). This is defined as the direct staffing cost;

(7) for employee-related expenses, multiply the direct staffing cost, excluding any shared and individual direct staff hours provided through monitoring technology, by one plus the employee-related cost ratio in subdivision 5, paragraph (b), clause (3);

(8) for client programming and supports, the commissioner shall add $2,179; and

(9) for transportation, if provided, the commissioner shall add $1,680, or $3,000 if customized for adapted transport, based on the resident with the highest assessed need.

(b) The total rate must be calculated using the following steps:

(1) subtotal paragraph (a), clauses (7) to (9), and the direct staffing cost of any shared and individual direct staff hours provided through monitoring technology that was excluded in clause (7);

(2) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization ratio; and

(3) divide the result of clause (1) by one minus the result of clause (2). This is the total payment amount~~; and~~.

~~(4) adjust the result of clause (3) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.~~

(c) The payment methodology for customized living, 24-hour customized living, and residential care services must be the customized living tool. Revisions to the customized living tool must be made to reflect the services and activities unique to disability-related recipient needs.

(d) For individuals enrolled prior to January 1, 2014, the days of service authorized must meet or exceed the days of service used to convert service agreements in effect on December 1, 2013, and must not result in a reduction in spending or service utilization due to conversion during the implementation period under section 256B.4913, subdivision 4a. If during the implementation period, an individual's historical rate, including adjustments required under section 256B.4913, subdivision 4a, paragraph (c), is equal to or greater than the rate determined in this subdivision, the number of days authorized for the individual is 365.

(e) The number of days authorized for all individuals enrolling after January 1, 2014, in residential services must include every day that services start and end.

EFFECTIVE DATE. This section is effective January 1, 2022.

Sec. 22. Minnesota Statutes 2017 Supplement, section 256B.4914, subdivision 7, is amended to read:

Subd. 7. **Payments for day programs.** Payments for services with day programs including adult day care, day treatment and habilitation, prevocational services, and structured day services must be calculated as follows:

(1) determine the number of units of service and staffing ratio to meet a recipient's needs:

(i) the staffing ratios for the units of service provided to a recipient in a typical week must be averaged to determine an individual's staffing ratio; and

(ii) the commissioner, in consultation with service providers, shall develop a uniform staffing ratio worksheet to be used to determine staffing ratios under this subdivision;

(2) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5;

(3) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (2). This is defined as the customized direct-care rate;

(4) multiply the number of day program direct staff hours and nursing hours by the appropriate staff wage in subdivision 5, paragraph (a), or the customized direct-care rate;

(5) multiply the number of day direct staff hours by the product of the supervision span of control ratio in subdivision 5, paragraph (d), clause (1), and the appropriate supervision wage in subdivision 5, paragraph (a), clause (21);

(6) combine the results of clauses (4) and (5), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (d), clause (2). This is defined as the direct staffing rate;

(7) for program plan support, multiply the result of clause (6) by one plus the program plan support ratio in subdivision 5, paragraph (d), clause (4);

(8) for employee-related expenses, multiply the result of clause (7) by one plus the employee-related cost ratio in subdivision 5, paragraph (d), clause (3);

(9) for client programming and supports, multiply the result of clause (8) by one plus the client programming and support ratio in subdivision 5, paragraph (d), clause (5);

(10) for program facility costs, add $19.30 per week with consideration of staffing ratios to meet individual needs;

(11) for adult day bath services, add $7.01 per 15 minute unit;

(12) this is the subtotal rate;

(13) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(14) divide the result of clause (12) by one minus the result of clause (13). This is the total payment amount;

~~(15) adjust the result of clause (14) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services;~~

~~(16)~~ (15) for transportation provided as part of day training and habilitation for an individual who does not require a lift, add:

(i) $10.50 for a trip between zero and ten miles for a nonshared ride in a vehicle without a lift, $8.83 for a shared ride in a vehicle without a lift, and $9.25 for a shared ride in a vehicle with a lift;

(ii) $15.75 for a trip between 11 and 20 miles for a nonshared ride in a vehicle without a lift, $10.58 for a shared ride in a vehicle without a lift, and $11.88 for a shared ride in a vehicle with a lift;

(iii) $25.75 for a trip between 21 and 50 miles for a nonshared ride in a vehicle without a lift, $13.92 for a shared ride in a vehicle without a lift, and $16.88 for a shared ride in a vehicle with a lift; or

(iv) $33.50 for a trip of 51 miles or more for a nonshared ride in a vehicle without a lift, $16.50 for a shared ride in a vehicle without a lift, and $20.75 for a shared ride in a vehicle with a lift; and

~~(17)~~ (16) for transportation provided as part of day training and habilitation for an individual who does require a lift, add:

(i) $19.05 for a trip between zero and ten miles for a nonshared ride in a vehicle with a lift, and $15.05 for a shared ride in a vehicle with a lift;

(ii) $32.16 for a trip between 11 and 20 miles for a nonshared ride in a vehicle with a lift, and $28.16 for a shared ride in a vehicle with a lift;

(iii) $58.76 for a trip between 21 and 50 miles for a nonshared ride in a vehicle with a lift, and $58.76 for a shared ride in a vehicle with a lift; or

(iv) $80.93 for a trip of 51 miles or more for a nonshared ride in a vehicle with a lift, and $80.93 for a shared ride in a vehicle with a lift.

EFFECTIVE DATE. This section is effective January 1, 2022.

Sec. 23. Minnesota Statutes 2017 Supplement, section 256B.4914, subdivision 8, is amended to read:

Subd. 8. **Payments for unit-based services with programming.** Payments for unit-based services with programming, including behavior programming, housing access coordination,

in-home family support, independent living skills training, independent living skills specialist services, individualized home supports, hourly supported living services, employment exploration services, employment development services, supported employment, and employment support services provided to an individual outside of any day or residential service plan must be calculated as follows, unless the services are authorized separately under subdivision 6 or 7:

(1) determine the number of units of service to meet a recipient's needs;

(2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5;

(3) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (2). This is defined as the customized direct-care rate;

(4) multiply the number of direct staff hours by the appropriate staff wage in subdivision 5, paragraph (a), or the customized direct-care rate;

(5) multiply the number of direct staff hours by the product of the supervision span of control ratio in subdivision 5, paragraph (e), clause (1), and the appropriate supervision wage in subdivision 5, paragraph (a), clause (21);

(6) combine the results of clauses (4) and (5), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (e), clause (2). This is defined as the direct staffing rate;

(7) for program plan support, multiply the result of clause (6) by one plus the program plan supports ratio in subdivision 5, paragraph (e), clause (4);

(8) for employee-related expenses, multiply the result of clause (7) by one plus the employee-related cost ratio in subdivision 5, paragraph (e), clause (3);

(9) for client programming and supports, multiply the result of clause (8) by one plus the client programming and supports ratio in subdivision 5, paragraph (e), clause (5);

(10) this is the subtotal rate;

(11) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(12) divide the result of clause (10) by one minus the result of clause (11). This is the total payment amount; and

(13) for supported employment provided in a shared manner, divide the total payment amount in clause (12) by the number of service recipients, not to exceed three. For employment support services provided in a shared manner, divide the total payment amount in clause (12) by the number of service recipients, not to exceed six. For independent living skills training and individualized home supports provided in a shared manner, divide the total payment amount in clause (12) by the number of service recipients, not to exceed two~~;~~ ~~and~~.

~~(14) adjust the result of clause (13) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.~~

EFFECTIVE DATE. This section is effective January 1, 2022.

Sec. 24. Minnesota Statutes 2017 Supplement, section 256B.4914, subdivision 9, is amended to read:

Subd. 9. **Payments for unit-based services without programming.** Payments for unit-based services without programming, including night supervision, personal support, respite, and companion care provided to an individual outside of any day or residential service plan must be calculated as follows unless the services are authorized separately under subdivision 6 or 7:

(1) for all services except respite, determine the number of units of service to meet a recipient's needs;

(2) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rate or rates derived by the commissioner as provided in subdivision 5;

(3) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (2). This is defined as the customized direct care rate;

(4) multiply the number of direct staff hours by the appropriate staff wage in subdivision 5 or the customized direct care rate;

(5) multiply the number of direct staff hours by the product of the supervision span of control ratio in subdivision 5, paragraph (f), clause (1), and the appropriate supervision wage in subdivision 5, paragraph (a), clause (21);

(6) combine the results of clauses (4) and (5), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (f), clause (2). This is defined as the direct staffing rate;

(7) for program plan support, multiply the result of clause (6) by one plus the program plan support ratio in subdivision 5, paragraph (f), clause (4);

(8) for employee-related expenses, multiply the result of clause (7) by one plus the employee-related cost ratio in subdivision 5, paragraph (f), clause (3);

(9) for client programming and supports, multiply the result of clause (8) by one plus the client programming and support ratio in subdivision 5, paragraph (f), clause (5);

(10) this is the subtotal rate;

(11) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(12) divide the result of clause (10) by one minus the result of clause (11). This is the total payment amount;

(13) for respite services, determine the number of day units of service to meet an individual's needs;

(14) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rate or rates derived by the commissioner as provided in subdivision 5;

(15) for a recipient requiring deaf and hard-of-hearing customization under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (14). This is defined as the customized direct care rate;

(16) multiply the number of direct staff hours by the appropriate staff wage in subdivision 5, paragraph (a);

(17) multiply the number of direct staff hours by the product of the supervisory span of control ratio in subdivision 5, paragraph (g), clause (1), and the appropriate supervision wage in subdivision 5, paragraph (a), clause (21);

(18) combine the results of clauses (16) and (17), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (g), clause (2). This is defined as the direct staffing rate;

(19) for employee-related expenses, multiply the result of clause (18) by one plus the employee-related cost ratio in subdivision 5, paragraph (g), clause (3);

(20) this is the subtotal rate;

(21) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio; and

(22) divide the result of clause (20) by one minus the result of clause (21). This is the total payment amount~~; and~~.

~~(23) adjust the result of clauses (12) and (22) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.~~

EFFECTIVE DATE. This section is effective January 1, 2022.

Sec. 25. Minnesota Statutes 2017 Supplement, section 256B.4914, subdivision 10, is amended to read:

Subd. 10. **Updating payment values and additional information.** (a) From January 1, 2014, through December 31, 2017, the commissioner shall develop and implement uniform procedures to refine terms and adjust values used to calculate payment rates in this section.

(b) No later than July 1, 2014, the commissioner shall, within available resources, begin to conduct research and gather data and information from existing state systems or other outside sources on the following items:

(1) differences in the underlying cost to provide services and care across the state; and

(2) mileage, vehicle type, lift requirements, incidents of individual and shared rides, and units of transportation for all day services, which must be collected from providers using the rate management worksheet and entered into the rates management system; and

(3) the distinct underlying costs for services provided by a license holder under sections 245D.05, 245D.06, 245D.07, 245D.071, 245D.081, and 245D.09, and for services provided by a license holder certified under section 245D.33.

(c) Beginning January 1, 2014, through December 31, 2018, using a statistically valid set of rates management system data, the commissioner, in consultation with stakeholders, shall analyze for each service the average difference in the rate on December 31, 2013, and the framework rate at the individual, provider, lead agency, and state levels. The commissioner shall issue semiannual reports to the stakeholders on the difference in rates by service and by county during the banding period under section 256B.4913, subdivision 4a. The commissioner shall issue the first report by October 1, 2014, and the final report shall be issued by December 31, 2018.

(d) No later than July 1, 2014, the commissioner, in consultation with stakeholders, shall begin the review and evaluation of the following values already in subdivisions 6 to 9, or issues that impact all services, including, but not limited to:

(1) values for transportation rates;

(2) values for services where monitoring technology replaces staff time;

(3) values for indirect services;

(4) values for nursing;

(5) values for the facility use rate in day services, and the weightings used in the day service ratios and adjustments to those weightings;

(6) values for workers' compensation as part of employee-related expenses;

(7) values for unemployment insurance as part of employee-related expenses;

(8) any changes in state or federal law with a direct impact on the underlying cost of providing home and community-based services; ~~and~~

(9) direct care staff labor market measures; and

(10) outcome measures, determined by the commissioner, for home and community-based services rates determined under this section.

(e) The commissioner shall report to the chairs and the ranking minority members of the legislative committees and divisions with jurisdiction over health and human services policy and finance with the information and data gathered under paragraphs (b) to (d) on the following dates:

(1) January 15, 2015, with preliminary results and data;

(2) January 15, 2016, with a status implementation update, and additional data and summary information;

(3) January 15, 2017, with the full report; and

(4) January 15, 2020, with another full report, and a full report once every four years thereafter.

(f) The commissioner shall implement a regional adjustment factor to all rate calculations in subdivisions 6 to 9, effective no later than January 1, 2015. Beginning July 1, 2017, the commissioner shall renew analysis and implement changes to the regional adjustment factors when adjustments required under subdivision 5, paragraph (h), occur. Prior to implementation, the commissioner shall consult with stakeholders on the methodology to calculate the adjustment.

(g) The commissioner shall provide a public notice via LISTSERV in October of each year beginning October 1, 2014, containing information detailing legislatively approved changes in:

(1) calculation values including derived wage rates and related employee and administrative factors;

(2) service utilization;

(3) county and tribal allocation changes; and

(4) information on adjustments made to calculation values and the timing of those adjustments.

The information in this notice must be effective January 1 of the following year.

(h) When the available shared staffing hours in a residential setting are insufficient to meet the needs of an individual who enrolled in residential services after January 1, 2014, or insufficient to meet the needs of an individual with a service agreement adjustment described in section 256B.4913, subdivision 4a, paragraph (f), then individual staffing hours shall be used.

(i) The commissioner shall study the underlying cost of absence and utilization for day services. Based on the commissioner's evaluation of the data collected under this paragraph, the commissioner shall make recommendations to the legislature by January 15, 2018, for changes, if any, to the absence and utilization factor ratio component value for day services.

(j) Beginning July 1, 2017, the commissioner shall collect transportation and trip information for all day services through the rates management system.

Sec. 26. Minnesota Statutes 2017 Supplement, section 256B.4914, subdivision 10a, is amended to read:

Subd. 10a. **Reporting and analysis of cost data.** (a) The commissioner must ensure that wage values and component values in subdivisions 5 to 9 reflect the cost to provide the service. As determined by the commissioner, in consultation with stakeholders identified in section 256B.4913, subdivision 5, a provider enrolled to provide services with rates determined under this section must submit requested cost data to the commissioner to support research on the cost of providing services that have rates determined by the disability waiver rates system. Requested cost data may include, but is not limited to:

(1) worker wage costs;

(2) benefits paid;

(3) supervisor wage costs;

(4) executive wage costs;

(5) vacation, sick, and training time paid;

(6) taxes, workers' compensation, and unemployment insurance costs paid;

(7) administrative costs paid;

(8) program costs paid;

(9) transportation costs paid;

(10) vacancy rates; and

(11) other data relating to costs required to provide services requested by the commissioner.

(b) At least once in any five-year period, a provider must submit cost data for a fiscal year that ended not more than 18 months prior to the submission date. The commissioner shall provide each provider a 90-day notice prior to its submission due date. If a provider fails to submit required reporting data, the commissioner shall provide notice to providers that have not provided required data 30 days after the required submission date, and a second notice for providers who have not provided required data 60 days after the required submission date. The commissioner shall temporarily suspend payments to the provider if cost data is not received 90 days after the required submission date. Withheld payments shall be made once data is received by the commissioner.

(c) The commissioner shall conduct a random validation of data submitted under paragraph (a) to ensure data accuracy. The commissioner shall analyze cost documentation in paragraph (a) and provide recommendations for adjustments to cost components.

(d) The commissioner shall analyze cost documentation in paragraph (a) and, in consultation with stakeholders identified in section 256B.4913, subdivision 5, may submit recommendations on component values and inflationary factor adjustments to the chairs and ranking minority members of the legislative committees with jurisdiction over human services every four years beginning January 1, 2020. The commissioner shall make recommendations in conjunction with reports submitted to the legislature according to subdivision 10, paragraph (e). The commissioner shall release cost data in an aggregate form, and cost data from individual providers shall not be released except as provided for in current law.

(e) The commissioner, in consultation with stakeholders identified in section 256B.4913, subdivision 5, shall develop and implement a process for providing training and technical assistance necessary to support provider submission of cost documentation required under paragraph (a).

(f) Beginning January 1, 2019, providers enrolled to provide services with rates determined under this section shall submit labor market data to the commissioner annually, including, but not limited to:

(1) number of direct care staff;

(2) wages of direct care staff;

(3) overtime wages of direct care staff;

(4) hours worked by direct care staff;

(5) overtime hours worked by direct care staff;

(6) benefits provided to direct care staff;

(7) direct care staff job vacancies; and

(8) direct care staff retention rates.

(g) Beginning January 15, 2020, the commissioner shall publish annual reports on provider and state-level labor market data, including, but not limited to:

(1) number of direct care staff;

(2) wages of direct care staff;

(3) overtime wages of direct care staff;

(4) hours worked by direct care staff;

(5) overtime hours worked by direct care staff;

(6) benefits provided to direct care staff;

(7) direct care staff job vacancies; and

(8) direct care staff retention rates.

Sec. 27. Minnesota Statutes 2016, section 256B.5012, is amended by adding a subdivision to read:

Subd. 18. **ICF/DD rate increase effective July 1, 2018; Steele County.** Effective July 1, 2018, the daily rate for an intermediate care facility for persons with developmental disabilities located in Steele County that is classified as a class B facility and licensed for 16 beds is $400. The increase under this subdivision is in addition to any other increase that is effective on July 1, 2018.

Sec. 28. Minnesota Statutes 2016, section 256R.53, subdivision 2, is amended to read:

Subd. 2. **Nursing ~~facility~~ facilities in ~~Breckenridge~~ border cities.** The operating payment rate of a nonprofit nursing facility that exists on January 1, 2015, is located within the boundaries of the ~~city~~ cities of Breckenridge or Moorhead, and is reimbursed under this chapter, is equal to the greater of:

(1) the operating payment rate determined under section 256R.21, subdivision 3; or

(2) the median case mix adjusted rates, including comparable rate components as determined by the median case mix adjusted rates, including comparable rate components as determined by the commissioner, for the equivalent case mix indices of the nonprofit nursing facility or facilities located in an adjacent city in another state and in cities contiguous to the adjacent city. The commissioner shall make the comparison required in this subdivision on November 1 of each year and shall apply it to the rates to be effective on the following January 1. The Minnesota facility's operating payment rate with a case mix index of 1.0 is computed by dividing the adjacent city's nursing facility or facilities' median operating payment rate with an index of 1.02 by 1.02. If the adjustments under this subdivision result in a rate that exceeds the limits in section 256R.23, subdivision 5, and whose costs exceed the rate in section 256R.24, subdivision 3, in a given rate year, the facility's rate shall not be subject to the limits in section 256R.23, subdivision 5, and shall not be limited to the rate established in section 256R.24, subdivision 3, for that rate year.

EFFECTIVE DATE. The rate increases for a facility located in Moorhead are effective for the rate year beginning January 1, 2020, and annually thereafter.

Sec. 29. Laws 2014, chapter 312, article 27, section 76, is amended to read:

Sec. 76. **DISABILITY WAIVER REIMBURSEMENT RATE ADJUSTMENTS.**

~~Subdivision 1.~~ **~~Historical rate.~~** The commissioner of human services shall adjust the historical rates calculated in Minnesota Statutes, section 256B.4913, subdivision 4a, paragraph (b), in effect during the banding period under Minnesota Statutes, section 256B.4913, subdivision 4a, paragraph (a), for the reimbursement rate increases effective April 1, 2014, and any rate modification enacted during the 2014 legislative session.

~~Subd. 2. **Residential support services.** The commissioner of human services shall adjust the rates calculated in Minnesota Statutes, section 256B.4914, subdivision 6, paragraphs (b), clause (4), and (c), for the reimbursement rate increases effective April 1, 2014, and any rate modification enacted during the 2014 legislative session.~~

~~Subd. 3. **Day programs.** The commissioner of human services shall adjust the rates calculated in Minnesota Statutes, section 256B.4914, subdivision 7, paragraph (a), clauses (15) to (17), for the reimbursement rate increases effective April 1, 2014, and any rate modification enacted during the 2014 legislative session.~~

~~Subd. 4. **Unit-based services with programming.** The commissioner of human services shall adjust the rate calculated in Minnesota Statutes, section 256B.4914, subdivision 8, paragraph (a), clause (14), for the reimbursement rate increases effective April 1, 2014, and any rate modification enacted during the 2014 legislative session.~~

~~Subd. 5. **Unit-based services without programming.** The commissioner of human services shall adjust the rate calculated in Minnesota Statutes, section 256B.4914, subdivision 9, paragraph (a), clause (23), for the reimbursement rate increases effective April 1, 2014, and any rate modification enacted during the 2014 legislative session.~~

Sec. 30. Laws 2017, First Special Session chapter 6, article 3, section 49, is amended to read:

Sec. 49. **ELECTRONIC ~~SERVICE DELIVERY DOCUMENTATION SYSTEM~~ VISIT VERIFICATION.**

Subdivision 1. **Documentation; establishment.** The commissioner of human services shall establish implementation requirements and standards for ~~an~~ electronic ~~service delivery documentation system~~ visit verification to comply with the 21st Century Cures Act, Public Law 114-255. Within available appropriations, the commissioner shall take steps to comply with the electronic visit verification requirements in the 21st Century Cures Act, Public Law 114-255.

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

(b) "Electronic ~~service delivery documentation~~ visit verification" means the electronic documentation of the:

(1) type of service performed;

(2) individual receiving the service;

(3) date of the service;

(4) location of the service delivery;

(5) individual providing the service; and

(6) time the service begins and ends.

(c) "Electronic ~~service delivery documentation~~ visit verification system" means a system that provides electronic ~~service delivery documentation~~ verification of services that complies with the 21st Century Cures Act, Public Law 114-255, and the requirements of subdivision 3.

(d) "Service" means one of the following:

(1) personal care assistance services as defined in Minnesota Statutes, section 256B.0625, subdivision 19a, and provided according to Minnesota Statutes, section 256B.0659; ~~or~~

(2) community first services and supports under Minnesota Statutes, section 256B.85;

(3) home health services under Minnesota Statutes, section 256B.0625, subdivision 6a; or

(4) other medical supplies and equipment or home and community-based services that are required to be electronically verified by the 21st Century Cures Act, Public Law 114-255.

Subd. 3. **Requirements.** (a) In developing implementation requirements for ~~an~~ electronic ~~service delivery documentation system~~ visit verification, the commissioner shall ~~consider electronic visit verification systems and other electronic service delivery documentation methods. The commissioner shall convene stakeholders that will be impacted by an electronic service delivery system, including service providers and their representatives, service recipients and their representatives, and, as appropriate, those with expertise in the development and operation of an electronic service delivery documentation system, to~~ ensure that the requirements:

(1) are minimally administratively and financially burdensome to a provider;

(2) are minimally burdensome to the service recipient and the least disruptive to the service recipient in receiving and maintaining allowed services;

(3) consider existing best practices and use of electronic ~~service delivery documentation~~ visit verification;

(4) are conducted according to all state and federal laws;

(5) are effective methods for preventing fraud when balanced against the requirements of clauses (1) and (2); and

(6) are consistent with the Department of Human Services' policies related to covered services, flexibility of service use, and quality assurance.

(b) The commissioner shall make training available to providers on the electronic ~~service delivery documentation~~ visit verification system requirements.

(c) The commissioner shall establish baseline measurements related to preventing fraud and establish measures to determine the effect of electronic ~~service delivery documentation~~ visit verification requirements on program integrity.

(d) The commissioner shall make a state-selected electronic visit verification system available to providers of services.

Subd. 3a. **Provider requirements.** (a) Providers of services may select their own electronic visit verification system that meets the requirements established by the commissioner.

(b) All electronic visit verification systems used by providers to comply with the requirements established by the commissioner must provide data to the commissioner in a format and at a frequency to be established by the commissioner.

(c) Providers must implement the electronic visit verification systems required under this section by January 1, 2019, for personal care services and by January 1, 2023, for home health services in accordance with the 21st Century Cures Act, Public Law 114-255, and the Centers for Medicare and Medicaid Services guidelines. For the purposes of this paragraph, "personal care services" and "home health services" have the meanings given in United States Code, title 42, section 1396b(l)(5).

~~Subd. 4. **Legislative report.** (a) The commissioner shall submit a report by January 15, 2018, to the chairs and ranking minority members of the legislative committees with jurisdiction over human services with recommendations, based on the requirements of subdivision 3, to establish electronic service delivery documentation system requirements and standards. The report shall identify:~~

~~(1) the essential elements necessary to operationalize a base-level electronic service delivery documentation system to be implemented by January 1, 2019; and~~

~~(2) enhancements to the base-level electronic service delivery documentation system to be implemented by January 1, 2019, or after, with projected operational costs and the costs and benefits for system enhancements.~~

~~(b) The report must also identify current regulations on service providers that are either inefficient, minimally effective, or will be unnecessary with the implementation of an electronic service delivery documentation system.~~

Sec. 31. **COMPETITIVE WORKFORCE SUSTAINABILITY GRANTS.**

Subdivision 1. **Establishment; eligibility.** The commissioner of human services shall establish competitive workforce sustainability grants for providers reimbursed under Minnesota Statutes, section 256B.4914.

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

(b) "Provider" means a provider of services with rates determined under Minnesota Statutes, section 256B.4914, that has:

(1) a unique Minnesota provider identifier or national provider identifier; and

(2) revenues from unbanded services for the period beginning July 1, 2018, and ending on January 31, 2019, that are ten percent or more of its total revenues from all services with rates determined under Minnesota Statutes, section 256B.4914, for that same period.

(c) "Unbanded services" means services with rates determined under Minnesota Statutes, section 256B.4914, that are not banded under Minnesota Statutes, section 256B.4913.

Subd. 3. **Applications.** Eligible providers must apply to the commissioner of human services on the forms and according to the timelines established by the commissioner.

Subd. 4. **Grant awards.** The commissioner may award grants in an amount up to 7.1 percent of the total revenues generated from unbanded services delivered by a provider during the period beginning July 1, 2018, and ending January 31, 2019.

Sec. 32. **DIRECTION TO COMMISSIONER; PRESCRIBED PEDIATRIC EXTENDED CARE.**

No later than August 15, 2018, the commissioner of human services shall submit to the federal Centers for Medicare and Medicaid Services any medical assistance state plan amendments necessary to cover prescribed pediatric extended care center basic services according to Minnesota Statutes, section 256B.0625, subdivision 65.

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

Sec. 33. **DIRECTION TO COMMISSIONER; BI AND CADI WAIVER CUSTOMIZED LIVING SERVICES PROVIDER LOCATED IN HENNEPIN COUNTY.**

(a) The commissioner of human services shall allow a housing with services establishment located in Minneapolis that provides customized living and 24-hour customized living

services for clients enrolled in the brain injury (BI) or community access for disability inclusion (CADI) waiver and had a capacity to serve 66 clients as of July 1, 2017, to transfer service capacity of up to 66 clients to no more than three new housing with services establishments located in Hennepin County.

(b) Notwithstanding Minnesota Statutes, section 256B.492, the commissioner shall determine the new housing with services establishments described under paragraph (a) meet the BI and CADI waiver customized living and 24-hour customized living size limitation exception for clients receiving those services at the new housing with services establishments described under paragraph (a).

Sec. 34. **DIRECTION TO COMMISSIONER; HOME AND COMMUNITY-BASED SERVICES FEDERAL WAIVER SUBMISSION.**

No later than July 1, 2018, the commissioner of human services shall submit to the federal Centers for Medicare and Medicaid services any home and community-based services waivers necessary to implement the changes to the disability waiver rate system under Minnesota Statutes, sections 256B.4913 and 256B.4914. The priorities for submittal to the federal Centers for Medicare and Medicaid services are as follows:

(1) first priority for submittal are the changes related to the transition to the new employment services and the establishment of the competitive workforce factor; and

(2) second priority for submittal are the changes related to the inflationary adjustments, removal of the regional variance factor, and changes to the reporting requirements.

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

Sec. 35. **REVISOR'S INSTRUCTION.**

The revisor of statutes shall codify Laws 2017, First Special Session chapter 6, article 3, section 49, as amended in this article, in Minnesota Statutes, chapter 256B.

Sec. 36. **REPEALER.**

Minnesota Statutes 2016, section 256B.0705, is repealed.

EFFECTIVE DATE. This section is effective January 1, 2019.

ARTICLE 6

PROTECTIONS FOR OLDER ADULTS AND VULNERABLE ADULTS

Section 1. **CITATION.**

Sections 1 to 61 may be cited as the "Vulnerable Adult Maltreatment Prevention and Accountability Act of 2018."

Sec. 2. Minnesota Statutes 2016, section 144.6501, subdivision 3, is amended to read:

Subd. 3. **Contracts of admission.** (a) A facility shall make complete unsigned copies of its admission contract available to potential applicants and to the state or local long-term care ombudsman immediately upon request.

(b) A facility shall post conspicuously within the facility, in a location accessible to public view, either a complete copy of its admission contract or notice of its availability from the facility.

(c) An admission contract must be printed in black type of at least ten-point type size. The facility shall give a complete copy of the admission contract to the resident or the resident's legal representative promptly after it has been signed by the resident or legal representative.

(d) The admission contract must contain the name, address, and contact information of the current owner, manager, and if different from the owner, license holder of the facility, and the name and physical mailing address of at least one natural person who is authorized to accept service of process.

~~(d)~~ (e) An admission contract is a consumer contract under sections 325G.29 to 325G.37.

~~(e)~~ (f) All admission contracts must state in bold capital letters the following notice to applicants for admission: "NOTICE TO APPLICANTS FOR ADMISSION. READ YOUR ADMISSION CONTRACT. ORAL STATEMENTS OR COMMENTS MADE BY THE FACILITY OR YOU OR YOUR REPRESENTATIVE ARE NOT PART OF YOUR ADMISSION CONTRACT UNLESS THEY ARE ALSO IN WRITING. DO NOT RELY ON ORAL STATEMENTS OR COMMENTS THAT ARE NOT INCLUDED IN THE WRITTEN ADMISSION CONTRACT."

Sec. 3. Minnesota Statutes 2016, section 144.6501, is amended by adding a subdivision to read:

Subd. 3a. **Changes to contracts of admission.** Within 30 days of a change in ownership, management, or license holder, the facility must provide prompt written notice to the resident or resident's legal representative of a new owner, manager, and if different from the owner, license holder of the facility, and the name and physical mailing address of any new or

additional natural person not identified in the admission contract who is newly authorized to accept service of process.

Sec. 4. Minnesota Statutes 2016, section 144.651, subdivision 1, is amended to read:

Subdivision 1. **Legislative intent.** It is the intent of the legislature and the purpose of this section to promote the interests and well being of the patients and residents of health care facilities. It is the intent of this section that every patient's and resident's civil and religious liberties, including the right to independent personal decisions and knowledge of available choices, must not be infringed and that the facility must encourage and assist in the fullest possible exercise of these rights. The rights provided under this section are established for the benefit of patients and residents. No health care facility may require or request a patient or resident to waive any of these rights at any time or for any reason including as a condition of admission to the facility. Any guardian or conservator of a patient or resident or, in the absence of a guardian or conservator, an interested person, may seek enforcement of these rights on behalf of a patient or resident. An interested person may also seek enforcement of these rights on behalf of a patient or resident who has a guardian or conservator through administrative agencies or in district court having jurisdiction over guardianships and conservatorships. Pending the outcome of an enforcement proceeding the health care facility may, in good faith, comply with the instructions of a guardian or conservator. ~~It is the intent of this section that every patient's civil and religious liberties, including the right to independent personal decisions and knowledge of available choices, shall not be infringed and that the facility shall encourage and assist in the fullest possible exercise of these rights.~~

Sec. 5. Minnesota Statutes 2016, section 144.651, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) For the purposes of this section and section 144.6511, the terms defined in this subdivision have the meanings given them.

(b) "Patient" means:

(1) a person who is admitted to an acute care inpatient facility for a continuous period longer than 24 hours, for the purpose of diagnosis or treatment bearing on the physical or mental health of that person~~.~~;

(2) a minor who is admitted to a residential program as defined in section 253C.01;

(3) for purposes of subdivisions 1, 4 to 9, 12, 13, 15, 16, and 18 to 20, ~~"patient" also means~~ a person who receives health care services at an outpatient surgical center or at a

birth center licensed under section 144.615~~. "Patient" also means a minor who is admitted to a residential program as defined in section 253C.01.~~; and

(4) for purposes of subdivisions 1, 3 to 16, 18, 20 and 30, ~~"patient" also means~~ any person who is receiving mental health treatment on an outpatient basis or in a community support program or other community-based program.

(c) "Resident" means a person who is admitted to:

(1) a nonacute care facility including extended care facilities~~,~~;

(2) a nursing ~~homes, and~~ home;

(3) a boarding care ~~homes~~ home for care required because of prolonged mental or physical illness or disability, recovery from injury or disease, or advancing age~~.~~; and

(4) for purposes of ~~all subdivisions except~~ subdivisions ~~28 and 29, "resident" also means a person who is admitted to~~ 1 to 27 and 30 to 33, a facility licensed as a board and lodging facility under Minnesota Rules, ~~parts 4625.0100 to 4625.2355~~ chapter 4625, or a supervised living facility under Minnesota Rules, ~~parts 4665.0100 to 4665.9900~~ chapter 4665, and which operates a rehabilitation program licensed under Minnesota Rules, parts ~~9530.6405~~ 9530.6510 to 9530.6590.

(d) "Health care facility" or "facility" means:

(1) an acute care inpatient facility;

(2) a residential program as defined in section 253C.01;

(3) for purposes of subdivisions 1, 4 to 9, 12, 13, 15, 16, and 18 to 20, an outpatient surgical center or a birth center licensed under section 144.615;

(4) for purposes of subdivisions 1, 3 to 16, 18, 20, and 30, a setting in which outpatient mental health services are provided, or a community support program or other community-based program providing mental health treatment;

(5) a nonacute care facility, including extended care facilities;

(6) a nursing home;

(7) a boarding care home for care required because of prolonged mental or physical illness or disability, recovery from injury or disease, or advancing age; or

(8) for the purposes of subdivisions 1 to 27 and 30 to 33, a facility licensed as a board and lodging facility under Minnesota Rules, parts 4625.0100 to 4625.2355, or a supervised

living facility under Minnesota Rules, parts 4665.0100 to 4665.9900, and which operates a rehabilitation program licensed under Minnesota Rules, parts 9530.6510 to 9530.6590.

Sec. 6. Minnesota Statutes 2016, section 144.651, subdivision 4, is amended to read:

Subd. 4. **Information about rights.** (a) Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement in plain language and in terms patients and residents can understand of the applicable rights and responsibilities set forth in this section. The written statement must be developed by the commissioner, in consultation with stakeholders, and must also include the name, address, and telephone number of the state or county agency to contact for additional information or assistance. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs.

(b) Reasonable accommodations shall be made for people who have communication disabilities and those who speak a language other than English.

(c) Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults.

Sec. 7. Minnesota Statutes 2016, section 144.651, subdivision 14, is amended to read:

Subd. 14. **Freedom from maltreatment.** (a) Patients and residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and nontherapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Patients and residents shall receive notification from the lead investigative agency regarding a report of alleged maltreatment, disposition of a report, and appeal rights, as provided under section 626.557, subdivision 9c.

(b) Every patient and resident shall also be free from nontherapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing

after examination by a patient's or resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others.

Sec. 8. Minnesota Statutes 2016, section 144.651, subdivision 16, is amended to read:

Subd. 16. **Confidentiality of records.** Patients and residents shall be assured confidential treatment of their personal, financial, and medical records, and may approve or refuse their release to any individual outside the facility. Residents shall be notified when personal records are requested by any individual outside the facility and may select someone to accompany them when the records or information are the subject of a personal interview. Patients and residents have a right to access their own records and written information from those records. Copies of records and written information from the records shall be made available in accordance with this subdivision and sections 144.291 to 144.298. This right does not apply to complaint investigations and inspections by the Department of Health, where required by third-party payment contracts, or where otherwise provided by law.

Sec. 9. Minnesota Statutes 2016, section 144.651, subdivision 20, is amended to read:

Subd. 20. **Grievances.** (a) Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances, assert the rights granted under this section personally, and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, retaliation, or reprisal, including threat of discharge. ~~Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place.~~

(b) The facility must investigate and attempt resolution of the complaint or grievance. The patient or resident has the right to be informed of the name of the individual who is responsible for handling grievances.

(c) Notice must be posted in a conspicuous place of the facility's or program's grievance procedure, as well as telephone numbers and, where applicable, addresses for the common entry point, as defined in section 626.5572, subdivision 5, the protection and advocacy agency, and the area ombudsman for long-term care pursuant to the Older Americans Act, section 307(a)(12).

(d) Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people

that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure.

Sec. 10. Minnesota Statutes 2016, section 144.651, subdivision 21, is amended to read:

Subd. 21. **Communication privacy.** Patients and residents may associate and communicate privately with persons of their choice and enter and, except as provided by the Minnesota Commitment Act, leave the facility as they choose. Patients and residents shall have access, at their own expense, unless provided by the facility, to writing instruments, stationery, ~~and~~ postage, and Internet service. Personal mail shall be sent without interference and received unopened unless medically or programmatically contraindicated and documented by the physician in the medical record. There shall be access to a telephone where patients and residents can make and receive calls as well as speak privately. Facilities which are unable to provide a private area shall make reasonable arrangements to accommodate the privacy of patients' or residents' calls. Upon admission to a facility where federal law prohibits unauthorized disclosure of patient or resident identifying information to callers and visitors, the patient or resident, or the legal guardian or conservator of the patient or resident, shall be given the opportunity to authorize disclosure of the patient's or resident's presence in the facility to callers and visitors who may seek to communicate with the patient or resident. To the extent possible, the legal guardian or conservator of a patient or resident shall consider the opinions of the patient or resident regarding the disclosure of the patient's or resident's presence in the facility. This right is limited where medically inadvisable, as documented by the attending physician in a patient's or resident's care record. Where programmatically limited by a facility abuse prevention plan pursuant to section 626.557, subdivision 14, paragraph (b), this right shall also be limited accordingly.

Sec. 11. **[144.6511] CONSUMER TRANSPARENCY.**

(a) Deceptive marketing and business practices are prohibited.

(b) For the purposes of this section, it is a deceptive practice for a facility to:

(1) make any false, fraudulent, deceptive, or misleading statements in marketing, advertising, or written description or representation of care or services, whether in written or electronic form;

(2) arrange for or provide health care or services other than those contracted for;

(3) fail to deliver any care or services the provider or facility promised that the facility was able to provide;

(4) fail to inform the patient or resident in writing of any limitations to care services available prior to executing a contract for admission;

(5) fail to fulfill a written promise that the facility shall continue the same services and the same lease terms if a private pay resident converts to the elderly waiver program;

(6) fail to disclose in writing the purpose of a nonrefundable community fee or other fee prior to contracting for services with a patient or resident;

(7) advertise or represent, in writing, that the facility is or has a special care unit, such as for dementia or memory care, without complying with training and disclosure requirements under sections 144D.065 and 325F.72, and any other applicable law; or

(8) define the terms "facility," "contract of admission," "admission contract," "admission agreement," "legal representative," or "responsible party" to mean anything other than the meanings of those terms under section 144.6501.

Sec. 12. Minnesota Statutes 2016, section 144A.10, subdivision 1, is amended to read:

Subdivision 1. **Enforcement authority.** The commissioner of health is the exclusive state agency charged with the responsibility and duty of inspecting all facilities required to be licensed under section 144A.02, and issuing correction orders and imposing fines as provided in this section, Minnesota Rules, chapter 4658, or any other applicable law. The commissioner of health shall enforce the rules established pursuant to sections 144A.01 to 144A.155, subject only to the authority of the Department of Public Safety respecting the enforcement of fire and safety standards in nursing homes and the responsibility of the commissioner of human services under sections 245A.01 to 245A.16 or 252.28.

The commissioner may request and must be given access to relevant information, records, incident reports, or other documents in the possession of a licensed facility if the commissioner considers them necessary for the discharge of responsibilities. For the purposes of inspections and securing information to determine compliance with the licensure laws and rules, the commissioner need not present a release, waiver, or consent of the individual.

A facility's refusal to cooperate in providing lawfully requested information is grounds for a correction order or fine. The identities of patients or residents must be kept private as defined by section 13.02, subdivision 12.

Sec. 13. Minnesota Statutes 2017 Supplement, section 144A.10, subdivision 4, is amended to read:

Subd. 4. **Correction orders.** Whenever a duly authorized representative of the commissioner of health finds upon inspection of a nursing home, that the facility or a controlling person or an employee of the facility is not in compliance with sections 144.411 to 144.417, 144.651, 144.6503, 144A.01 to 144A.155, or 626.557 or the rules promulgated thereunder, a correction order shall be issued to the facility. The correction order shall state the deficiency, cite the specific rule or statute violated, state the suggested method of correction, and specify the time allowed for correction. Upon receipt of a correction order, a facility shall develop and submit to the commissioner a corrective action plan based on the correction order. The corrective action plan must specify the steps the facility will take to correct the violation and to prevent such violations in the future, how the facility will monitor its compliance with the corrective action plan, and when the facility plans to complete the steps in the corrective action plan. The commissioner is presumed to accept a corrective action plan unless the commissioner notifies the submitting facility that the plan is not accepted within 15 calendar days after the plan is submitted to the commissioner. The commissioner shall monitor the facility's compliance with the corrective action plan. If the commissioner finds that the nursing home had uncorrected or repeated violations which create a risk to resident care, safety, or rights, the commissioner shall notify the commissioner of human services.

Sec. 14. Minnesota Statutes 2016, section 144A.44, subdivision 1, is amended to read:

Subdivision 1. **Statement of rights.** A person who receives home care services has these rights:

(1) the right to receive written information about rights before receiving services, including what to do if rights are violated;

(2) the right to receive care and services according to a suitable and up-to-date plan, and subject to accepted health care, medical or nursing standards, to take an active part in developing, modifying, and evaluating the plan and services;

(3) the right to be told before receiving services the type and disciplines of staff who will be providing the services, the frequency of visits proposed to be furnished, other choices

that are available for addressing home care needs, and the potential consequences of refusing these services;

(4) the right to be told in advance of any recommended changes by the provider in the service plan and to take an active part in any decisions about changes to the service plan;

(5) the right to refuse services or treatment;

(6) the right to know, before receiving services or during the initial visit, any limits to the services available from a home care provider;

(7) the right to be told before services are initiated what the provider charges for the services; to what extent payment may be expected from health insurance, public programs, or other sources, if known; and what charges the client may be responsible for paying;

(8) the right to know that there may be other services available in the community, including other home care services and providers, and to know where to find information about these services;

(9) the right to choose freely among available providers and to change providers after services have begun, within the limits of health insurance, long-term care insurance, medical assistance, or other health programs;

(10) the right to have personal, financial, and medical information kept private, and to be advised of the provider's policies and procedures regarding disclosure of such information;

(11) the right to access the client's own records and written information from those records in accordance with sections 144.291 to 144.298;

(12) the right to be served by people who are properly trained and competent to perform their duties;

(13) the right to be treated with courtesy and respect, and to have the client's property treated with respect;

(14) the right to be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act;

(15) the right to reasonable, advance notice of changes in services or charges;

(16) the right to know the provider's reason for termination of services;

(17) the right to at least ten days' advance notice of the termination of a service by a provider, except in cases where:

(i) the client engages in conduct that significantly alters the terms of the service plan with the home care provider;

(ii) the client, person who lives with the client, or others create an abusive or unsafe work environment for the person providing home care services; or

(iii) an emergency or a significant change in the client's condition has resulted in service needs that exceed the current service plan and that cannot be safely met by the home care provider;

(18) the right to a coordinated transfer when there will be a change in the provider of services;

(19) the right to complain about services that are provided, or fail to be provided, and the lack of courtesy or respect to the client or the client's property;

(20) the right to recommend changes in policies and services to the home care provider, provider staff, and others of the person's choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of termination of services;

~~(20)~~ (21) the right to know how to contact an individual associated with the home care provider who is responsible for handling problems and to have the home care provider investigate and attempt to resolve the grievance or complaint;

~~(21)~~ (22) the right to know the name and address of the state or county agency to contact for additional information or assistance; and

~~(22)~~ (23) the right to assert these rights personally, or have them asserted by the client's representative or by anyone on behalf of the client, without retaliation.

Sec. 15. Minnesota Statutes 2016, section 144A.442, is amended to read:

144A.442 ~~ASSISTED LIVING CLIENTS; SERVICE~~ ARRANGED HOME CARE PROVIDER RESPONSIBILITIES; TERMINATION OF SERVICES.

Subdivision 1. **Contents of service termination notice.** If an arranged home care provider, as defined in section 144D.01, subdivision 2a, who is not also Medicare certified terminates a service agreement or service plan with an assisted living client, as defined in section 144G.01, subdivision 3, the home care provider shall provide the assisted living client and the legal or designated representatives of the client, if any, with a written notice of termination ~~which~~ that includes the following information:

(1) the effective date of termination;

(2) the reason for termination;

(3) without extending the termination notice period, an affirmative offer to meet with the assisted living client or client representatives within no more than five business days of the date of the termination notice to discuss the termination;

(4) contact information for a reasonable number of other home care providers in the geographic area of the assisted living client, as required by section 144A.4791, subdivision 10;

(5) a statement that the provider will participate in a coordinated transfer of the care of the client to another provider or caregiver, as required by section 144A.44, subdivision 1, clause (18);

(6) the name and contact information of a representative of the home care provider with whom the client may discuss the notice of termination;

(7) a copy of the home care bill of rights; and

(8) a statement that the notice of termination of home care services by the home care provider does not constitute notice of termination of the housing with services contract with a housing with services establishment.

Subd. 2. **Discontinuation of services.** An arranged home care provider's responsibilities when voluntarily discontinuing services to all clients are governed by section 144A.4791, subdivision 10.

Sec. 16. Minnesota Statutes 2016, section 144A.45, subdivision 1, is amended to read:

Subdivision 1. **Regulations.** The commissioner shall regulate home care providers pursuant to sections 144A.43 to 144A.482. The regulations shall include the following:

(1) provisions to assure, to the extent possible, the health, safety, well-being, and appropriate treatment of persons who receive home care services while respecting a client's autonomy and choice;

(2) requirements that home care providers furnish the commissioner with specified information necessary to implement sections 144A.43 to 144A.482;

(3) standards of training of home care provider personnel;

(4) standards for provision of home care services;

(5) standards for medication management;

(6) standards for supervision of home care services;

(7) standards for client evaluation or assessment;

(8) requirements for the involvement of a client's health care provider, the documentation of health care providers' orders, if required, and the client's service plan;

(9) standards for the maintenance of accurate, current client records;

(10) the establishment of basic and comprehensive levels of licenses based on services provided; and

(11) provisions to enforce these regulations and the home care bill of rights, including provisions for issuing penalties and fines as allowed under law.

Sec. 17. Minnesota Statutes 2016, section 144A.45, subdivision 2, is amended to read:

Subd. 2. **Regulatory functions.** The commissioner shall:

(1) license, survey, and monitor without advance notice, home care providers in accordance with sections 144A.43 to 144A.482;

(2) survey every temporary licensee within one year of the temporary license issuance date subject to the temporary licensee providing home care services to a client or clients;

(3) survey all licensed home care providers on an interval that will promote the health and safety of clients;

(4) with the consent of the client, visit the home where services are being provided;

(5) issue correction orders and assess civil penalties in accordance with ~~section~~ sections 144.653, subdivisions 5 to 8, 144A.474, and 144A.475, for violations of sections 144A.43 to 144A.482;

(6) take action as authorized in section 144A.475; and

(7) take other action reasonably required to accomplish the purposes of sections 144A.43 to 144A.482.

Sec. 18. Minnesota Statutes 2016, section 144A.473, subdivision 2, is amended to read:

Subd. 2. **Temporary license.** (a) For new license applicants, the commissioner shall issue a temporary license for either the basic or comprehensive home care level. A temporary license is effective for up to one year from the date of issuance. Temporary licensees must comply with sections 144A.43 to 144A.482.

(b) During the temporary license ~~year~~ period, the commissioner shall survey the temporary licensee within 90 calendar days after the commissioner is notified or has evidence that the temporary licensee is providing home care services.

(c) Within five days of beginning the provision of services, the temporary licensee must notify the commissioner that it is serving clients. The notification to the commissioner may be mailed or e-mailed to the commissioner at the address provided by the commissioner. If the temporary licensee does not provide home care services during the temporary license ~~year~~ period, then the temporary license expires at the end of the ~~year~~ period and the applicant must reapply for a temporary home care license.

(d) A temporary licensee may request a change in the level of licensure prior to being surveyed and granted a license by notifying the commissioner in writing and providing additional documentation or materials required to update or complete the changed temporary license application. The applicant must pay the difference between the application fees when changing from the basic level to the comprehensive level of licensure. No refund will be made if the provider chooses to change the license application to the basic level.

(e) If the temporary licensee notifies the commissioner that the licensee has clients within 45 days prior to the temporary license expiration, the commissioner may extend the temporary license for up to 60 days in order to allow the commissioner to complete the on-site survey required under this section and follow-up survey visits.

Sec. 19. Minnesota Statutes 2016, section 144A.474, subdivision 2, is amended to read:

Subd. 2. **Types of home care surveys.** (a) "Initial full survey" means the survey of a new temporary licensee conducted after the department is notified or has evidence that the temporary licensee is providing home care services to determine if the provider is in compliance with home care requirements. Initial full surveys must be completed within 14 months after the department's issuance of a temporary basic or comprehensive license.

(b) "Change in ownership survey" means a full survey of a new licensee due to a change in ownership. Change in ownership surveys must be completed within six months after the department's issuance of a new license due to a change in ownership.

~~(b)~~ (c) "Core survey" means periodic inspection of home care providers to determine ongoing compliance with the home care requirements, focusing on the essential health and safety requirements. Core surveys are available to licensed home care providers who have been licensed for three years and surveyed at least once in the past three years with the latest survey having no widespread violations beyond Level 1 as provided in subdivision 11.

Providers must also not have had any substantiated licensing complaints, substantiated complaints against the agency under the Vulnerable Adults Act or Maltreatment of Minors Act, or an enforcement action as authorized in section 144A.475 in the past three years.

(1) The core survey for basic home care providers must review compliance in the following areas:

(i) reporting of maltreatment;

(ii) orientation to and implementation of the home care bill of rights;

(iii) statement of home care services;

(iv) initial evaluation of clients and initiation of services;

(v) client review and monitoring;

(vi) service plan implementation and changes to the service plan;

(vii) client complaint and investigative process;

(viii) competency of unlicensed personnel; and

(ix) infection control.

(2) For comprehensive home care providers, the core survey must include everything in the basic core survey plus these areas:

(i) delegation to unlicensed personnel;

(ii) assessment, monitoring, and reassessment of clients; and

(iii) medication, treatment, and therapy management.

~~(c)~~ (d) "Full survey" means the periodic inspection of home care providers to determine ongoing compliance with the home care requirements that cover the core survey areas and all the legal requirements for home care providers. A full survey is conducted for all temporary licensees and for providers who do not meet the requirements needed for a core survey, and when a surveyor identifies unacceptable client health or safety risks during a core survey. A full survey must include all the tasks identified as part of the core survey and any additional review deemed necessary by the department, including additional observation, interviewing, or records review of additional clients and staff.

~~(d)~~ (e) "Follow-up surveys" means surveys conducted to determine if a home care provider has corrected deficient issues and systems identified during a core survey, full survey, or complaint investigation. Follow-up surveys may be conducted via phone, e-mail, fax, mail, or on-site reviews. Follow-up surveys, other than complaint surveys, shall be

concluded with an exit conference and written information provided on the process for requesting a reconsideration of the survey results.

~~(e)~~ (f) Upon receiving information alleging that a home care provider has violated or is currently violating a requirement of sections 144A.43 to 144A.482, the commissioner shall investigate the complaint according to sections 144A.51 to 144A.54.

Sec. 20. Minnesota Statutes 2016, section 144A.474, subdivision 8, is amended to read:

Subd. 8. **Correction orders.** (a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a home care provider, a managerial official, or an employee of the provider is not in compliance with sections 144A.43 to 144A.482. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction.

(b) The commissioner shall mail copies of any correction order to the last known address of the home care provider, or electronically scan the correction order and e-mail it to the last known home care provider e-mail address, within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the home care provider, and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically.

(c) By the correction order date, the home care provider must ~~document in the provider's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the home care provider's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed~~ develop and submit to the commissioner a corrective action plan based on the correction order. The corrective action plan must specify the steps the provider will take to comply with the correction order and how to prevent noncompliance in the future, how the provider will monitor its compliance with the corrective action plan, and when the provider plans to complete the steps in the corrective action plan. The commissioner is presumed to accept a corrective action plan unless the commissioner notifies the submitting home care provider that the plan is not accepted within 15 calendar days after the plan is submitted to the commissioner. The commissioner shall monitor the provider's compliance with the corrective action plan.

Sec. 21. Minnesota Statutes 2016, section 144A.474, subdivision 9, is amended to read:

Subd. 9. **Follow-up surveys.** For providers that have Level 3 or Level 4 violations under subdivision 11, or any violations determined to be widespread, the department shall conduct

a follow-up survey within 90 calendar days of the survey. When conducting a follow-up survey, the surveyor will focus on whether the previous violations have been corrected and may also address any new violations that are observed while evaluating the corrections that have been made. If a new violation is identified on a follow-up survey, ~~no fine will be imposed unless it is not corrected on the next follow-up survey~~ the surveyor shall issue a correction order for the new violation and may impose an immediate fine for the new violation.

Sec. 22. Minnesota Statutes 2017 Supplement, section 144A.474, subdivision 11, is amended to read:

Subd. 11. **Fines.** (a) Fines and enforcement actions under this subdivision may be assessed based on the level and scope of the violations described in paragraph (c) as follows:

(1) Level 1, no fines or enforcement;

(2) Level 2, fines ranging from $0 to $500, in addition to any of the enforcement mechanisms authorized in section 144A.475 for widespread violations;

(3) Level 3, fines ranging from $500 to $1,000, in addition to any of the enforcement mechanisms authorized in section 144A.475; and

(4) Level 4, fines ranging from $1,000 to $5,000, in addition to any of the enforcement mechanisms authorized in section 144A.475.

(b) Correction orders for violations are categorized by both level and scope and fines shall be assessed as follows:

(1) level of violation:

(i) Level 1 is a violation that has no potential to cause more than a minimal impact on the client and does not affect health or safety;

(ii) Level 2 is a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death;

(iii) Level 3 is a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death; and

(iv) Level 4 is a violation that results in serious injury, impairment, or death.

(2) scope of violation:

(i) isolated, when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally;

(ii) pattern, when more than a limited number of clients are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly but is not found to be pervasive; and

(iii) widespread, when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the clients.

(c) If the commissioner finds that the applicant or a home care provider required to be licensed under sections 144A.43 to 144A.482 has not corrected violations by the date specified in the correction order or conditional license resulting from a survey or complaint investigation, the commissioner may impose ~~a~~ an additional fine for noncompliance with a correction order. A notice of noncompliance with a correction order must be mailed to the applicant's or provider's last known address. The ~~noncompliance~~ notice of noncompliance with a correction order must list the violations not corrected and any fines imposed.

(d) The license holder must pay the fines assessed on or before the payment date specified on a correction order or on a notice of noncompliance with a correction order. If the license holder fails to ~~fully comply with the order~~ pay a fine by the specified date, the commissioner may issue a ~~second~~ late payment fine or suspend the license until the license holder ~~complies by paying the fine~~ pays all outstanding fines. A timely appeal shall stay payment of the late payment fine until the commissioner issues a final order.

(e) A license holder shall promptly notify the commissioner in writing when a violation specified in ~~the order~~ a notice of noncompliance with a correction order is corrected. If upon reinspection the commissioner determines that a violation has not been corrected as indicated by the ~~order~~ notice of noncompliance with a correction order, the commissioner may issue ~~a second~~ an additional fine for noncompliance with a notice of noncompliance with a correction order. The commissioner shall notify the license holder by mail to the last known address in the licensing record that ~~a second~~ an additional fine has been assessed. The license holder may appeal the ~~second~~ additional fine as provided under this subdivision.

(f) A home care provider that has been assessed a fine under this subdivision or subdivision 8 has a right to a reconsideration or a hearing under this section and chapter 14.

(g) When a fine has been assessed, the license holder may not avoid payment by closing, selling, or otherwise transferring the licensed program to a third party. In such an event, the license holder shall be liable for payment of the fine.

(h) In addition to any fine imposed under this section, the commissioner may assess costs related to an investigation that results in a final order assessing a fine or other enforcement action authorized by this chapter.

(i) Fines collected under this subdivision shall be deposited in the state government special revenue fund and credited to an account separate from the revenue collected under section 144A.472. Subject to an appropriation by the legislature, the revenue from the fines collected must be used by the commissioner for special projects to improve home care in Minnesota as recommended by the advisory council established in section 144A.4799.

Sec. 23. Minnesota Statutes 2016, section 144A.4791, subdivision 10, is amended to read:

Subd. 10. **Termination of service plan.** (a) Except as provided in section 144A.442, if a home care provider terminates a service plan with a client, and the client continues to need home care services, the home care provider shall provide the client and the client's representative, if any, with a written notice of termination which includes the following information:

(1) the effective date of termination;

(2) the reason for termination;

(3) a list of known licensed home care providers in the client's immediate geographic area;

(4) a statement that the home care provider will participate in a coordinated transfer of care of the client to another home care provider, health care provider, or caregiver, as required by the home care bill of rights, section 144A.44, subdivision 1, clause (17);

(5) the name and contact information of a person employed by the home care provider with whom the client may discuss the notice of termination; and

(6) if applicable, a statement that the notice of termination of home care services does not constitute notice of termination of the housing with services contract with a housing with services establishment.

(b) When the home care provider voluntarily discontinues services to all clients, the home care provider must notify the commissioner, lead agencies, and ombudsman for long-term care about its clients and comply with the requirements in this subdivision.

Sec. 24. Minnesota Statutes 2016, section 144A.53, subdivision 1, is amended to read:

Subdivision 1. **Powers.** The director may:

(a) Promulgate by rule, pursuant to chapter 14, and within the limits set forth in subdivision 2, the methods by which complaints against health facilities, health care providers, home care providers, or residential care homes, or administrative agencies are to be made, reviewed, investigated, and acted upon; provided, however, that a fee may not be charged for filing a complaint.

(b) Recommend legislation and changes in rules to the state commissioner of health, governor, administrative agencies or the federal government.

(c) Investigate, upon a complaint or upon initiative of the director, any action or failure to act by a health care provider, home care provider, residential care home, or a health facility.

(d) Request and receive access to relevant information, records, incident reports, or documents in the possession of an administrative agency, a health care provider, a home care provider, a residential care home, or a health facility, and issue investigative subpoenas to individuals and facilities for oral information and written information, including privileged information which the director deems necessary for the discharge of responsibilities. For purposes of investigation and securing information to determine violations, the director need not present a release, waiver, or consent of an individual. The identities of patients or residents must be kept private as defined by section 13.02, subdivision 12.

(e) Enter and inspect, at any time, a health facility or residential care home and be permitted to interview staff; provided that the director shall not unduly interfere with or disturb the provision of care and services within the facility or home or the activities of a patient or resident unless the patient or resident consents.

(f) Issue correction orders and assess civil fines pursuant to ~~section~~ sections 144.653, 144A.10, 144A.45, and 144A.474; Minnesota Rules, chapters 4655, 4658, 4664, and 4665; or any other law ~~which~~ or rule that provides for the issuance of correction orders or fines to health facilities, residential care homes, or home care ~~provider, or under section 144A.45~~ providers. This authority includes the authority to issue correction orders and assess civil fines for violations identified in the appeal or review process. A health facility's, residential care home's, or ~~home's~~ home care provider's refusal to cooperate in providing lawfully requested information may also be grounds for a correction order or fine.

(g) Recommend the certification or decertification of health facilities pursuant to Title XVIII or XIX of the United States Social Security Act.

(h) Assist patients or residents of health facilities or residential care homes in the enforcement of their rights under Minnesota law.

(i) Work with administrative agencies, health facilities, home care providers, residential care homes, and health care providers and organizations representing consumers on programs designed to provide information about health facilities to the public and to health facility residents.

Sec. 25. Minnesota Statutes 2016, section 144A.53, subdivision 4, is amended to read:

Subd. 4. **Referral of complaints.** (a) If a complaint received by the director relates to a matter more properly within the jurisdiction of law enforcement, an occupational licensing board, or other governmental agency, the director shall forward the complaint ~~to that agency~~ appropriately and shall inform the complaining party of the forwarding. ~~The~~

(b) An agency shall promptly act in respect to the complaint, and shall inform the complaining party and the director of its disposition. If a governmental agency receives a complaint which is more properly within the jurisdiction of the director, it shall promptly forward the complaint to the director, and shall inform the complaining party of the forwarding.

(c) If the director has reason to believe that an official or employee of an administrative agency, a home care provider, residential care home, ~~or~~ health facility, or a client or resident of any of these entities has acted in a manner warranting criminal or disciplinary proceedings, the director shall refer the matter to the state commissioner of health, the commissioner of human services, an appropriate prosecuting authority, or other appropriate agency.

Sec. 26. Minnesota Statutes 2016, section 144A.53, is amended by adding a subdivision to read:

Subd. 5. **Safety and quality improvement technical panel.** The director shall establish an expert technical panel to examine and make recommendations, on an ongoing basis, on how to apply proven safety and quality improvement practices and infrastructure to settings and providers that provide long-term services and supports. The technical panel must include representation from nonprofit Minnesota-based organizations dedicated to patient safety or innovation in health care safety and quality, Department of Health staff with expertise in issues related to adverse health events, the University of Minnesota, organizations representing long-term care providers and home care providers in Minnesota, national patient safety experts, and other experts in the safety and quality improvement field. The technical panel shall periodically provide recommendations to the legislature on legislative changes needed to promote safety and quality improvement practices in long-term care settings and with long-term care providers.

Sec. 27. Minnesota Statutes 2016, section 144A.53, is amended by adding a subdivision to read:

Subd. 6. **Training and operations panel.** (a) The director shall establish a training and operations panel within the Office of Health Facility Complaints to examine and make recommendations, on an ongoing basis, on continual improvements to the operation of the office. The training and operations panel shall be composed of office staff, including investigators and intake and triage staff, one or more representatives of the commissioner's office, and employees from any other divisions in the Department of Health with relevant knowledge or expertise. The training and operations panel may also consult with employees from other agencies in state government with relevant knowledge or expertise.

(b) The training and operations panel shall examine and make recommendations to the director and the commissioner regarding introducing or refining office systems, procedures, and staff training in order to improve office and staff efficiency; enhance communications between the office, health care facilities, home care providers, and residents or clients; and provide for appropriate, effective protection for vulnerable adults through rigorous investigations and enforcement of laws. Panel duties include but are not limited to:

(1) developing the office's training processes to adequately prepare and support investigators in performing their duties;

(2) developing clear, consistent internal policies for conducting investigations as required by federal law, including policies to ensure staff meet the deadlines in state and federal laws for triaging, investigating, and making final dispositions of cases involving maltreatment, and procedures for notifying the vulnerable adult, reporter, and facility of any delays in investigations; communicating these policies to staff in a clear, timely manner; and developing procedures to evaluate and modify these internal policies on an ongoing basis;

(3) developing and refining quality control measures for the intake and triage processes, through such practices as reviewing a random sample of the triage decisions made in case reports or auditing a random sample of the case files to ensure the proper information is being collected, the files are being properly maintained, and consistent triage and investigations determinations are being made;

(4) developing and maintaining systems and procedures to accurately determine the situations in which the office has jurisdiction over a maltreatment allegation;

(5) developing and maintaining audit procedures for investigations to ensure investigators obtain and document information necessary to support decisions;

(6) developing and maintaining procedures to, following a maltreatment determination, clearly communicate the appeal or review rights of all parties upon final disposition;

(7) continuously upgrading the information on and utility of the office's Web site through such steps as providing clear, detailed information about the appeal or review rights of vulnerable adults, alleged perpetrators, and providers and facilities; and

(8) publishing, in coordination with other areas at the Department of Health and in a manner that does not duplicate information already published by the Department of Health, the public portions of all investigation memoranda prepared by the commissioner of health in the past three years under section 626.557, subdivision 12b, and the public portions of all final orders in the past three years related to licensing violations under this chapter. These memoranda and orders must be published in a manner that allows consumers to search memoranda and orders by facility or provider name and by the physical location of the facility or provider.

Sec. 28. Minnesota Statutes 2016, section 144D.01, subdivision 1, is amended to read:

Subdivision 1. **Scope.** As used in ~~sections 144D.01 to 144D.06~~ this chapter, the following terms have the meanings given them.

Sec. 29. Minnesota Statutes 2016, section 144D.02, is amended to read:

144D.02 REGISTRATION REQUIRED.

No entity may establish, operate, conduct, or maintain a housing with services establishment in this state without registering and operating as required in sections 144D.01 to ~~144D.06~~ 144D.11.

Sec. 30. Minnesota Statutes 2017 Supplement, section 144D.04, subdivision 2, is amended to read:

Subd. 2. **Contents of contract.** A housing with services contract, which need not be entitled as such to comply with this section, shall include at least the following elements in itself or through supporting documents or attachments:

(1) the name, street address, and mailing address of the establishment;

(2) the name and mailing address of the owner or owners of the establishment and, if the owner or owners is not a natural person, identification of the type of business entity of the owner or owners;

(3) the name and mailing address of the managing agent, through management agreement or lease agreement, of the establishment, if different from the owner or owners;

(4) the name and physical mailing address of at least one natural person who is authorized to accept service of process on behalf of the owner or owners and managing agent;

(5) a statement describing the registration and licensure status of the establishment and any provider providing health-related or supportive services under an arrangement with the establishment;

(6) the term of the contract;

(7) a description of the services to be provided to the resident in the base rate to be paid by the resident, including a delineation of the portion of the base rate that constitutes rent and a delineation of charges for each service included in the base rate;

(8) a description of any additional services, including home care services, available for an additional fee from the establishment directly or through arrangements with the establishment, and a schedule of fees charged for these services;

(9) a conspicuous notice informing the tenant of the policy concerning the conditions under which and the process through which the contract may be modified, amended, or terminated, including whether a move to a different room or sharing a room would be required in the event that the tenant can no longer pay the current rent;

(10) a description of the establishment's complaint resolution process available to residents including the toll-free complaint line for the Office of Ombudsman for Long-Term Care;

(11) the resident's designated representative, if any;

(12) the establishment's referral procedures if the contract is terminated;

(13) requirements of residency used by the establishment to determine who may reside or continue to reside in the housing with services establishment;

(14) billing and payment procedures and requirements;

(15) a statement regarding the ability of a resident to receive services from service providers with whom the establishment does not have an arrangement;

(16) a statement regarding the availability of public funds for payment for residence or services in the establishment; ~~and~~

(17) a statement regarding the availability of and contact information for long-term care consultation services under section 256B.0911 in the county in which the establishment is located;

(18) a statement that a resident has the right to request a reasonable accommodation; and

(19) a statement describing the conditions under which a contract may be amended.

Sec. 31. Minnesota Statutes 2016, section 144D.04, is amended by adding a subdivision to read:

Subd. 2b. **Changes to contract.** The housing with services establishment must provide prompt written notice to the resident or resident's legal representative of a new owner or manager of the housing with services establishment, and the name and physical mailing address of any new or additional natural person not identified in the admission contract who is authorized to accept service of process.

Sec. 32. **[144D.044] INFORMATION REQUIRED TO BE POSTED.**

A housing with services establishment must post conspicuously within the establishment, in a location accessible to public view, the following information:

(1) the name, mailing address, and contact information of the current owner or owners of the establishment and, if the owner or owners are not natural persons, identification of the type of business entity of the owner or owners;

(2) the name, mailing address, and contact information of the managing agent, through management agreement or lease agreement, of the establishment, if different from the owner or owners, and the name and contact information of the on-site manager, if any; and

(3) the name and mailing address of at least one natural person who is authorized to accept service of process on behalf of the owner or owners and managing agent.

Sec. 33. **[144D.095] TERMINATION OF SERVICES.**

A termination of services initiated by an arranged home care provider is governed by section 144A.442.

Sec. 34. Minnesota Statutes 2016, section 144G.01, subdivision 1, is amended to read:

Subdivision 1. **Scope; other definitions.** For purposes of sections 144G.01 to ~~144G.05~~ 144G.08, the following definitions apply. In addition, the definitions provided in section 144D.01 also apply to sections 144G.01 to ~~144G.05~~ 144G.08.

Sec. 35. **[144G.07] TERMINATION OF LEASE.**

A lease termination initiated by a registered housing with services establishment using "assisted living" is governed by section 144D.09.

Sec. 36. **[144G.08] TERMINATION OF SERVICES.**

A termination of services initiated by an arranged home care provider as defined in section 144D.01, subdivision 2a, is governed by section 144A.442.

Sec. 37. Minnesota Statutes 2017 Supplement, section 256.045, subdivision 3, is amended to read:

Subd. 3. **State agency hearings.** (a) State agency hearings are available for the following:

(1) any person applying for, receiving or having received public assistance, medical care, or a program of social services granted by the state agency or a county agency or the federal Food Stamp Act whose application for assistance is denied, not acted upon with reasonable promptness, or whose assistance is suspended, reduced, terminated, or claimed to have been incorrectly paid;

(2) any patient or relative aggrieved by an order of the commissioner under section 252.27;

(3) a party aggrieved by a ruling of a prepaid health plan;

(4) except as provided under chapter 245C~~,~~:

(i) any individual or facility determined by a lead investigative agency to have maltreated a vulnerable adult under section 626.557 after they have exercised their right to administrative reconsideration under section 626.557; and

(ii) any vulnerable adult who is the subject of a maltreatment investigation under section 626.557 or a guardian or health care agent of the vulnerable adult, after the right to administrative reconsideration under section 626.557, subdivision 9d, has been exercised;

(5) any person whose claim for foster care payment according to a placement of the child resulting from a child protection assessment under section 626.556 is denied or not acted upon with reasonable promptness, regardless of funding source;

(6) any person to whom a right of appeal according to this section is given by other provision of law;

(7) an applicant aggrieved by an adverse decision to an application for a hardship waiver under section 256B.15;

(8) an applicant aggrieved by an adverse decision to an application or redetermination for a Medicare Part D prescription drug subsidy under section 256B.04, subdivision 4a;

(9) except as provided under chapter 245A, an individual or facility determined to have maltreated a minor under section 626.556, after the individual or facility has exercised the right to administrative reconsideration under section 626.556;

(10) except as provided under chapter 245C, an individual disqualified under sections 245C.14 and 245C.15, following a reconsideration decision issued under section 245C.23, on the basis of serious or recurring maltreatment; a preponderance of the evidence that the individual has committed an act or acts that meet the definition of any of the crimes listed in section 245C.15, subdivisions 1 to 4; or for failing to make reports required under section 626.556, subdivision 3, or 626.557, subdivision 3. Hearings regarding a maltreatment determination under clause (4) or (9) and a disqualification under this clause in which the basis for a disqualification is serious or recurring maltreatment, shall be consolidated into a single fair hearing. In such cases, the scope of review by the human services judge shall include both the maltreatment determination and the disqualification. The failure to exercise the right to an administrative reconsideration shall not be a bar to a hearing under this section if federal law provides an individual the right to a hearing to dispute a finding of maltreatment;

(11) any person with an outstanding debt resulting from receipt of public assistance, medical care, or the federal Food Stamp Act who is contesting a setoff claim by the Department of Human Services or a county agency. The scope of the appeal is the validity of the claimant agency's intention to request a setoff of a refund under chapter 270A against the debt;

(12) a person issued a notice of service termination under section 245D.10, subdivision 3a, from residential supports and services as defined in section 245D.03, subdivision 1, paragraph (c), clause (3), that is not otherwise subject to appeal under subdivision 4a;

(13) an individual disability waiver recipient based on a denial of a request for a rate exception under section 256B.4914; or

(14) a person issued a notice of service termination under section 245A.11, subdivision 11, that is not otherwise subject to appeal under subdivision 4a.

(b) The hearing for an individual or facility under paragraph (a), clause (4), (9), or (10), is the only administrative appeal to the final agency determination specifically, including a challenge to the accuracy and completeness of data under section 13.04. Hearings requested under paragraph (a), clause (4), apply only to incidents of maltreatment that occur on or after October 1, 1995. Hearings requested by nursing assistants in nursing homes alleged to have maltreated a resident prior to October 1, 1995, shall be held as a contested case proceeding under the provisions of chapter 14. Hearings requested under paragraph (a), clause (9), apply only to incidents of maltreatment that occur on or after July 1, 1997. A hearing for an individual or facility under paragraph (a), clauses (4), (9), and (10), is only available when there is no district court action pending. If such action is filed in district court while an administrative review is pending that arises out of some or all of the events or circumstances on which the appeal is based, the administrative review must be suspended until the judicial actions are completed. If the district court proceedings are completed, dismissed, or overturned, the matter may be considered in an administrative hearing.

(c) For purposes of this section, bargaining unit grievance procedures are not an administrative appeal.

(d) The scope of hearings involving claims to foster care payments under paragraph (a), clause (5), shall be limited to the issue of whether the county is legally responsible for a child's placement under court order or voluntary placement agreement and, if so, the correct amount of foster care payment to be made on the child's behalf and shall not include review of the propriety of the county's child protection determination or child placement decision.

(e) The scope of hearings under paragraph (a), clauses (12) and (14), shall be limited to whether the proposed termination of services is authorized under section 245D.10, subdivision 3a, paragraph (b), or 245A.11, subdivision 11, and whether the requirements of section 245D.10, subdivision 3a, paragraphs (c) to (e), or 245A.11, subdivision 2a, paragraphs (d) to (f), were met. If the appeal includes a request for a temporary stay of termination of services, the scope of the hearing shall also include whether the case management provider has finalized arrangements for a residential facility, a program, or services that will meet the assessed needs of the recipient by the effective date of the service termination.

(f) A vendor of medical care as defined in section 256B.02, subdivision 7, or a vendor under contract with a county agency to provide social services is not a party and may not request a hearing under this section, except if assisting a recipient as provided in subdivision 4.

(g) An applicant or recipient is not entitled to receive social services beyond the services prescribed under chapter 256M or other social services the person is eligible for under state law.

(h) The commissioner may summarily affirm the county or state agency's proposed action without a hearing when the sole issue is an automatic change due to a change in state or federal law.

(i) Unless federal or Minnesota law specifies a different time frame in which to file an appeal, an individual or organization specified in this section may contest the specified action, decision, or final disposition before the state agency by submitting a written request for a hearing to the state agency within 30 days after receiving written notice of the action, decision, or final disposition, or within 90 days of such written notice if the applicant, recipient, patient, or relative shows good cause, as defined in section 256.0451, subdivision 13, why the request was not submitted within the 30-day time limit. The individual filing the appeal has the burden of proving good cause by a preponderance of the evidence.

Sec. 38. Minnesota Statutes 2017 Supplement, section 256.045, subdivision 4, is amended to read:

Subd. 4. **Conduct of hearings.** (a) All hearings held pursuant to subdivision 3, 3a, 3b, or 4a shall be conducted according to the provisions of the federal Social Security Act and the regulations implemented in accordance with that act to enable this state to qualify for federal grants-in-aid, and according to the rules and written policies of the commissioner of human services. County agencies shall install equipment necessary to conduct telephone hearings. A state human services judge may schedule a telephone conference hearing when the distance or time required to travel to the county agency offices will cause a delay in the issuance of an order, or to promote efficiency, or at the mutual request of the parties. Hearings may be conducted by telephone conferences unless the applicant, recipient, former recipient, person, or facility contesting maltreatment objects. A human services judge may grant a request for a hearing in person by holding the hearing by interactive video technology or in person. The human services judge must hear the case in person if the person asserts that either the person or a witness has a physical or mental disability that would impair the person's or witness's ability to fully participate in a hearing held by interactive video

technology. The hearing shall not be held earlier than five days after filing of the required notice with the county or state agency. The state human services judge shall notify all interested persons of the time, date, and location of the hearing at least five days before the date of the hearing. Interested persons may be represented by legal counsel or other representative of their choice, including a provider of therapy services, at the hearing and may appear personally, testify and offer evidence, and examine and cross-examine witnesses. The applicant, recipient, former recipient, person, or facility contesting maltreatment shall have the opportunity to examine the contents of the case file and all documents and records to be used by the county or state agency at the hearing at a reasonable time before the date of the hearing and during the hearing. In hearings under subdivision 3, paragraph (a), clauses (4), (9), and (10), either party may subpoena the private data relating to the investigation prepared by the agency under section 626.556 or 626.557 that is not otherwise accessible under section 13.04, provided the identity of the reporter may not be disclosed.

(b) The private data obtained by subpoena in a hearing under subdivision 3, paragraph (a), clause (4), (9), or (10), must be subject to a protective order which prohibits its disclosure for any other purpose outside the hearing provided for in this section without prior order of the district court. Disclosure without court order is punishable by a sentence of not more than 90 days imprisonment or a fine of not more than $1,000, or both. These restrictions on the use of private data do not prohibit access to the data under section 13.03, subdivision 6. Except for appeals under subdivision 3, paragraph (a), clauses (4), (5), (9), and (10), upon request, the county agency shall provide reimbursement for transportation, child care, photocopying, medical assessment, witness fee, and other necessary and reasonable costs incurred by the applicant, recipient, or former recipient in connection with the appeal. All evidence, except that privileged by law, commonly accepted by reasonable people in the conduct of their affairs as having probative value with respect to the issues shall be submitted at the hearing and such hearing shall not be "a contested case" within the meaning of section 14.02, subdivision 3. The agency must present its evidence prior to or at the hearing, and may not submit evidence after the hearing except by agreement of the parties at the hearing, provided the petitioner has the opportunity to respond.

(c) In hearings under subdivision 3, paragraph (a), clauses (4), (9), and (10), involving determinations of maltreatment or disqualification made by more than one county agency, by a county agency and a state agency, or by more than one state agency, the hearings may be consolidated into a single fair hearing upon the consent of all parties and the state human services judge.

(d) For hearings under subdivision 3, paragraph (a), clause (4) or (10), involving a vulnerable adult, the human services judge shall notify the vulnerable adult who is the subject of the maltreatment determination and, if known, a guardian of the vulnerable adult appointed under section 524.5-310, or a health care agent designated by the vulnerable adult in a health care directive that is currently effective under section 145C.06 and whose authority to make health care decisions is not suspended under section 524.5-310, of the hearing and shall notify the facility or individual who is the alleged perpetrator of maltreatment. The notice must be sent by certified mail and inform the vulnerable adult or the alleged perpetrator of the right to file a signed written statement in the proceedings. A guardian or health care agent who prepares or files a written statement for the vulnerable adult must indicate in the statement that the person is the vulnerable adult's guardian or health care agent and sign the statement in that capacity. The vulnerable adult, the guardian, or the health care agent may file a written statement with the human services judge hearing the case no later than five business days before commencement of the hearing. The human services judge shall include the written statement in the hearing record and consider the statement in deciding the appeal. This subdivision does not limit, prevent, or excuse the vulnerable adult or alleged perpetrator from being called as a witness testifying at the hearing or grant the vulnerable adult, the guardian, or health care agent a right to participate in the proceedings or appeal the human services judge's decision in the case. The lead investigative agency must consider including the vulnerable adult victim of maltreatment as a witness in the hearing. If the lead investigative agency determines that participation in the hearing would endanger the well-being of the vulnerable adult or not be in the best interests of the vulnerable adult, the lead investigative agency shall inform the human services judge of the basis for this determination, which must be included in the final order. If the human services judge is not reasonably able to determine the address of the vulnerable adult, the guardian, the alleged perpetrator, or the health care agent, the human services judge is not required to send a hearing notice under this subdivision.

Sec. 39. Minnesota Statutes 2016, section 325F.71, is amended to read:

325F.71 SENIOR CITIZENS, VULNERABLE ADULTS, AND ~~DISABLED~~ PERSONS WITH DISABILITIES; ADDITIONAL CIVIL PENALTY FOR DECEPTIVE ACTS.

Subdivision 1. **Definitions.** For the purposes of this section, the following words have the meanings given them:

(a) "Senior citizen" means a person who is 62 years of age or older.

(b) "~~Disabled~~ Person with a disability" means a person who has an impairment of physical or mental function or emotional status that substantially limits one or more major life activities.

(c) "Major life activities" means functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

(d) "Vulnerable adult" has the meaning given in section 626.5572, subdivision 21.

Subd. 2. **Supplemental civil penalty.** (a) In addition to any liability for a civil penalty pursuant to sections 325D.43 to 325D.48, regarding deceptive trade practices; 325F.67, regarding false advertising; and 325F.68 to 325F.70, regarding consumer fraud; a person who engages in any conduct prohibited by those statutes, and whose conduct is perpetrated against one or more senior citizens, vulnerable adults, or ~~disabled~~ persons with a disability, is liable for an additional civil penalty not to exceed $10,000 for each violation, if one or more of the factors in paragraph (b) are present.

(b) In determining whether to impose a civil penalty pursuant to paragraph (a), and the amount of the penalty, the court shall consider, in addition to other appropriate factors, the extent to which one or more of the following factors are present:

(1) whether the defendant knew or should have known that the defendant's conduct was directed to one or more senior citizens, vulnerable adults, or ~~disabled~~ persons with a disability;

(2) whether the defendant's conduct caused one or more senior citizens, vulnerable adults, or ~~disabled~~ persons with a disability to suffer: loss or encumbrance of a primary residence, principal employment, or source of income; substantial loss of property set aside for retirement or for personal or family care and maintenance; substantial loss of payments received under a pension or retirement plan or a government benefits program; or assets essential to the health or welfare of the senior citizen, vulnerable adult, or ~~disabled~~ person with a disability;

(3) whether one or more senior citizens, vulnerable adults, or ~~disabled~~ persons with a disability are more vulnerable to the defendant's conduct than other members of the public because of age, poor health or infirmity, impaired understanding, restricted mobility, or disability, and actually suffered physical, emotional, or economic damage resulting from the defendant's conduct; or

(4) whether the defendant's conduct caused senior citizens, vulnerable adults, or ~~disabled~~ persons with a disability to make an uncompensated asset transfer that resulted in the person being found ineligible for medical assistance.

Subd. 3. **Restitution to be given priority.** Restitution ordered pursuant to the statutes listed in subdivision 2 shall be given priority over imposition of civil penalties designated by the court under this section.

Subd. 4. **Private remedies.** A person injured by a violation of this section may bring a civil action and recover damages, together with costs and disbursements, including costs of investigation and reasonable attorney's fees, and receive other equitable relief as determined by the court.

Sec. 40. Minnesota Statutes 2016, section 609.2231, subdivision 8, is amended to read:

Subd. 8. **Vulnerable adults.** (a) As used in this subdivision, "vulnerable adult" has the meaning given in section 609.232, subdivision 11.

(b) Whoever assaults ~~and inflicts demonstrable bodily harm on~~ a vulnerable adult, knowing or having reason to know that the person is a vulnerable adult, is guilty of a gross misdemeanor.

Sec. 41. Minnesota Statutes 2016, section 626.557, subdivision 3, is amended to read:

Subd. 3. **Timing of report.** (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall ~~immediately~~ report the information to the common entry point as soon as possible but in no event longer than 24 hours. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless:

(1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or

(2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4).

(b) A person not required to report under the provisions of this section may voluntarily report as described above.

(c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.

(d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.

(e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c.

Sec. 42. Minnesota Statutes 2016, section 626.557, subdivision 4, is amended to read:

Subd. 4. **Reporting.** (a) Except as provided in paragraph (b), a mandated reporter shall immediately make an oral report to the common entry point. The common entry point may accept electronic reports submitted through a Web-based reporting system established by the commissioner. Use of a telecommunications device for the deaf or other similar device shall be considered an oral report. The common entry point may not require written reports. To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment, any evidence of previous maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment. The common entry point must provide a method for the reporter to electronically submit evidence to support the maltreatment report, including but not limited to uploading photographs, videos, or documents. A mandated reporter may disclose not public data, as defined in section 13.02, and medical records under sections 144.291 to 144.298, to the extent necessary to comply with this subdivision.

(b) A boarding care home that is licensed under sections 144.50 to 144.58 and certified under Title 19 of the Social Security Act, a nursing home that is licensed under section 144A.02 and certified under Title 18 or Title 19 of the Social Security Act, or a hospital that is licensed under sections 144.50 to 144.58 and has swing beds certified under Code

of Federal Regulations, title 42, section 482.66, may submit a report electronically to the common entry point instead of submitting an oral report. ~~The report may be a duplicate of the initial report the facility submits electronically to the commissioner of health to comply with the reporting requirements under Code of Federal Regulations, title 42, section 483.13.~~ The commissioner of health may modify these reporting requirements to include items required under paragraph (a) that are not currently included in the electronic reporting form.

(c) All reports must be directed to the common entry point, including reports from federally licensed facilities, vulnerable adults, and interested persons.

Sec. 43. Minnesota Statutes 2016, section 626.557, subdivision 9, is amended to read:

Subd. 9. **Common entry point designation.** (a) Each county board shall designate a common entry point for reports of suspected maltreatment, for use until the commissioner of human services establishes a common entry point. Two or more county boards may jointly designate a single common entry point. The commissioner of human services shall establish a common entry point effective July 1, 2015. The common entry point is the unit responsible for receiving the report of suspected maltreatment under this section.

(b) The common entry point must be available 24 hours per day to take calls from reporters of suspected maltreatment. The common entry point staff must receive training on how to screen and dispatch reports efficiently and in accordance with this section. The common entry point shall use a standard intake form that includes:

(1) the time and date of the report;

(2) the name, address, and telephone number of the person reporting;

(3) the time, date, and location of the incident;

(4) the names of the persons involved, including but not limited to, perpetrators, alleged victims, and witnesses;

(5) whether there was a risk of imminent danger to the alleged victim;

(6) a description of the suspected maltreatment;

(7) the disability, if any, of the alleged victim;

(8) the relationship of the alleged perpetrator to the alleged victim;

(9) whether a facility was involved and, if so, which agency licenses the facility;

(10) any action taken by the common entry point;

(11) whether law enforcement has been notified;

(12) whether the reporter wishes to receive notification of the initial and final reports; and

(13) if the report is from a facility with an internal reporting procedure, the name, mailing address, and telephone number of the person who initiated the report internally.

(c) The common entry point is not required to complete each item on the form prior to dispatching the report to the appropriate lead investigative agency.

(d) The common entry point shall immediately report to a law enforcement agency any incident in which there is reason to believe a crime has been committed.

(e) If a report is initially made to a law enforcement agency or a lead investigative agency, those agencies shall take the report on the appropriate common entry point intake forms and immediately forward a copy to the common entry point.

(f) The common entry point ~~staff~~ must ~~receive training on how to screen and dispatch reports efficiently and in accordance with this section.~~ cross-reference multiple complaints to the lead investigative agency concerning:

(1) the same alleged perpetrator, facility, or licensee;

(2) the same vulnerable adult; or

(3) the same incident.

(g) The commissioner of human services shall maintain a centralized database for the collection of common entry point data, lead investigative agency data including maltreatment report disposition, and appeals data. The common entry point shall have access to the centralized database and must log the reports into the database and immediately identify and locate prior reports of abuse, neglect, or exploitation.

(h) When appropriate, the common entry point staff must refer calls that do not allege the abuse, neglect, or exploitation of a vulnerable adult to other organizations that might resolve the reporter's concerns.

(i) A common entry point must be operated in a manner that enables the commissioner of human services to:

(1) track critical steps in the reporting, evaluation, referral, response, disposition, and investigative process to ensure compliance with all requirements for all reports;

(2) maintain data to facilitate the production of aggregate statistical reports for monitoring patterns of abuse, neglect, or exploitation;

(3) serve as a resource for the evaluation, management, and planning of preventative and remedial services for vulnerable adults who have been subject to abuse, neglect, or exploitation;

(4) set standards, priorities, and policies to maximize the efficiency and effectiveness of the common entry point; and

(5) track and manage consumer complaints related to the common entry point~~.~~, including tracking and cross-referencing multiple complaints concerning:

(i) the same alleged perpetrator, facility, or licensee;

(ii) the same vulnerable adult; and

(iii) the same incident.

(j) The commissioners of human services and health shall collaborate on the creation of a system for referring reports to the lead investigative agencies. This system shall enable the commissioner of human services to track critical steps in the reporting, evaluation, referral, response, disposition, investigation, notification, determination, and appeal processes.

Sec. 44. Minnesota Statutes 2016, section 626.557, subdivision 9a, is amended to read:

Subd. 9a. **Evaluation and referral of reports made to common entry point.** (a) The common entry point must screen the reports of alleged or suspected maltreatment for immediate risk and make all necessary referrals as follows:

(1) if the common entry point determines that there is an immediate need for emergency adult protective services, the common entry point agency shall immediately notify the appropriate county agency;

(2) if the common entry point determines an immediate need exists for response by law enforcement, including the urgent need to secure a crime scene, interview witnesses, remove the alleged perpetrator, or safeguard the vulnerable adult's property, or if the report contains suspected criminal activity against a vulnerable adult, the common entry point shall immediately notify the appropriate law enforcement agency;

(3) the common entry point shall refer all reports of alleged or suspected maltreatment to the appropriate lead investigative agency as soon as possible, but in any event no longer than two working days;

(4) if the report contains information about a suspicious death, the common entry point shall immediately notify the appropriate law enforcement agencies, the local medical examiner, and the ombudsman for mental health and developmental disabilities established

under section 245.92. Law enforcement agencies shall coordinate with the local medical examiner and the ombudsman as provided by law; and

(5) for reports involving multiple locations or changing circumstances, the common entry point shall determine the county agency responsible for emergency adult protective services and the county responsible as the lead investigative agency, using referral guidelines established by the commissioner.

(b) If the lead investigative agency receiving a report believes the report was referred by the common entry point in error, the lead investigative agency shall immediately notify the common entry point of the error, including the basis for the lead investigative agency's belief that the referral was made in error. The common entry point shall review the information submitted by the lead investigative agency and immediately refer the report to the appropriate lead investigative agency.

Sec. 45. Minnesota Statutes 2016, section 626.557, subdivision 9b, is amended to read:

Subd. 9b. **Response to reports.** Law enforcement is the primary agency to conduct investigations of any incident in which there is reason to believe a crime has been committed. Law enforcement shall initiate a response immediately. If the common entry point notified a county agency for emergency adult protective services, law enforcement shall cooperate with that county agency when both agencies are involved and shall exchange data to the extent authorized in subdivision 12b, paragraph ~~(g)~~ (k). County adult protection shall initiate a response immediately. Each lead investigative agency shall complete the investigative process for reports within its jurisdiction. A lead investigative agency, county, adult protective agency, licensed facility, or law enforcement agency shall cooperate with other agencies in the provision of protective services, coordinating its investigations, and assisting another agency within the limits of its resources and expertise and shall exchange data to the extent authorized in subdivision 12b, paragraph ~~(g)~~ (k). The lead investigative agency shall obtain the results of any investigation conducted by law enforcement officials, and law enforcement shall obtain the results of any investigation conducted by the lead investigative agency to determine if criminal action is warranted. The lead investigative agency has the right to enter facilities and inspect and copy records as part of investigations. The lead investigative agency has access to not public data, as defined in section 13.02, and medical records under sections 144.291 to 144.298, that are maintained by facilities to the extent necessary to conduct its investigation. Each lead investigative agency shall develop guidelines for prioritizing reports for investigation. Nothing in this subdivision alters the duty of the lead

investigative agency to serve as the agency responsible for investigating reports made under this section.

Sec. 46. Minnesota Statutes 2016, section 626.557, subdivision 9c, is amended to read:

Subd. 9c. **Lead investigative agency; notifications, dispositions, determinations.** (a) ~~Upon request of the reporter,~~ The lead investigative agency shall notify the reporter that it has received the report, and provide information on the initial disposition of the report within five business days of receipt of the report, provided that the notification will not endanger the vulnerable adult or hamper the investigation.

(b) The lead investigative agency must provide the following information to the vulnerable adult or the vulnerable adult's guardian or health care agent, if known, within five days of receipt of the report:

(1) the nature of the maltreatment allegations, including the report of maltreatment as allowed under law;

(2) the name of the facility or other location at which alleged maltreatment occurred;

(3) the name of the alleged perpetrator if the lead investigative agency believes disclosure of the name is necessary to protect the vulnerable adult's physical, emotional, or financial interests;

(4) protective measures that may be recommended or taken as a result of the maltreatment report;

(5) contact information for the investigator or other information as requested and allowed under law; and

(6) confirmation of whether the lead investigative agency is investigating the matter and, if so:

(i) an explanation of the process and estimated timeline for the investigation; and

(ii) a statement that the lead investigative agency will provide an update on the investigation approximately every three weeks upon request by the vulnerable adult or the vulnerable adult's guardian or health care agent and a report when the investigation is concluded.

(c) The lead investigative agency may assign multiple reports of maltreatment for the same or separate incidences related to the same vulnerable adult to the same investigator, as deemed appropriate. Reports related to the same vulnerable adult must, at a minimum, be cross-referenced.

~~(b)~~ (d) Upon conclusion of every investigation it conducts, the lead investigative agency shall make a final disposition as defined in section 626.5572, subdivision 8.

~~(c)~~ (e) When determining whether the facility or individual is the responsible party for substantiated maltreatment or whether both the facility and the individual are responsible for substantiated maltreatment, the lead investigative agency shall consider at least the following mitigating factors:

(1) whether the actions of the facility or the individual caregivers were in accordance with, and followed the terms of, an erroneous physician order, prescription, resident care plan, or directive. This is not a mitigating factor when the facility or caregiver is responsible for the issuance of the erroneous order, prescription, plan, or directive or knows or should have known of the errors and took no reasonable measures to correct the defect before administering care;

(2) the comparative responsibility between the facility, other caregivers, and requirements placed upon the employee, including but not limited to, the facility's compliance with related regulatory standards and factors such as the adequacy of facility policies and procedures, the adequacy of facility training, the adequacy of an individual's participation in the training, the adequacy of caregiver supervision, the adequacy of facility staffing levels, and a consideration of the scope of the individual employee's authority; and

(3) whether the facility or individual followed professional standards in exercising professional judgment.

~~(d)~~ (f) When substantiated maltreatment is determined to have been committed by an individual who is also the facility license holder, both the individual and the facility must be determined responsible for the maltreatment, and both the background study disqualification standards under section 245C.15, subdivision 4, and the licensing actions under section 245A.06 or 245A.07 apply.

~~(e)~~ (g) The lead investigative agency shall complete its final disposition within 60 calendar days. If the lead investigative agency is unable to complete its final disposition within 60 calendar days, the lead investigative agency shall notify the following persons provided that the notification will not endanger the vulnerable adult or hamper the investigation: (1) the vulnerable adult or the vulnerable adult's guardian or health care agent, when known, if the lead investigative agency knows them to be aware of the investigation; and (2) the facility, where applicable. The notice shall contain the reason for the delay and the projected completion date. If the lead investigative agency is unable to complete its final disposition by a subsequent projected completion date, the lead investigative agency shall

again notify the vulnerable adult or the vulnerable adult's guardian or health care agent, when known if the lead investigative agency knows them to be aware of the investigation, and the facility, where applicable, of the reason for the delay and the revised projected completion date provided that the notification will not endanger the vulnerable adult or hamper the investigation. The lead investigative agency must notify the health care agent of the vulnerable adult only if the health care agent's authority to make health care decisions for the vulnerable adult is currently effective ~~under section 145C.06~~ and not suspended under section 524.5-310 ~~and the investigation relates to a duty assigned to the health care agent by the principal~~. A lead investigative agency's inability to complete the final disposition within 60 calendar days or by any projected completion date does not invalidate the final disposition.

~~(f)~~ (h) Within ten calendar days of completing the final disposition, the lead investigative agency shall provide a copy of the public investigation memorandum under subdivision 12b, paragraph ~~(b), clause (1)~~ (d), when required to be completed under this section, to the following persons:

(1) the vulnerable adult, or the vulnerable adult's guardian or health care agent, if known, unless the lead investigative agency knows that the notification would endanger the well-being of the vulnerable adult;

(2) the reporter, ~~if~~ unless the reporter requested ~~notification~~ otherwise when making the report, provided this notification would not endanger the well-being of the vulnerable adult;

(3) the alleged perpetrator, if known;

(4) the facility; ~~and~~

(5) the ombudsman for long-term care, or the ombudsman for mental health and developmental disabilities, as appropriate;

(6) law enforcement; and

(7) the county attorney, as appropriate.

~~(g)~~ (i) If, as a result of a reconsideration, review, or hearing, the lead investigative agency changes the final disposition, or if a final disposition is changed on appeal, the lead investigative agency shall notify the parties specified in paragraph ~~(f)~~ (h).

~~(h)~~ (j) The lead investigative agency shall notify the vulnerable adult who is the subject of the report or the vulnerable adult's guardian or health care agent, if known, and any person or facility determined to have maltreated a vulnerable adult, of their appeal or review rights under this section or section ~~256.021~~ 256.045.

~~(i)~~ (k) The lead investigative agency shall routinely provide investigation memoranda for substantiated reports to the appropriate licensing boards. These reports must include the names of substantiated perpetrators. The lead investigative agency may not provide investigative memoranda for inconclusive or false reports to the appropriate licensing boards unless the lead investigative agency's investigation gives reason to believe that there may have been a violation of the applicable professional practice laws. If the investigation memorandum is provided to a licensing board, the subject of the investigation memorandum shall be notified and receive a summary of the investigative findings.

~~(j)~~ (l) In order to avoid duplication, licensing boards shall consider the findings of the lead investigative agency in their investigations if they choose to investigate. This does not preclude licensing boards from considering other information.

~~(k)~~ (m) The lead investigative agency must provide to the commissioner of human services its final dispositions, including the names of all substantiated perpetrators. The commissioner of human services shall establish records to retain the names of substantiated perpetrators.

Sec. 47. Minnesota Statutes 2016, section 626.557, subdivision 9d, is amended to read:

Subd. 9d. **Administrative reconsideration; review panel.** (a) Except as provided under paragraph (e), any individual or facility which a lead investigative agency determines has maltreated a vulnerable adult, or the vulnerable adult or an interested person acting on behalf of the vulnerable adult, regardless of the lead investigative agency's determination, who contests the lead investigative agency's final disposition of an allegation of maltreatment, may request the lead investigative agency to reconsider its final disposition. The request for reconsideration must be submitted in writing to the lead investigative agency within 15 calendar days after receipt of notice of final disposition or, if the request is made by an interested person who is not entitled to notice, within 15 days after receipt of the notice by the vulnerable adult or the vulnerable adult's guardian or health care agent. If mailed, the request for reconsideration must be postmarked and sent to the lead investigative agency within 15 calendar days of the individual's or facility's receipt of the final disposition. If the request for reconsideration is made by personal service, it must be received by the lead investigative agency within 15 calendar days of the individual's or facility's receipt of the final disposition. An individual who was determined to have maltreated a vulnerable adult under this section and who was disqualified on the basis of serious or recurring maltreatment under sections 245C.14 and 245C.15, may request reconsideration of the maltreatment determination and the disqualification. The request for reconsideration of the maltreatment

determination and the disqualification must be submitted in writing within 30 calendar days of the individual's receipt of the notice of disqualification under sections 245C.16 and 245C.17. If mailed, the request for reconsideration of the maltreatment determination and the disqualification must be postmarked and sent to the lead investigative agency within 30 calendar days of the individual's receipt of the notice of disqualification. If the request for reconsideration is made by personal service, it must be received by the lead investigative agency within 30 calendar days after the individual's receipt of the notice of disqualification.

(b) Except as provided under paragraphs (e) and (f), if the lead investigative agency denies the request or fails to act upon the request within 15 working days after receiving the request for reconsideration, the person or facility entitled to a fair hearing under section 256.045, may submit to the commissioner of human services a written request for a hearing under that statute. ~~The vulnerable adult, or an interested person acting on behalf of the vulnerable adult, may request a review by the Vulnerable Adult Maltreatment Review Panel under section 256.021 if the lead investigative agency denies the request or fails to act upon the request, or if the vulnerable adult or interested person contests a reconsidered disposition.~~ The lead investigative agency shall notify persons who request reconsideration of their rights under this paragraph. The request must be submitted in writing to the review panel and a copy sent to the lead investigative agency within 30 calendar days of receipt of notice of a denial of a request for reconsideration or of a reconsidered disposition. The request must specifically identify the aspects of the lead investigative agency determination with which the person is dissatisfied.

(c) If, as a result of a reconsideration or review, the lead investigative agency changes the final disposition, it shall notify the parties specified in subdivision 9c, paragraph (f).

(d) For purposes of this subdivision, "interested person acting on behalf of the vulnerable adult" means a person designated in writing by the vulnerable adult to act on behalf of the vulnerable adult, or a legal guardian or conservator or other legal representative, a proxy or health care agent appointed under chapter 145B or 145C, or an individual who is related to the vulnerable adult, as defined in section 245A.02, subdivision 13.

(e) If an individual was disqualified under sections 245C.14 and 245C.15, on the basis of a determination of maltreatment, which was serious or recurring, and the individual has requested reconsideration of the maltreatment determination under paragraph (a) and reconsideration of the disqualification under sections 245C.21 to 245C.27, reconsideration of the maltreatment determination and requested reconsideration of the disqualification shall be consolidated into a single reconsideration. If reconsideration of the maltreatment determination is denied and the individual remains disqualified following a reconsideration

decision, the individual may request a fair hearing under section 256.045. If an individual requests a fair hearing on the maltreatment determination and the disqualification, the scope of the fair hearing shall include both the maltreatment determination and the disqualification.

(f) If a maltreatment determination or a disqualification based on serious or recurring maltreatment is the basis for a denial of a license under section 245A.05 or a licensing sanction under section 245A.07, the license holder has the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. As provided for under section 245A.08, the scope of the contested case hearing must include the maltreatment determination, disqualification, and licensing sanction or denial of a license. In such cases, a fair hearing must not be conducted under section 256.045. Except for family child care and child foster care, reconsideration of a maltreatment determination under this subdivision, and reconsideration of a disqualification under section 245C.22, must not be conducted when:

(1) a denial of a license under section 245A.05, or a licensing sanction under section 245A.07, is based on a determination that the license holder is responsible for maltreatment or the disqualification of a license holder based on serious or recurring maltreatment;

(2) the denial of a license or licensing sanction is issued at the same time as the maltreatment determination or disqualification; and

(3) the license holder appeals the maltreatment determination or disqualification, and denial of a license or licensing sanction.

Notwithstanding clauses (1) to (3), if the license holder appeals the maltreatment determination or disqualification, but does not appeal the denial of a license or a licensing sanction, reconsideration of the maltreatment determination shall be conducted under sections 626.556, subdivision 10i, and 626.557, subdivision 9d, and reconsideration of the disqualification shall be conducted under section 245C.22. In such cases, a fair hearing shall also be conducted as provided under sections 245C.27, 626.556, subdivision 10i, and 626.557, subdivision 9d.

If the disqualified subject is an individual other than the license holder and upon whom a background study must be conducted under chapter 245C, the hearings of all parties may be consolidated into a single contested case hearing upon consent of all parties and the administrative law judge.

(g) Until August 1, 2002, an individual or facility that was determined by the commissioner of human services or the commissioner of health to be responsible for neglect under section 626.5572, subdivision 17, after October 1, 1995, and before August 1, 2001,

that believes that the finding of neglect does not meet an amended definition of neglect may request a reconsideration of the determination of neglect. The commissioner of human services or the commissioner of health shall mail a notice to the last known address of individuals who are eligible to seek this reconsideration. The request for reconsideration must state how the established findings no longer meet the elements of the definition of neglect. The commissioner shall review the request for reconsideration and make a determination within 15 calendar days. The commissioner's decision on this reconsideration is the final agency action.

(1) For purposes of compliance with the data destruction schedule under subdivision 12b, paragraph (d), when a finding of substantiated maltreatment has been changed as a result of a reconsideration under this paragraph, the date of the original finding of a substantiated maltreatment must be used to calculate the destruction date.

(2) For purposes of any background studies under chapter 245C, when a determination of substantiated maltreatment has been changed as a result of a reconsideration under this paragraph, any prior disqualification of the individual under chapter 245C that was based on this determination of maltreatment shall be rescinded, and for future background studies under chapter 245C the commissioner must not use the previous determination of substantiated maltreatment as a basis for disqualification or as a basis for referring the individual's maltreatment history to a health-related licensing board under section 245C.31.

Sec. 48. Minnesota Statutes 2016, section 626.557, subdivision 10b, is amended to read:

Subd. 10b. **Investigations; guidelines.** (a) Each lead investigative agency shall develop guidelines for prioritizing reports for investigation. When investigating a report, the lead investigative agency shall conduct the following activities, as appropriate:

(1) interview of the alleged victim;

(2) interview of the reporter and others who may have relevant information;

(3) interview of the alleged perpetrator;

(4) examination of the environment surrounding the alleged incident;

(5) review of pertinent documentation of the alleged incident; and

(6) consultation with professionals.

(b) The lead investigator must contact the alleged victim or, if known, the alleged victim's guardian or health care agent, within five days after initiation of an investigation to provide the investigator's name and contact information and communicate with the alleged victim

or the alleged victim's guardian or health care agent approximately every three weeks during the course of the investigation.

Sec. 49. Minnesota Statutes 2016, section 626.557, subdivision 12b, is amended to read:

Subd. 12b. **Data management.** (a) In performing any of the duties of this section as a lead investigative agency, the county social service agency shall maintain appropriate records. Data collected by the county social service agency under this section are welfare data under section 13.46. Notwithstanding section 13.46, subdivision 1, paragraph (a), data under this paragraph that are inactive investigative data on an individual who is a vendor of services are private data on individuals, as defined in section 13.02. The identity of the reporter may only be disclosed as provided in paragraph ~~(c)~~ (g).

(b) Data maintained by the common entry point are ~~confidential~~ private data on individuals or ~~protected~~ nonpublic data as defined in section 13.02, provided that the name of the reporter is confidential data on individuals. Notwithstanding section 138.163, the common entry point shall maintain data for three calendar years after date of receipt and then destroy the data unless otherwise directed by federal requirements.

~~(b)~~ (c) The commissioners of health and human services shall prepare an investigation memorandum for each report alleging maltreatment investigated under this section. County social service agencies must maintain private data on individuals but are not required to prepare an investigation memorandum. During an investigation by the commissioner of health or the commissioner of human services, data collected under this section are confidential data on individuals or protected nonpublic data as defined in section 13.02, provided that data may be shared with the vulnerable adult or guardian or health care agent if both commissioners determine that sharing of the data is needed to protect the vulnerable adult. Upon completion of the investigation, the data are classified as provided in ~~clauses (1) to (3) and paragraph (c)~~ paragraphs (d) to (g).

~~(1)~~ (d) The investigation memorandum must contain the following data, which are public:

~~(i)~~ (1) the name of the facility investigated;

~~(ii)~~ (2) a statement of the nature of the alleged maltreatment;

~~(iii)~~ (3) pertinent information obtained from medical or other records reviewed;

~~(iv)~~ (4) the identity of the investigator;

~~(v)~~ (5) a summary of the investigation's findings;

~~(vi)~~ (6) statement of whether the report was found to be substantiated, inconclusive, false, or that no determination will be made;

~~(vii)~~ (7) a statement of any action taken by the facility;

~~(viii)~~ (8) a statement of any action taken by the lead investigative agency; and

~~(ix)~~ (9) when a lead investigative agency's determination has substantiated maltreatment, a statement of whether an individual, individuals, or a facility were responsible for the substantiated maltreatment, if known.

The investigation memorandum must be written in a manner which protects the identity of the reporter and of the vulnerable adult and may not contain the names or, to the extent possible, data on individuals or private data on individuals listed in ~~clause (2)~~ paragraph (e).

~~(2)~~ (e) Data on individuals collected and maintained in the investigation memorandum are private data on individuals, including:

~~(i)~~ (1) the name of the vulnerable adult;

~~(ii)~~ (2) the identity of the individual alleged to be the perpetrator;

~~(iii)~~ (3) the identity of the individual substantiated as the perpetrator; and

~~(iv)~~ (4) the identity of all individuals interviewed as part of the investigation.

~~(3)~~ (f) Other data on individuals maintained as part of an investigation under this section are private data on individuals upon completion of the investigation.

~~(c)~~ (g) After the assessment or investigation is completed, the name of the reporter must be confidential~~.~~, except:

(1) the subject of the report may compel disclosure of the name of the reporter only with the consent of the reporter; or

(2) upon a written finding by a court that the report was false and there is evidence that the report was made in bad faith.

This subdivision does not alter disclosure responsibilities or obligations under the Rules of Criminal Procedure, except that where the identity of the reporter is relevant to a criminal prosecution, the district court shall do an in-camera review prior to determining whether to order disclosure of the identity of the reporter.

~~(d)~~ (h) Notwithstanding section 138.163, data maintained under this section by the commissioners of health and human services must be maintained under the following schedule and then destroyed unless otherwise directed by federal requirements:

(1) data from reports determined to be false, maintained for three years after the finding was made;

(2) data from reports determined to be inconclusive, maintained for four years after the finding was made;

(3) data from reports determined to be substantiated, maintained for seven years after the finding was made; and

(4) data from reports which were not investigated by a lead investigative agency and for which there is no final disposition, maintained for three years from the date of the report.

~~(e)~~ (i) The commissioners of health and human services shall annually publish on their Web sites the number and type of reports of alleged maltreatment involving licensed facilities reported under this section, the number of those requiring investigation under this section, and the resolution of those investigations. On a biennial basis, the commissioners of health and human services shall jointly report the following information to the legislature and the governor:

(1) the number and type of reports of alleged maltreatment involving licensed facilities reported under this section, the number of those requiring investigations under this section, the resolution of those investigations, and which of the two lead agencies was responsible;

(2) trends about types of substantiated maltreatment found in the reporting period;

(3) ~~if there are upward trends for types of maltreatment substantiated,~~ recommendations for preventing, addressing, and responding to ~~them~~ substantiated maltreatment;

(4) efforts undertaken or recommended to improve the protection of vulnerable adults;

(5) whether and where backlogs of cases result in a failure to conform with statutory time frames and recommendations for reducing backlogs if applicable;

(6) recommended changes to statutes affecting the protection of vulnerable adults; and

(7) any other information that is relevant to the report trends and findings.

~~(f)~~ (j) Each lead investigative agency must have a record retention policy.

~~(g)~~ (k) Lead investigative agencies, prosecuting authorities, and law enforcement agencies may exchange not public data, as defined in section 13.02, if the agency or authority

requesting the data determines that the data are pertinent and necessary to the requesting agency in initiating, furthering, or completing an investigation under this section. Data collected under this section must be made available to prosecuting authorities and law enforcement officials, local county agencies, and licensing agencies investigating the alleged maltreatment under this section. ~~The lead investigative agency shall exchange not public data with the vulnerable adult maltreatment review panel established in section 256.021 if the data are pertinent and necessary for a review requested under that section.~~ Notwithstanding section 138.17, upon completion of the review, not public data received by the review panel must be destroyed.

~~(h)~~ (l) Each lead investigative agency shall keep records of the length of time it takes to complete its investigations.

~~(i)~~ (m) Notwithstanding paragraph (a) or (b), a lead investigative agency may share common entry point or investigative data and may notify other affected parties, including the vulnerable adult and their authorized representative, if the lead investigative agency has reason to believe maltreatment has occurred and determines the information will safeguard the well-being of the affected parties or dispel widespread rumor or unrest in the affected facility.

~~(j)~~ (n) Under any notification provision of this section, where federal law specifically prohibits the disclosure of patient identifying information, a lead investigative agency may not provide any notice unless the vulnerable adult has consented to disclosure in a manner which conforms to federal requirements.

Sec. 50. Minnesota Statutes 2016, section 626.557, subdivision 14, is amended to read:

Subd. 14. **Abuse prevention plans.** (a) Each facility, except home health agencies and personal care ~~attendant services providers~~ assistance provider agencies, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency.

(b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements

of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse.

(c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult.

(d) The commissioner of health must issue a correction order and may impose an immediate fine upon a finding that the facility has failed to comply with this subdivision.

Sec. 51. Minnesota Statutes 2016, section 626.557, subdivision 17, is amended to read:

Subd. 17. **Retaliation prohibited.** (a) A facility or person shall not retaliate against any person who reports in good faith suspected maltreatment pursuant to this section, or against a vulnerable adult with respect to whom a report is made, because of the report.

(b) In addition to any remedies allowed under sections 181.931 to 181.935, any facility or person which retaliates against any person because of a report of suspected maltreatment is liable to that person for actual damages, punitive damages up to $10,000, and attorney fees.

(c) There shall be a rebuttable presumption that any adverse action, as defined below, within 90 days of a report, is retaliatory. For purposes of this clause, the term "adverse action" refers to action taken by a facility or person involved in a report against the person making the report or the person with respect to whom the report was made because of the report, and includes, but is not limited to:

(1) discharge or transfer from the facility;

(2) discharge from or termination of employment;

(3) demotion or reduction in remuneration for services;

(4) restriction or prohibition of access to the facility or its residents; or

(5) any restriction of rights set forth in section 144.651, 144A.44, or 144A.441.

Sec. 52. Minnesota Statutes 2016, section 626.5572, subdivision 6, is amended to read:

Subd. 6. **Facility.** (a) "Facility" means:

(1) a hospital or other entity required to be licensed under sections 144.50 to 144.58;

(2) a nursing home required to be licensed to serve adults under section 144A.02;

(3) a facility or service required to be licensed under chapter 245A;

(4) a home care provider licensed or required to be licensed under sections 144A.43 to 144A.482;

(5) a hospice provider licensed under sections 144A.75 to 144A.755;

(6) a housing with services establishment registered under chapter 144D, including an entity operating under chapter 144G, assisted living title protection; or

(7) a person or organization that offers, provides, or arranges for personal care assistance services under the medical assistance program as authorized under sections 256B.0625, subdivision 19a, 256B.0651 to 256B.0654, 256B.0659, or 256B.85.

(b) For personal care assistance services identified in paragraph (a), clause (7), that are provided in the vulnerable adult's own home or in another unlicensed location other than an unlicensed setting listed in paragraph (a), the term "facility" refers to the provider, person, or organization that offers, provides, or arranges for personal care assistance services, and does not refer to the vulnerable adult's home or other location at which services are rendered.

Sec. 53. **REPORT; SAFETY AND QUALITY IMPROVEMENT PRACTICES.**

By January 15, 2019, the safety and quality improvement technical panel established under Minnesota Statutes, section 144A.53, subdivision 5, shall provide recommendations to the legislature on legislative changes needed to promote safety and quality improvement practices in long-term care settings and with long-term care providers. The recommendations must address:

(1) how to implement a system for adverse health events reporting, learning, and prevention in long-term care settings and with long-term care providers; and

(2) interim actions to improve systems for the timely analysis of reports and complaints submitted to the Office of Health Facility Complaints to identify common themes and key prevention opportunities, and to disseminate key findings to providers across the state for the purposes of shared learning and prevention.

Sec. 54. **REPORTS; OFFICE OF HEALTH FACILITY COMPLAINTS' RESPONSE TO VULNERABLE ADULT MALTREATMENT ALLEGATIONS.**

(a) On a quarterly basis until January 2021, and annually thereafter, the commissioner of health must publish on the Department of Health Web site, a report on the Office of Health Facility Complaints' response to allegations of maltreatment of vulnerable adults. The report must include:

(1) a description and assessment of the office's efforts to improve its internal processes and compliance with federal and state requirements concerning allegations of maltreatment of vulnerable adults, including any relevant timelines;

(2)(i) the number of reports received by type of reporter; (ii) the number of reports investigated; (iii) the percentage and number of reported cases awaiting triage; (iv) the number and percentage of open investigations; (v) the number and percentage of reports that have failed to meet state or federal timelines for triaging, investigating, or making a final disposition of an investigation by cause of delay; and (vi) processes the office will implement to bring the office into compliance with state and federal timelines for triaging, investigating, and making final dispositions of investigations;

(3) a trend analysis of internal audits conducted by the office; and

(4) trends and patterns in maltreatment of vulnerable adults, licensing violations by facilities or providers serving vulnerable adults, and other metrics as determined by the commissioner.

(b) The commissioner shall maintain on the Department of Health Web site reports published under this section for at least the past three years.

Sec. 55. **ASSISTED LIVING AND DEMENTIA CARE LICENSING WORKING GROUP.**

Subdivision 1. **Establishment; membership.** (a) An assisted living and dementia care licensing working group is established.

(b) The commissioner of health shall appoint the following members of the working group:

(1) four providers from the senior housing with services profession, two providing services in the seven-county metropolitan area and two providing services outside the seven-county metropolitan area. The providers appointed must include providers from establishments of different sizes;

(2) two persons who reside in senior housing with services establishments, or family members of persons who reside in senior housing with services establishments. One resident or family member must reside in the seven-county metropolitan area and one resident or family member must reside outside the seven-county metropolitan area;

(3) one representative from the Home Care and Assisted Living Program Advisory Council;

(4) one representative of a health plan company;

(5) one representative from Care Providers of Minnesota;

(6) one representative from LeadingAge Minnesota;

(7) one representative from the Alzheimer's Association;

(8) one representative from the Metropolitan Area Agency on Aging and one representative from an area agency on aging other than the Metropolitan Area Agency on Aging;

(9) one representative from the Minnesota Rural Health Association;

(10) one federal compliance official; and

(11) one representative from the Minnesota Home Care Association.

(c) The following individuals shall also be members of the working group:

(1) two members of the house of representatives, one appointed by the speaker of the house and one appointed by the minority leader;

(2) two members of the senate, one appointed by the majority leader and one appointed by the minority leader;

(3) one member of the Minnesota Council on Disability or a designee, appointed by the council;

(4) one member of the Commission of Deaf, Deafblind and Hard of Hearing Minnesotans or a designee, appointed by the commission;

(5) the commissioner of health or a designee;

(6) the commissioner of human services or a designee;

(7) the ombudsman for long-term care or a designee; and

(8) one member of the Minnesota Board of Aging, appointed by the board.

(d) The appointing authorities under this subdivision must complete the appointments no later than July 1, 2018.

Subd. 2. **Duties; recommendations.** (a) The assisted living and dementia care licensing working group shall consider and make recommendations on a new regulatory framework for assisted living and dementia care. In developing the licensing framework, the working group must address at least the following:

(1) the appropriate level of regulation, including licensure, registration, or certification;

(2) coordination of care;

(3) the scope of care to be provided and limits on acuity levels of residents;

(4) consumer rights;

(5) building design and physical environment;

(6) dietary services;

(7) support services;

(8) transition planning;

(9) the installation and use of electronic monitoring in settings in which assisted living or dementia care services are provided;

(10) staff training and qualifications;

(11) options for the engagement of seniors and their families;

(12) notices and financial requirements; and

(13) compliance with federal Medicaid waiver requirements for home and community-based services settings.

(b) Facilities and providers licensed by the commissioner of human services shall be exempt from licensing requirements for assisted living recommended under this section.

Subd. 3. **Meetings.** The commissioner of health or a designee shall convene the first meeting of the working group no later than August 1, 2018. The members of the working group shall elect a chair from among the group's members at the first meeting, and the commissioner of health or a designee shall serve as the working group's chair until a chair is elected. Meetings of the working group shall be open to the public.

Subd. 4. **Compensation.** Members of the working group appointed under subdivision 1, paragraph (b), shall serve without compensation or reimbursement for expenses.

Subd. 5. **Administrative support.** The commissioner of health shall provide administrative support for the working group and arrange meeting space.

Subd. 6. **Report.** By January 15, 2019, the working group must submit a report with findings, recommendations, and draft legislation to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance.

Subd. 7. **Expiration.** The working group expires January 16, 2019, or the day after the working group submits the report required under subdivision 6, whichever is earlier.

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

Sec. 56. **DEMENTIA CARE CERTIFICATION WORKING GROUP.**

Subdivision 1. **Establishment; membership.** (a) A dementia care certification working group is established.

(b) The commissioner of health shall appoint the following members of the working group:

(1) two caregivers of persons who have been diagnosed with Alzheimer's disease or other dementia, one caregiver residing in the seven-county metropolitan area and one caregiver residing outside the seven-county metropolitan area;

(2) two providers from the senior housing with services profession, one providing services in the seven-county metropolitan area and one providing services outside the seven-county metropolitan area;

(3) two geriatricians, one of whom serves a diverse or underserved community;

(4) one psychologist who specializes in dementia care;

(5) one representative of the Alzheimer's Association;

(6) one representative from Care Providers of Minnesota;

(7) one representative from LeadingAge Minnesota; and

(8) one representative from the Minnesota Home Care Association.

(c) The following individuals shall also be members of the working group:

(1) two members of the house of representatives, one appointed by the speaker of the house and one appointed by the minority leader;

(2) two members of the senate, one appointed by the majority leader and one appointed by the minority leader;

(3) the commissioner of health or a designee;

(4) the commissioner of human services or a designee;

(5) the ombudsman for long-term care or a designee;

(6) one member of the Minnesota Board on Aging, appointed by the board; and

(7) the executive director of the Minnesota Board on Aging, who shall serve as a nonvoting member of the working group.

(d) The appointing authorities under this subdivision must complete their appointments no later than July 1, 2018.

Subd. 2. **Duties; recommendations.** The dementia care certification working group shall consider and make recommendations regarding the certification of providers offering dementia care services to clients diagnosed with Alzheimer's disease or other dementias. The working group must:

(1) develop standards in the following areas that nursing homes, boarding care homes, and housing with services establishments offering care for clients diagnosed with Alzheimer's disease or other dementias must meet in order to obtain dementia care certification, including staffing, egress control, access to secured outdoor spaces, specialized therapeutic activities, and specialized life enrichment programming;

(2) develop requirements for disclosing dementia care certification standards to consumers; and

(3) develop mechanisms for enforcing dementia care certification standards.

Subd. 3. **Meetings.** The commissioner of health or a designee shall convene the first meeting of the working group no later than August 1, 2018. The members of the working group shall elect a chair from among the group's members at the first meeting, and the commissioner of health or a designee shall serve as the working group's chair until a chair is elected. Meetings of the working group shall be open to the public.

Subd. 4. **Compensation.** Members of the working group appointed under subdivision 1, paragraph (b), shall serve without compensation or reimbursement for expenses.

Subd. 5. **Administrative support.** The commissioner of health shall provide administrative support for the working group and arrange meeting space.

Subd. 6. **Report.** By January 15, 2019, the working group must submit a report with findings, recommendations, and draft legislation to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance.

Subd. 7. **Expiration.** The working group expires January 16, 2019, or the day after the working group submits the report required under subdivision 6, whichever is earlier.

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

Sec. 57. **ASSISTED LIVING REPORT CARD WORKING GROUP.**

Subdivision 1. **Establishment; membership.** (a) An assisted living report card working group, tasked with researching and making recommendations on the development of an assisted living report card, is established.

(b) The commissioner of human services shall appoint the following members of the working group:

(1) two persons who reside in senior housing with services establishments, one residing in an establishment in the seven-county metropolitan area and one residing in an establishment outside the seven-county metropolitan area;

(2) four representatives of the senior housing with services profession, two providing services in the seven-county metropolitan area and two providing services outside the seven-county metropolitan area;

(3) one family member of a person who resides in a senior housing with services establishment in the seven-county metropolitan area, and one family member of a person who resides in a senior housing with services establishment outside the seven-county metropolitan area;

(4) a representative from the Home Care and Assisted Living Program Advisory Council;

(5) a representative from the University of Minnesota with expertise in data and analytics;

(6) a representative from Care Providers of Minnesota; and

(7) a representative from LeadingAge Minnesota.

(c) The following individuals shall also be appointed to the working group:

(1) the commissioner of human services or a designee;

(2) the commissioner of health or a designee;

(3) the ombudsman for long-term care or a designee;

(4) one member of the Minnesota Board on Aging, appointed by the board; and

(5) the executive director of the Minnesota Board on Aging who shall serve on the working group as a nonvoting member.

(d) The appointing authorities under this subdivision must complete the appointments no later than July 1, 2018.

Subd. 2. **Duties.** The assisted living report card working group shall consider and make recommendations on the development of an assisted living report card. The quality metrics considered shall include, but are not limited to:

(1) an annual customer satisfaction survey measure using the CoreQ questions for assisted-living residents and family members;

(2) a measure utilizing level 3 or 4 citations from Department of Health home care survey findings and substantiated Office of Health Facility Complaints findings against a home care provider;

(3) a home care staff retention measure; and

(4) a measure that scores a provider's staff according to their level of training and education.

Subd. 3. **Meetings.** The commissioner of human services or a designee shall convene the first meeting of the working group no later than August 1, 2018. The members of the working group shall elect a chair from among the group's members at the first meeting, and the commissioner of human services or a designee shall serve as the working group's chair until a chair is elected. Meetings of the working group shall be open to the public.

Subd. 4. **Compensation.** Members of the working group shall serve without compensation or reimbursement for expenses.

Subd. 5. **Administrative support.** The commissioner of human services shall provide administrative support and arrange meeting space for the working group.

Subd. 6. **Report.** By January 15, 2019, the working group must submit a report with findings, recommendations, and draft legislation to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance.

Subd. 7. **Expiration.** The working group expires January 16, 2019, or the day after the working group submits the report required in subdivision 6, whichever is later.

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

Sec. 58. **DIRECTION TO COMMISSIONER OF HEALTH; PROGRESS IN IMPLEMENTING RECOMMENDATIONS OF LEGISLATIVE AUDITOR.**

By March 1, 2019, the commissioner of health must submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over health, human services, or aging on the progress toward implementing each recommendation of the Office of the Legislative Auditor with which the commissioner agreed in the commissioner's letter to the legislative auditor dated March 1, 2018. The commissioner shall include in the report existing data collected in the course of the commissioner's continuing oversight of the Office of Health Facility Complaints sufficient to demonstrate the implementation of the recommendations with which the commissioner agreed.

Sec. 59. **DIRECTION TO COMMISSIONER OF HEALTH; POSTING SUBSTANTIATED MALTREATMENT REPORTS.**

The commissioner of health must post every substantiated report of maltreatment of a vulnerable adult at the Web site of the Office of Health Facility Complaints.

Sec. 60. **DIRECTION TO COMMISSIONER OF HEALTH; PROVIDER EDUCATION.**

(a) The commissioner of health shall develop decision-making tools, including decision trees, regarding provider self-reported maltreatment allegations, and shall share these tools with providers. As soon as practicable, the commissioner shall update the decision-making tools as necessary, including whenever federal or state requirements change, and shall inform providers when the updated tools are available. The commissioner shall develop decision-making tools that clarify and encourage reporting whether the provider is licensed or registered under federal or state law, while also educating providers on any distinctions in reporting under federal versus state law.

(b) The commissioner of health shall conduct rigorous trend analyses of maltreatment reports, triage decisions, investigation determinations, enforcement actions, and appeals to identify trends and patterns in reporting of maltreatment, substantiated maltreatment, and licensing violations and shall share these findings with providers and interested stakeholders.

Sec. 61. **REPEALER.**

Minnesota Statutes 2016, section 256.021, is repealed.

ARTICLE 7

CHILDREN AND FAMILIES

Section 1. Minnesota Statutes 2016, section 119B.011, is amended by adding a subdivision to read:

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

Sec. 2. Minnesota Statutes 2017 Supplement, section 119B.011, subdivision 20, is amended to read:

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

Sec. 3. Minnesota Statutes 2016, section 119B.02, subdivision 7, is amended to read:

Subd. 7. **Child care market rate survey.** ~~Biennially,~~ The commissioner shall survey prices charged by child care providers in Minnesota every three years to determine the 75th percentile for like-care arrangements in county price clusters.

EFFECTIVE DATE. This section is effective retroactively from the market rate survey conducted in calendar year 2016 and applies to any market rate survey conducted after the 2016 market rate survey.

Sec. 4. Minnesota Statutes 2017 Supplement, section 119B.025, subdivision 1, is amended to read:

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

(1) identity of adults;

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

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

(4) age;

(5) immigration status, if related to eligibility;

(6) Social Security number, if given;

(7) counted income;

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

(9) residence; and

(10) inconsistent information, if related to eligibility.

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

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

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

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

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

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

(5) follow limits set by the commissioner for how frequently expedited application processing may be used for an applicant who declares that the applicant is homeless.

(d) An applicant who declares that the applicant is homeless must submit proof of eligibility within three months of the date the application was received. If proof of eligibility

is not submitted within three months, eligibility ends. A 15-day adverse action notice is required to end eligibility.

Sec. 5. Minnesota Statutes 2016, section 119B.03, subdivision 9, is amended to read:

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

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

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

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

(c) The receiving county must:

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

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

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

Sec. 6. Minnesota Statutes 2017 Supplement, section 119B.095, is amended by adding a subdivision to read:

Subd. 3. **Assistance for persons who are experiencing homelessness.** An applicant who is homeless and eligible for child care assistance under this chapter is eligible for 60 hours of child care assistance per service period for three months from the date the county receives the application. Additional hours may be authorized as needed based on the

applicant's participation in employment, education, or MFIP or DWP employment plan. To continue receiving child care assistance after the initial three months, the parent must verify that the parent meets eligibility and activity requirements for child care assistance under this chapter.

Sec. 7. Minnesota Statutes 2017 Supplement, section 119B.13, subdivision 1, is amended to read:

Subdivision 1. **Subsidy restrictions.** (a) Beginning ~~February 3, 2014~~ July 1, 2019, the maximum rate paid for child care assistance in any county or county price cluster under the child care fund shall be the greater of the 25th percentile of the ~~2011~~ 2016 child care provider rate survey under section 119B.02, subdivision 7, or the ~~maximum rate effective November 28, 2011.~~ rates in effect at the time of the update. For a child care provider located within the boundaries of a city located in two or more of the counties of Benton, Sherburne, and Stearns, the maximum rate paid for child care assistance shall be equal to the maximum rate paid in the county with the highest maximum reimbursement rates or the provider's charge, whichever is less. The commissioner may: (1) assign a county with no reported provider prices to a similar price cluster; and (2) consider county level access when determining final price clusters.

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

(c) The department shall monitor the effect of this paragraph on provider rates. The county shall pay the provider's full charges for every child in care up to the maximum established. The commissioner shall determine the maximum rate for each type of care on an hourly, full-day, and weekly basis, including special needs and disability care.

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

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

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

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

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

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

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

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

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

(j) For calendar year 2019, notwithstanding section 119B.03, subdivisions 6, 6a, and 6b, the commissioner must allocate the additional basic sliding fee child care funds for calendar year 2019 due to the updated provider rate survey under paragraph (a) to counties based on relative need to cover the maximum rate increases. In distributing the additional funds, the commissioner shall consider the following factors by county:

(1) expenditures;

(2) provider type;

(3) age of children; and

(4) amount of the increase in maximum rates.

Sec. 8. Minnesota Statutes 2017 Supplement, section 245A.06, subdivision 8, is amended to read:

Subd. 8. **Requirement to post ~~correction order~~ conditional license.** ~~(a)~~ For licensed family child care providers and child care centers, upon receipt of any ~~correction order or~~ order of conditional license issued by the commissioner under this section, and notwithstanding a pending request for reconsideration of the ~~correction order or~~ order of conditional license by the license holder, the license holder shall post the ~~correction order or~~ order of conditional license in a place that is conspicuous to the people receiving services and all visitors to the facility for two years. When the ~~correction order or~~ order of conditional license is accompanied by a maltreatment investigation memorandum prepared under section 626.556 or 626.557, the investigation memoranda must be posted with the ~~correction order or~~ order of conditional license.

~~(b) If the commissioner reverses or rescinds a violation in a correction order upon reconsideration under subdivision 2, the commissioner shall issue an amended correction order and the license holder shall post the amended order according to paragraph (a).~~

~~(c) If the correction order is rescinded or reversed in full upon reconsideration under subdivision 2, the license holder shall remove the original correction order posted according to paragraph (a).~~

Sec. 9. Minnesota Statutes 2017 Supplement, section 245A.50, subdivision 7, is amended to read:

Subd. 7. **Training requirements for family and group family child care.** (a) For purposes of family and group family child care, the license holder and each primary caregiver must complete 16 hours of ongoing training each year. For purposes of this subdivision, a primary caregiver is an adult caregiver who provides services in the licensed setting for more than 30 days in any 12-month period. Repeat of topical training requirements in subdivisions 2 to ~~8~~ 9 shall count toward the annual 16-hour training requirement. Additional ongoing training subjects to meet the annual 16-hour training requirement must be selected from the following areas:

(1) child development and learning training under subdivision 2, paragraph (a);

(2) developmentally appropriate learning experiences, including training in creating positive learning experiences, promoting cognitive development, promoting social and emotional development, promoting physical development, promoting creative development; and behavior guidance;

(3) relationships with families, including training in building a positive, respectful relationship with the child's family;

(4) assessment, evaluation, and individualization, including training in observing, recording, and assessing development; assessing and using information to plan; and assessing and using information to enhance and maintain program quality;

(5) historical and contemporary development of early childhood education, including training in past and current practices in early childhood education and how current events and issues affect children, families, and programs;

(6) professionalism, including training in knowledge, skills, and abilities that promote ongoing professional development; and

(7) health, safety, and nutrition, including training in establishing healthy practices; ensuring safety; and providing healthy nutrition.

(b) A family or group family child care license holder or primary caregiver who is an approved trainer through the Minnesota Center for Professional Development and who conducts an approved training course through the Minnesota Center for Professional Development in any of the topical training in subdivisions 2 to 9 shall receive training credit for the training topic in the applicable annual period. Each hour of approved training conducted shall count toward the annual 16-hour training requirement.

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

Sec. 10. Minnesota Statutes 2016, section 256K.45, subdivision 2, is amended to read:

Subd. 2. **Homeless youth report.** The commissioner shall prepare a biennial report, beginning in February 2015, which provides meaningful information to the legislative committees having jurisdiction over the issue of homeless youth, that includes, but is not limited to: (1) a list of the areas of the state with the greatest need for services and housing for homeless youth, and the level and nature of the needs identified; (2) details about grants made; (3) the distribution of funds throughout the state based on population need; (4) follow-up information, if available, on the status of homeless youth and whether they have stable housing two years after services are provided; and (5) any other outcomes for populations served to determine the effectiveness of the programs and use of funding. The commissioner is exempt from preparing this report in 2019 and must instead update the 2007 report on homeless youth under section 16.

Sec. 11. **[256K.46] STABLE HOUSING AND SUPPORT SERVICES FOR VULNERABLE YOUTH.**

Subdivision 1. **Definitions.** For purposes of this section, the following terms have the meanings given them:

(a) "Eligible applicant" means a program licensed by the commissioner of human services to provide transitional housing and support services to youth. An eligible applicant must have staff on site 24 hours per day and must have established confidentiality protocols as required by state and federal law.

(b) "Living essentials" means clothing, toiletries, transportation, interpreters, other supplies, and services necessary for daily living.

(c) "Support services" has the meaning given in section 256E.33, subdivision 1, paragraph (b), and includes crisis intervention, conflict mediation, family reunification services, educational services, and employment resources.

(d) "Transitional housing" means secure shelter and housing that:

(1) is provided at low or no cost;

(2) is designed to assist people transitioning from homelessness, family or relationship violence, or sexual exploitation, to living independently in the community; and

(3) provides residents with regular staff interaction, supervision plans, and living skills training and assistance.

(e) "Vulnerable youth" means youth 13 years of age through 17 years of age who have reported histories of sexual exploitation or family or relationship violence. Vulnerable youth includes youth who are homeless and youth who are parents and their children.

Subd. 2. **Grants authorized.** The commissioner of human services may award grants to eligible applicants to plan, establish, or operate programs to provide transitional housing and support services to vulnerable youth. An applicant may apply for and the commissioner may award grants for two-year periods, and the commissioner shall determine the number of grants awarded. The commissioner may reallocate underspending among grantees within the same grant period.

Subd. 3. **Program variance.** For purposes of this grant program, the commissioner may grant a program variance under chapter 245A allowing a program licensed to provide transitional housing and support services to youth 16 years of age through 17 years of age to serve youth 13 years of age through 17 years of age.

Subd. 4. **Allocation of grants.** (a) An application must be on a form and contain information as specified by the commissioner but at a minimum must contain:

(1) a description of the purpose or project for which grant funds will be used;

(2) a description of the specific problem the grant funds are intended to address;

(3) a description of achievable objectives, a work plan, and a timeline for implementation and completion of processes or projects enabled by the grant;

(4) a description of the eligible applicant's existing frameworks and experience providing transitional housing and support services to vulnerable youth; and

(5) a proposed process for documenting and evaluating results of the grant.

(b) Grant funds allocated under this section may be used for purposes that include, but are not limited to, the following:

(1) transitional housing, meals, and living essentials for vulnerable youth and their children;

(2) support services;

(3) mental health and substance use disorder counseling;

(4) staff training;

(5) case management and referral services; and

(6) aftercare and follow-up services, including ongoing adult and peer support.

(c) The commissioner shall review each application to determine whether the application is complete and whether the applicant and the project are eligible for a grant. In evaluating applications, the commissioner shall establish criteria including, but not limited to:

(1) the eligibility of the applicant or project;

(2) the applicant's thoroughness and clarity in describing the problem grant funds are intended to address;

(3) a description of the population demographics and service area of the proposed project; and

(4) the proposed project's longevity and demonstrated financial sustainability after the initial grant period.

(d) In evaluating applications, the commissioner may request additional information regarding a proposed project, including information on project cost. An applicant's failure to provide the information requested disqualifies an applicant.

Subd. 5. **Awarding of grants.** The commissioner must notify grantees of awards by January 1, 2019.

Subd. 6. **Update.** The commissioner shall consult with providers serving homeless youth, sex-trafficked youth, or sexually exploited youth, including providers serving older youth under the Safe Harbor Act and Homeless Youth Act to make recommendations that resolve conflicting requirements placed on providers and foster best practices in delivering services to these populations of older youth. The recommendations may include the development of additional certifications not currently available under Minnesota Rules, chapter 2960. The commissioner shall provide an update on the stakeholder work and recommendations

identified through this process to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services finance and policy by January 15, 2019.

Sec. 12. Minnesota Statutes 2016, section 256M.41, subdivision 3, is amended to read:

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

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

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

(2) ten percent of the allocation shall be withheld until the commissioner determines if the county has met the performance outcome threshold of 90 percent based on face-to-face contact with alleged child victims. In order to receive the performance allocation, the county child protection workers must have a timely face-to-face contact with at least 90 percent of all alleged child victims of screened-in maltreatment reports. The standard requires that each initial face-to-face contact occur consistent with timelines defined in section 626.556, subdivision 10, paragraph (i). The commissioner shall make threshold determinations in January of each year and payments to counties meeting the performance outcome threshold shall occur in February of each year. Any withheld funds from this appropriation for counties that do not meet this requirement shall be ~~reallocated by the commissioner to those counties meeting the requirement~~ transferred to children and families operations for use under section 626.5591, subdivision 2, to support the Child Welfare Training Academy; and

(3) ten percent of the allocation shall be withheld until the commissioner determines that the county has met the performance outcome threshold of 90 percent based on face-to-face visits by the case manager. In order to receive the performance allocation, the total number of visits made by caseworkers on a monthly basis to children in foster care and children receiving child protection services while residing in their home must be at least 90 percent of the total number of such visits that would occur if every child were visited once per month. The commissioner shall make such determinations in January of each year and payments to counties meeting the performance outcome threshold shall occur in February of each year. Any withheld funds from this appropriation for counties that do not meet this requirement shall be ~~reallocated by the commissioner to those counties meeting the requirement~~ transferred to children and families operations for use under section 626.5591,

subdivision 2, to support the Child Welfare Training Academy. For 2015, the commissioner shall only apply the standard for monthly foster care visits.

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

Sec. 13. **[260C.81] MINN-LINK STUDY.**

(a) The commissioner of human services shall partner with the University of Minnesota's Minn-LInK statewide integrated administrative data project to conduct an annual study to understand characteristics, experiences, and outcomes of children and families served by the child welfare system. Minn-LInK researchers shall annually conduct research and provide research briefs, reports, and consultation to the Child Welfare Training Academy to inform the development and revision of training curriculum.

(b) The commissioner shall report a summary of the research results to the governor and to the committees in the house of representatives and senate with jurisdiction over human services annually by December 15.

Sec. 14. Minnesota Statutes 2016, section 518A.32, subdivision 3, is amended to read:

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

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

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

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

(4) the parent has been determined by an authorized government agency to be eligible to receive general assistance or Supplemental Security Income payments. Any income, not including public assistance payments, earned by the parent who is eligible for general assistance or Supplemental Security Income payments may be considered for the purpose of calculating child support.

Sec. 15. Minnesota Statutes 2016, section 518A.685, is amended to read:

518A.685 CONSUMER REPORTING AGENCY; REPORTING ARREARS.

(a) If a public authority determines that an obligor has not paid the current monthly support obligation plus any required arrearage payment for three months, the public authority must report this information to a consumer reporting agency.

(b) Before reporting that an obligor is in arrears for court-ordered child support, the public authority must:

(1) provide written notice to the obligor that the public authority intends to report the arrears to a consumer reporting agency; and

(2) mail the written notice to the obligor's last known mailing address at least 30 days before the public authority reports the arrears to a consumer reporting agency.

(c) The obligor may, within 21 days of receipt of the notice, do the following to prevent the public authority from reporting the arrears to a consumer reporting agency:

(1) pay the arrears in full; or

(2) request an administrative review. An administrative review is limited to issues of mistaken identity, a pending legal action involving the arrears, or an incorrect arrears balance.

~~(d) If the public authority has reported that an obligor is in arrears for court-ordered child support and subsequently determines that the obligor has paid the court-ordered child support arrears in full, or is paying the current monthly support obligation plus any required arrearage payment, the public authority must report to the consumer reporting agency that the obligor is currently paying child support as ordered by the court.~~

~~(e)~~ (d) A public authority that reports arrearage information under this section must make monthly reports to a consumer reporting agency. The monthly report must be consistent with credit reporting industry standards for child support.

~~(f)~~ (e) For purposes of this section, "consumer reporting agency" has the meaning given in section 13C.001, subdivision 4, and United States Code, title 15, section 1681a(f).

Sec. 16. **2018 REPORT TO LEGISLATURE ON HOMELESS YOUTH.**

Subdivision 1. **Report development.** In lieu of the biennial homeless youth report under Minnesota Statutes, section 256K.45, subdivision 2, the commissioner of human services shall update the information in the 2007 legislative report on runaway and homeless youth. In developing the updated report, the commissioner may use existing data, studies, and analysis provided by state, county, and other entities including, but not limited to:

(1) Minnesota Housing Finance Agency analysis on housing availability;

(2) Minnesota state plan to end homelessness;

(3) continuum of care counts of youth experiencing homelessness and assessments as provided by Department of Housing and Urban Development (HUD)-required coordinated entry systems;

(4) data collected through the Department of Human Services Homeless Youth Act grant program;

(5) Wilder Research homeless study;

(6) Voices of Youth Count sponsored by Hennepin County; and

(7) privately funded analysis, including:

(i) nine evidence-based principles to support youth in overcoming homelessness;

(ii) return on investment analysis conducted for YouthLink by Foldes Consulting; and

(iii) evaluation of Homeless Youth Act resources conducted by Rainbow Research.

Subd. 2. **Key elements; due date.** (a) The report may include three key elements where significant learning has occurred in the state since the 2007 report, including:

(1) unique causes of youth homelessness;

(2) targeted responses to youth homelessness, including significance of positive youth development as fundamental to each targeted response; and

(3) recommendations based on existing reports and analysis on what it will take to end youth homelessness.

(b) To the extent data is available, the report must include:

(1) general accounting of the federal and philanthropic funds leveraged to support homeless youth activities;

(2) general accounting of the increase in volunteer responses to support youth experiencing homelessness; and

(3) data-driven accounting of geographic areas or distinct populations that have gaps in service or are not yet served by homeless youth responses.

(c) The commissioner of human services may consult with community-based providers of homeless youth services and other expert stakeholders to complete the report. The commissioner shall submit the report to the chairs and ranking minority members of the legislative committees with jurisdiction over youth homelessness by February 15, 2019.

Sec. 17. **TASK FORCE ON CHILDHOOD TRAUMA-INFORMED POLICY AND PRACTICES.**

Subdivision 1. **Establishment.** The commissioner of human services must establish and appoint a task force on trauma-informed policy and practices to prevent and reduce children's exposure to adverse childhood experiences (ACEs) consisting of the following members:

(1) the commissioners of human services, public safety, health, and education or the commissioners' designees;

(2) two members representing law enforcement with expertise in juvenile justice;

(3) two members representing county social services agencies;

(4) four members, one representing each of the three ethnic councils established under Minnesota Statutes, section 15.0145, and one representing the Indian Affairs Council established under Minnesota Statutes, section 3.922;

(5) two members representing tribal social services providers;

(6) two members with expertise in prekindergarten through grade 12 education;

(7) three licensed health care professionals with expertise in the neurobiology of childhood development representing public health, mental health, and primary health;

(8) one member representing family service or children's mental health collaboratives;

(9) two parents who had ACEs;

(10) two ombudspersons from the Minnesota Office of Ombudsperson for Families; and

(11) representatives of any other group the commissioner of human services deems appropriate to complete the duties of the task force.

Subd. 2. **Staff.** The commissioner of human services must provide meeting space, support staff, and administrative services for the task force.

Subd. 3. **Duties.** The task force must perform the following duties:

(1) engage the human services, education, public health, juvenile justice, and criminal justice systems in the creation of trauma-informed policy and practices in each of these systems to prevent and reduce ACEs and to support the health and well-being of all families; and

(2) identify social determinants of the health and well-being of all families and recommend solutions to eliminate racial and ethnic disparities in the state.

Subd. 4. **Report.** The task force must submit a report on the results of its duties outlined in subdivision 3 and any policy recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services, public safety, judiciary, and education by January 15, 2019.

Subd. 5. **Expiration.** The task force expires upon submission of the report required under subdivision 4.

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

Sec. 18. **CHILD WELFARE TRAINING ACADEMY.**

Subdivision 1. **Modifications.** (a) The commissioner of human services shall modify the Child Welfare Training System developed pursuant to Minnesota Statutes, section 626.5591, subdivision 2, as provided in this section. The new training framework shall be known as the Child Welfare Training Academy.

(b) The Child Welfare Training Academy shall be administered through five regional hubs in northwest, northeast, southwest, southeast, and central Minnesota. Each hub shall deliver training targeted to the needs of its particular region, taking into account varying demographics, resources, and practice outcomes.

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

(d) Each child welfare worker and supervisor shall be required to complete a certification, including a competency-based knowledge test and a skills demonstration, at the completion

of the worker's initial training and biennially thereafter. The commissioner shall develop ongoing training requirements and a method for tracking certifications.

(e) Each regional hub shall have a regional organizational effectiveness specialist trained in continuous quality improvement strategies. The specialist shall provide organizational change assistance to counties and tribes, with priority given to efforts intended to impact child safety.

(f) The Child Welfare Training Academy shall include training and resources that address worker well-being and secondary traumatic stress.

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

Subd. 2. **Partners.** (a) The commissioner of human services shall enter into a partnership with the University of Minnesota to collaborate in the administration of workforce training.

(b) The commissioner of human services shall enter into a partnership with one or more agencies to provide consultation, subject matter expertise, and capacity building in organizational resilience and child welfare workforce well-being.

Sec. 19. **CHILD WELFARE CASELOAD STUDY.**

(a) The commissioner of human services shall conduct a child welfare caseload study to collect data on (1) the number of child welfare workers in Minnesota, and (2) the amount of time that child welfare workers spend on different components of child welfare work. The study must be completed by July 1, 2019.

(b) The commissioner shall report the results of the child welfare caseload study to the governor and to the committees in the house of representatives and senate with jurisdiction over human services by December 1, 2019.

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

Sec. 20. **RULEMAKING.**

The commissioner of human services may adopt rules as necessary to establish the Child Welfare Training Academy.

Sec. 21. **REVISOR'S INSTRUCTION.**

The revisor of statutes, in consultation with the Department of Human Services, House Research Department, and Senate Counsel, Research and Fiscal Analysis shall change the terms "food support" and "food stamps" to "Supplemental Nutrition Assistance Program" or "SNAP" in Minnesota Statutes and Minnesota Rules when appropriate. The revisor may make technical and other necessary changes to sentence structure to preserve the meaning of the text.

Sec. 22. **EFFECTIVE DATE.**

(a) Sections 1, 2, and 4 to 7 are effective as soon as practicable contingent upon:

(1) receipt of additional federal child care and development funds above the amount received in federal fiscal year 2017 appropriated in the federal Consolidated Appropriations Act of 2018, Public Law 115-141, and any subsequent federal appropriations, in an amount sufficient to cover the cost associated with the amendments to those sections through June 30, 2021; and

(2) satisfactory completion of the requirements in Minnesota Statutes, section 3.3005.

(b) If the additional federal child care and development funds are not sufficient to cover the cost of the amendments to sections 1, 2, and 4 to 7, those sections are effective upon implementation by the commissioner of human services.

The commissioner of human services shall prioritize implementation of those sections as follows:

(1) first priority is implementation of the amendments to Minnesota Statutes, sections 119B.011, subdivision 13b; 119B.025, subdivision 1; and 119B.095, subdivision 3;

(2) second priority is implementation of the amendments to Minnesota Statutes, section 119B.011, subdivision 20;

(3) third priority is implementation of the amendments to Minnesota Statutes, section 119B.03, subdivision 9; and

(4) fourth priority is implementation of the amendments to Minnesota Statutes, section 119B.13, subdivision 1.

(c) The commissioner of human services shall determine if the additional child care and development funds are sufficient by June 30, 2018, and notify the revisor of statutes when sections 1, 2, and 4 to 7 are effective.

ARTICLE 8

HEALTH LICENSING BOARDS

Section 1. Minnesota Statutes 2016, section 13.83, subdivision 2, is amended to read:

Subd. 2. **Public data.** Unless specifically classified otherwise by state statute or federal law, the following data created or collected by a medical examiner or coroner on a deceased individual are public: name of the deceased; date of birth; date of death; address; sex; race; citizenship; height; weight; hair color; eye color; build; complexion; age, if known, or approximate age; identifying marks, scars and amputations; a description of the decedent's clothing; marital status; location of death including name of hospital where applicable; name of spouse; whether or not the decedent ever served in the armed forces of the United States; occupation; business; father's name (also birth name, if different); mother's name (also birth name, if different); birthplace; birthplace of parents; cause of death; causes of cause of death; whether an autopsy was performed and if so, whether it was conclusive; date and place of injury, if applicable, including work place; how injury occurred; whether death was caused by accident, suicide, homicide, or was of undetermined cause; certification of attendance by physician or advanced practice registered nurse; physician's or advanced practice registered nurse's name and address; certification by coroner or medical examiner; name and signature of coroner or medical examiner; type of disposition of body; burial place name and location, if applicable; date of burial, cremation or removal; funeral home name and address; and name of local register or funeral director.

Sec. 2. Minnesota Statutes 2016, section 144.651, subdivision 21, is amended to read:

Subd. 21. **Communication privacy.** Patients and residents may associate and communicate privately with persons of their choice and enter and, except as provided by the Minnesota Commitment Act, leave the facility as they choose. Patients and residents shall have access, at their expense, to writing instruments, stationery, and postage. Personal mail shall be sent without interference and received unopened unless medically or programmatically contraindicated and documented by the physician or advanced practice registered nurse in the medical record. There shall be access to a telephone where patients and residents can make and receive calls as well as speak privately. Facilities which are unable to provide a private area shall make reasonable arrangements to accommodate the privacy of patients' or residents' calls. Upon admission to a facility where federal law prohibits unauthorized disclosure of patient or resident identifying information to callers and visitors, the patient or resident, or the legal guardian or conservator of the patient or resident, shall be given the opportunity to authorize disclosure of the patient's or resident's

presence in the facility to callers and visitors who may seek to communicate with the patient or resident. To the extent possible, the legal guardian or conservator of a patient or resident shall consider the opinions of the patient or resident regarding the disclosure of the patient's or resident's presence in the facility. This right is limited where medically inadvisable, as documented by the attending physician or advanced practice registered nurse in a patient's or resident's care record. Where programmatically limited by a facility abuse prevention plan pursuant to section 626.557, subdivision 14, paragraph (b), this right shall also be limited accordingly.

Sec. 3. Minnesota Statutes 2016, section 144A.26, is amended to read:

144A.26 RECIPROCITY WITH OTHER STATES AND EQUIVALENCY OF HEALTH SERVICES EXECUTIVE.

Subdivision 1. **Reciprocity.** The Board of Examiners may issue a nursing home administrator's license, without examination, to any person who holds a current license as a nursing home administrator from another jurisdiction if the board finds that the standards for licensure in the other jurisdiction are at least the substantial equivalent of those prevailing in this state and that the applicant is otherwise qualified.

Subd. 2. **Health services executive license.** The Board of Examiners may issue a health services executive license to any person who (1) has been validated by the National Association of Long Term Care Administrator Boards as a health services executive, and (2) has met the education and practice requirements for the minimum qualifications of a nursing home administrator, assisted living administrator, and home and community-based service provider. Licensure decisions made by the board under this subdivision are final.

Sec. 4. Minnesota Statutes 2016, section 144A.4791, subdivision 13, is amended to read:

Subd. 13. **Request for discontinuation of life-sustaining treatment.** (a) If a client, family member, or other caregiver of the client requests that an employee or other agent of the home care provider discontinue a life-sustaining treatment, the employee or agent receiving the request:

(1) shall take no action to discontinue the treatment; and

(2) shall promptly inform the supervisor or other agent of the home care provider of the client's request.

(b) Upon being informed of a request for termination of treatment, the home care provider shall promptly:

(1) inform the client that the request will be made known to the physician or advanced practice registered nurse who ordered the client's treatment;

(2) inform the physician or advanced practice registered nurse of the client's request; and

(3) work with the client and the client's physician or advanced practice registered nurse to comply with the provisions of the Health Care Directive Act in chapter 145C.

(c) This section does not require the home care provider to discontinue treatment, except as may be required by law or court order.

(d) This section does not diminish the rights of clients to control their treatments, refuse services, or terminate their relationships with the home care provider.

(e) This section shall be construed in a manner consistent with chapter 145B or 145C, whichever applies, and declarations made by clients under those chapters.

Sec. 5. **[148.2855] NURSE LICENSURE COMPACT.**

The Nurse Licensure Compact is enacted into law and entered into with all other jurisdictions legally joining in it, in the form substantially as follows:

ARTICLE I

DEFINITIONS

As used in this compact:

(a) "Adverse action" means any administrative, civil, equitable, or criminal action permitted by a state's law that is imposed by a licensing board or other authority against a nurse, including actions against an individual's license or multistate licensure privilege such as revocation, suspension, probation, monitoring of the licensee, limitation on the licensee's practice, or any other encumbrance on licensure affecting a nurse's authorization to practice, including issuance of a cease and desist action.

(b) "Alternative program" means a nondisciplinary monitoring program approved by a licensing board.

(c) "Coordinated licensure information system" means an integrated process for collecting, storing, and sharing information on nurse licensure and enforcement activities related to nurse licensure laws that is administered by a nonprofit organization composed of and controlled by licensing boards.

(d) "Current significant investigative information" means:

(1) investigative information that a licensing board, after a preliminary inquiry that includes notification and an opportunity for the nurse to respond, if required by state law, has reason to believe is not groundless and, if proved true, would indicate more than a minor infraction; or

(2) investigative information that indicates that the nurse represents an immediate threat to public health and safety, regardless of whether the nurse has been notified and had an opportunity to respond.

(e) "Encumbrance" means a revocation or suspension of, or any limitation on, the full and unrestricted practice of nursing imposed by a licensing board.

(f) "Home state" means the party state which is the nurse's primary state of residence.

(g) "Licensing board" means a party state's regulatory body responsible for issuing nurse licenses.

(h) "Multistate license" means a license to practice as a registered or a licensed practical/vocational nurse (LPN/VN) issued by a home state licensing board that authorizes the licensed nurse to practice in all party states under a multistate licensure privilege.

(i) "Multistate licensure privilege" means a legal authorization associated with a multistate license permitting the practice of nursing as either a registered nurse (RN) or licensed practical/vocational nurse (LPN/VN) in a remote state.

(j) "Nurse" means a registered nurse (RN) or licensed practical/vocational nurse (LPN/VN), as those terms are defined by each party state's practice laws.

(k) "Party state" means any state that has adopted this compact.

(l) "Remote state" means a party state, other than the home state.

(m) "Single-state license" means a nurse license issued by a party state that authorizes practice only within the issuing state and does not include a multistate licensure privilege to practice in any other party state.

(n) "State" means a state, territory, or possession of the United States and the District of Columbia.

(o) "State practice laws" means a party state's laws, rules, and regulations that govern the practice of nursing, define the scope of nursing practice, and create the methods and grounds for imposing discipline. State practice laws do not include requirements necessary to obtain and retain a license, except for qualifications or requirements of the home state.

ARTICLE II

GENERAL PROVISIONS AND JURISDICTION

(a) A multistate license to practice registered or licensed practical/vocational nursing issued by a home state to a resident in that state will be recognized by each party state as authorizing a nurse to practice as an RN or as a LPN/VN under a multistate licensure privilege in each party state.

(b) A state must implement procedures for considering the criminal history records of applicants for initial multistate license or licensure by endorsement. Such procedures shall include the submission of fingerprints or other biometric-based information by applicants for the purpose of obtaining an applicant's criminal history record information from the Federal Bureau of Investigation and the agency responsible for retaining that state's criminal records.

(c) Each party state shall require the following for an applicant to obtain or retain a multistate license in the home state:

(1) meets the home state's qualifications for licensure or renewal of licensure, as well as all other applicable state laws;

(2)(i) has graduated or is eligible to graduate from a licensing board-approved RN or LPN/VN prelicensure education program; or

(ii) has graduated from a foreign RN or LPN/VN prelicensure education program that:

(A) has been approved by the authorized accrediting body in the applicable country; and

(B) has been verified by an independent credentials review agency to be comparable to a licensing board-approved prelicensure education program;

(3) has, if a graduate of a foreign prelicensure education program not taught in English or if English is not the individual's native language, successfully passed an English proficiency examination that includes the components of reading, speaking, writing, and listening;

(4) has successfully passed an NCLEX-RN or NCLEX-PN Examination or recognized predecessor, as applicable;

(5) is eligible for or holds an active, unencumbered license;

(6) has submitted, in connection with an application for initial licensure or licensure by endorsement, fingerprints, or other biometric data for the purpose of obtaining criminal

history record information from the Federal Bureau of Investigation and the agency responsible for retaining that state's criminal records;

(7) has not been convicted or found guilty, or has entered into an agreed disposition, of a felony offense under applicable state or federal criminal law;

(8) has not been convicted or found guilty, or has entered into an agreed disposition, of a misdemeanor offense related to the practice of nursing as determined on a case-by-case basis;

(9) is not currently enrolled in an alternative program;

(10) is subject to self-disclosure requirements regarding current participation in an alternative program; and

(11) has a valid United States Social Security number.

(d) All party states shall be authorized, in accordance with existing state due process law, to take adverse action against a nurse's multistate licensure privilege such as revocation, suspension, probation, or any other action that affects a nurse's authorization to practice under a multistate licensure privilege, including cease and desist actions. If a party state takes such action, it shall promptly notify the administrator of the coordinated licensure information system. The administrator of the coordinated licensure information system shall promptly notify the home state of any such actions by remote states.

(e) A nurse practicing in a party state must comply with the state practice laws of the state in which the client is located at the time service is provided. The practice of nursing is not limited to patient care, but shall include all nursing practice as defined by the state practice laws of the party state in which the client is located. The practice of nursing in a party state under a multistate licensure privilege will subject a nurse to the jurisdiction of the licensing board, the courts, and the laws of the party state in which the client is located at the time service is provided.

(f) Individuals not residing in a party state shall continue to be able to apply for a party state's single-state license as provided under the laws of each party state. However, the single-state license granted to these individuals will not be recognized as granting the privilege to practice nursing in any other party state. Nothing in this compact shall affect the requirements established by a party state for the issuance of a single-state license.

(g) Any nurse holding a home state multistate license, on the effective date of this compact, may retain and renew the multistate license issued by the nurse's then-current home state, provided that:

(1) a nurse, who changes primary state of residence after this compact's effective date, must meet all applicable paragraph (c) requirements to obtain a multistate license from a new home state; or

(2) a nurse who fails to satisfy the multistate licensure requirements in paragraph (c) due to a disqualifying event occurring after this compact's effective date shall be ineligible to retain or renew a multistate license, and the nurse's multistate license shall be revoked or deactivated in accordance with applicable rules adopted by the Interstate Commission of Nurse Licensure Compact Administrators ("Commission").

ARTICLE III

APPLICATIONS FOR LICENSURE IN A PARTY STATE

(a) Upon application for a multistate license, the licensing board in the issuing party state shall ascertain, through the coordinated licensure information system, whether the applicant has ever held, or is the holder of, a license issued by any other state, whether there are any encumbrances on any license or multistate licensure privilege held by the applicant, whether any adverse action has been taken against any license or multistate licensure privilege held by the applicant, and whether the applicant is currently participating in an alternative program.

(b) A nurse may hold a multistate license, issued by the home state, in only one party state at a time.

(c) If a nurse changes primary state of residence by moving between two party states, the nurse must apply for licensure in the new home state, and the multistate license issued by the prior home state will be deactivated in accordance with applicable rules adopted by the commission:

(1) the nurse may apply for licensure in advance of a change in primary state of residence; and

(2) a multistate license shall not be issued by the new home state until the nurse provides satisfactory evidence of a change in primary state of residence to the new home state and satisfies all applicable requirements to obtain a multistate license from the new home state.

(d) If a nurse changes primary state of residence by moving from a party state to a nonparty state, the multistate license issued by the prior home state will convert to a single-state license, valid only in the former home state.

ARTICLE IV

ADDITIONAL AUTHORITIES INVESTED IN PARTY STATE LICENSING BOARDS

(a) In addition to the other powers conferred by state law, a licensing board shall have the authority to:

(1) take adverse action against a nurse's multistate licensure privilege to practice within that party state:

(i) only the home state shall have the power to take adverse action against a nurse's license issued by the home state; and

(ii) for purposes of taking adverse action, the home state licensing board shall give the same priority and effect to reported conduct received from a remote state as it would if such conduct occurred within the home state. In so doing, the home state shall apply its own state laws to determine appropriate action;

(2) issue cease and desist orders or impose an encumbrance on a nurse's authority to practice within that party state;

(3) complete any pending investigations of a nurse who changes primary state of residence during the course of such investigations. The licensing board shall also have the authority to take appropriate action(s) and shall promptly report the conclusions of such investigations to the administrator of the coordinated licensure information system. The administrator of the coordinated licensure information system shall promptly notify the new home state of any such actions;

(4) issue subpoenas for both hearings and investigations that require the attendance and testimony of witnesses, as well as the production of evidence. Subpoenas issued by a licensing board in a party state for the attendance and testimony of witnesses or the production of evidence from another party state shall be enforced in the latter state by any court of competent jurisdiction, according to the practice and procedure of that court applicable to subpoenas issued in proceedings pending before it. The issuing authority shall pay any witness fees, travel expenses, mileage, and other fees required by the service statutes of the state in which the witnesses or evidence are located;

(5) obtain and submit, for each nurse licensure applicant, fingerprint, or other biometric-based information to the Federal Bureau of Investigation for criminal background checks, receive the results of the Federal Bureau of Investigation record search on criminal background checks, and use the results in making licensure decisions;

(6) if otherwise permitted by state law, recover from the affected nurse the costs of investigations and disposition of cases resulting from any adverse action taken against that nurse; and

(7) take adverse action based on the factual findings of the remote state, provided that the licensing board follows its own procedures for taking such adverse action.

(b) If adverse action is taken by the home state against a nurse's multistate license, the nurse's multistate licensure privilege to practice in all other party states shall be deactivated until all encumbrances have been removed from the multistate license. All home state disciplinary orders that impose adverse action against a nurse's multistate license shall include a statement that the nurse's multistate licensure privilege is deactivated in all party states during the pendency of the order.

(c) Nothing in this compact shall override a party state's decision that participation in an alternative program may be used in lieu of adverse action. The home state licensing board shall deactivate the multistate licensure privilege under the multistate license of any nurse for the duration of the nurse's participation in an alternative program.

ARTICLE V

COORDINATED LICENSURE INFORMATION SYSTEM AND EXCHANGE OF INFORMATION

(a) All party states shall participate in a coordinated licensure information system of all licensed registered nurses (RNs) and licensed practical/vocational nurses (LPN/VNs). This system will include information on the licensure and disciplinary history of each nurse, as submitted by party states, to assist in the coordination of nurse licensure and enforcement efforts.

(b) The commission, in consultation with the administrator of the coordinated licensure information system, shall formulate necessary and proper procedures for the identification, collection, and exchange of information under this compact.

(c) All licensing boards shall promptly report to the coordinated licensure information system any adverse action, any current significant investigative information, denials of applications, including the reasons for such denials, and nurse participation in alternative programs known to the licensing board, regardless of whether such participation is deemed nonpublic or confidential under state law.

(d) Current significant investigative information and participation in nonpublic or confidential alternative programs shall be transmitted through the coordinated licensure information system only to party state licensing boards.

(e) Notwithstanding any other provision of law, all party state licensing boards contributing information to the coordinated licensure information system may designate information that may not be shared with nonparty states or disclosed to other entities or individuals without the express permission of the contributing state.

(f) Any personally identifiable information obtained from the coordinated licensure information system by a party state licensing board shall not be shared with nonparty states or disclosed to other entities or individuals except to the extent permitted by the laws of the party state contributing the information.

(g) Any information contributed to the coordinated licensure information system that is subsequently required to be expunged by the laws of the party state contributing that information shall also be expunged from the coordinated licensure information system.

(h) The compact administrator of each party state shall furnish a uniform data set to the compact administrator of each other party state, which shall include, at a minimum:

(1) identifying information;

(2) licensure data;

(3) information related to alternative program participation; and

(4) other information that may facilitate the administration of this compact, as determined by commission rules.

(i) The compact administrator of a party state shall provide all investigative documents and information requested by another party state.

ARTICLE VI

ESTABLISHMENT OF THE INTERSTATE COMMISSION OF NURSE LICENSURE COMPACT ADMINISTRATORS

(a) The party states hereby create and establish a joint public entity known as the Interstate Commission of Nurse Licensure Compact Administrators:

(1) the commission is an instrumentality of the party states;

(2) venue is proper, and judicial proceedings by or against the commission shall be brought solely and exclusively, in a court of competent jurisdiction where the principal

office of the commission is located. The commission may waive venue and jurisdictional defenses to the extent it adopts or consents to participate in alternative dispute resolution proceedings; and

(3) nothing in this compact shall be construed to be a waiver of sovereign immunity.

(b) Membership, voting, and meetings:

(1) each party state shall have and be limited to one administrator. The head of the state licensing board or designee shall be the administrator of this compact for each party state. Any administrator may be removed or suspended from office as provided by the law of the state from which the administrator is appointed. Any vacancy occurring in the commission shall be filled in accordance with the laws of the party state in which the vacancy exists;

(2) each administrator shall be entitled to one vote with regard to the promulgation of rules and creation of bylaws and shall otherwise have an opportunity to participate in the business and affairs of the commission. An administrator shall vote in person or by such other means as provided in the bylaws. The bylaws may provide for an administrator's participation in meetings by telephone or other means of communication;

(3) the commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the bylaws or rules of the commission;

(4) all meetings shall be open to the public, and public notice of meetings shall be given in the same manner as required under the rulemaking provisions in article VII;

(5) the commission may convene in a closed, nonpublic meeting if the commission must discuss:

(i) noncompliance of a party state with its obligations under this compact;

(ii) the employment, compensation, discipline, or other personnel matters, practices, or procedures related to specific employees or other matters related to the commission's internal personnel practices and procedures;

(iii) current, threatened, or reasonably anticipated litigation;

(iv) negotiation of contracts for the purchase or sale of goods, services, or real estate;

(v) accusing any person of a crime or formally censuring any person;

(vi) disclosure of trade secrets or commercial or financial information that is privileged or confidential;

(vii) disclosure of information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;

(viii) disclosure of investigatory records compiled for law enforcement purposes;

(ix) disclosure of information related to any reports prepared by or on behalf of the commission for the purpose of investigation of compliance with this compact; or

(x) matters specifically exempted from disclosure by federal or state statute; and

(6) if a meeting, or portion of a meeting, is closed pursuant to this provision, the commission's legal counsel or designee shall certify that the meeting may be closed and shall reference each relevant exempting provision. The commission shall keep minutes that fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, and the reasons therefore, including a description of the views expressed. All documents considered in connection with an action shall be identified in minutes. All minutes and documents of a closed meeting shall remain under seal, subject to release by a majority vote of the commission or order of a court of competent jurisdiction.

(c) The commission shall, by a majority vote of the administrators, prescribe bylaws or rules to govern its conduct as may be necessary or appropriate to carry out the purposes and exercise the powers of this compact, including, but not limited to:

(1) establishing the fiscal year of the commission;

(2) providing reasonable standards and procedures:

(i) for the establishment and meetings of other committees; and

(ii) governing any general or specific delegation of any authority or function of the commission;

(3) providing reasonable procedures for calling and conducting meetings of the commission, ensuring reasonable advance notice of all meetings and providing an opportunity for attendance of such meetings by interested parties, with enumerated exceptions designed to protect the public's interest, the privacy of individuals, and proprietary information, including trade secrets. The commission may meet in closed session only after a majority of the administrators vote to close a meeting in whole or in part. As soon as practicable, the commission must make public a copy of the vote to close the meeting revealing the vote of each administrator, with no proxy votes allowed;

(4) establishing the titles, duties, and authority and reasonable procedures for the election of the officers of the commission;

(5) providing reasonable standards and procedures for the establishment of the personnel policies and programs of the commission. Notwithstanding any civil service or other similar laws of any party state, the bylaws shall exclusively govern the personnel policies and programs of the commission; and

(6) providing a mechanism for winding up the operations of the commission and the equitable disposition of any surplus funds that may exist after the termination of this compact after the payment or reserving of all of its debts and obligations.

(d) The commission shall publish its bylaws and rules, and any amendments thereto, in a convenient form on the Web site of the commission.

(e) The commission shall maintain its financial records in accordance with the bylaws.

(f) The commission shall meet and take actions as are consistent with the provisions of this compact and the bylaws.

(g) The commission shall have the following powers:

(1) to promulgate uniform rules to facilitate and coordinate implementation and administration of this compact. The rules shall have the force and effect of law and shall be binding in all party states;

(2) to bring and prosecute legal proceedings or actions in the name of the commission, provided that the standing of any licensing board to sue or be sued under applicable law shall not be affected;

(3) to purchase and maintain insurance and bonds;

(4) to borrow, accept, or contract for services of personnel, including, but not limited to, employees of a party state or nonprofit organizations;

(5) to cooperate with other organizations that administer state compacts related to the regulation of nursing, including, but not limited to, sharing administrative or staff expenses, office space, or other resources;

(6) to hire employees, elect or appoint officers, fix compensation, define duties, grant such individuals appropriate authority to carry out the purposes of this compact, and to establish the commission's personnel policies and programs relating to conflicts of interest, qualifications of personnel, and other related personnel matters;

(7) to accept any and all appropriate donations, grants, and gifts of money, equipment, supplies, materials, and services, and to receive, utilize, and dispose of the same; provided

that at all times the commission shall avoid any appearance of impropriety or conflict of interest;

(8) to lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve, or use any property, whether real, personal, or mixed; provided that at all times the commission shall avoid any appearance of impropriety;

(9) to sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property, whether real, personal, or mixed;

(10) to establish a budget and make expenditures;

(11) to borrow money;

(12) to appoint committees, including advisory committees comprised of administrators, state nursing regulators, state legislators or their representatives, and consumer representatives, and other such interested persons;

(13) to provide and receive information from, and to cooperate with, law enforcement agencies;

(14) to adopt and use an official seal; and

(15) to perform such other functions as may be necessary or appropriate to achieve the purposes of this Compact consistent with the state regulation of nurse licensure and practice.

(h) Financing of the commission:

(1) the commission shall pay, or provide for the payment of, the reasonable expenses of its establishment, organization, and ongoing activities;

(2) the commission may also levy on and collect an annual assessment from each party state to cover the cost of its operations, activities, and staff in its annual budget as approved each year. The aggregate annual assessment amount, if any, shall be allocated based upon a formula to be determined by the commission, which shall promulgate a rule that is binding upon all party states;

(3) the commission shall not incur obligations of any kind prior to securing the funds adequate to meet the same; nor shall the commission pledge the credit of any of the party states, except by, and with the authority of, such party state; and

(4) the commission shall keep accurate accounts of all receipts and disbursements. The receipts and disbursements of the commission shall be subject to the audit and accounting procedures established under its bylaws. However, all receipts and disbursements of funds handled by the commission shall be audited yearly by a certified or licensed public

accountant, and the report of the audit shall be included in and become part of the annual report of the commission.

(i) Qualified immunity, defense, and indemnification:

(1) the administrators, officers, executive director, employees, and representatives of the commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error, or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred, within the scope of commission employment, duties, or responsibilities; provided that nothing in this paragraph shall be construed to protect any such person from suit or liability for any damage, loss, injury, or liability caused by the intentional, willful, or wanton misconduct of that person;

(2) the commission shall defend any administrator, officer, executive director, employee, or representative of the commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of commission employment, duties, or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of commission employment, duties, or responsibilities; provided that nothing herein shall be construed to prohibit that person from retaining his or her own counsel; and provided further that the actual or alleged act, error, or omission did not result from that person's intentional, willful, or wanton misconduct; and

(3) the commission shall indemnify and hold harmless any administrator, officer, executive director, employee, or representative of the commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error, or omission that occurred within the scope of commission employment, duties, or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from the intentional, willful, or wanton misconduct of that person.

ARTICLE VII

RULEMAKING

(a) The commission shall exercise its rulemaking powers pursuant to the criteria set forth in this article and the rules adopted thereunder. Rules and amendments shall become

binding as of the date specified in each rule or amendment and shall have the same force and effect as provisions of this compact.

(b) Rules or amendments to the rules shall be adopted at a regular or special meeting of the commission.

(c) Prior to promulgation and adoption of a final rule or rules by the commission, and at least 60 days in advance of the meeting at which the rule will be considered and voted upon, the commission shall file a notice of proposed rulemaking:

(1) on the Web site of the commission; and

(2) on the Web site of each licensing board or the publication in which state would otherwise publish proposed rules.

(d) The notice of proposed rulemaking shall include:

(1) the proposed time, date, and location of the meeting in which the rule will be considered and voted upon;

(2) the text of the proposed rule or amendment, and the reason for the proposed rule;

(3) a request for comments on the proposed rule from any interested person; and

(4) the manner in which interested persons may submit notice to the commission of their intention to attend the public hearing and any written comments.

(e) Prior to adoption of a proposed rule, the commission shall allow persons to submit written data, facts, opinions, and arguments, which shall be made available to the public.

(f) The commission shall grant an opportunity for a public hearing before it adopts a rule or amendment.

(g) The commission shall publish the place, time, and date of the scheduled public hearing:

(1) hearings shall be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing. All hearings will be recorded, and a copy will be made available upon request; and

(2) nothing in this section shall be construed as requiring a separate hearing on each rule. Rules may be grouped for the convenience of the commission at hearings required by this section.

(h) If no one appears at the public hearing, the commission may proceed with promulgation of the proposed rule.

(i) Following the scheduled hearing date, or by the close of business on the scheduled hearing date if the hearing was not held, the commission shall consider all written and oral comments received.

(j) The commission shall, by majority vote of all administrators, take final action on the proposed rule and shall determine the effective date of the rule, if any, based on the rulemaking record and the full text of the rule.

(k) Upon determination that an emergency exists, the commission may consider and adopt an emergency rule without prior notice, opportunity for comment or hearing, provided that the usual rulemaking procedures provided in this compact and in this section shall be retroactively applied to the rule as soon as reasonably possible, in no event later than 90 days after the effective date of the rule. For the purposes of this provision, an emergency rule is one that must be adopted immediately in order to:

(1) meet an imminent threat to public health, safety, or welfare;

(2) prevent a loss of commission or party state funds; or

(3) meet a deadline for the promulgation of an administrative rule that is required by federal law or rule.

(l) The commission may direct revisions to a previously adopted rule or amendment for purposes of correcting typographical errors, errors in format, errors in consistency, or grammatical errors. Public notice of any revisions shall be posted on the Web site of the commission. The revision shall be subject to challenge by any person for a period of 30 days after posting. The revision may be challenged only on grounds that the revision results in a material change to a rule. A challenge shall be made in writing, and delivered to the commission prior to the end of the notice period. If no challenge is made, the revision will take effect without further action. If the revision is challenged, the revision may not take effect without the approval of the commission.

ARTICLE VIII

OVERSIGHT, DISPUTE RESOLUTION, AND ENFORCEMENT

(a) Oversight:

(1) each party state shall enforce this compact and take all actions necessary and appropriate to effectuate this compact's purposes and intent; and

(2) the commission shall be entitled to receive service of process in any proceeding that may affect the powers, responsibilities, or actions of the commission, and shall have standing

to intervene in such a proceeding for all purposes. Failure to provide service of process in such proceeding to the commission shall render a judgment or order void as to the commission, this compact, or promulgated rules.

(b) Default, technical assistance, and termination:

(1) if the commission determines that a party state has defaulted in the performance of its obligations or responsibilities under this compact or the promulgated rules, the commission shall:

(i) provide written notice to the defaulting state and other party states of the nature of the default, the proposed means of curing the default or any other action to be taken by the commission; and

(ii) provide remedial training and specific technical assistance regarding the default;

(2) if a state in default fails to cure the default, the defaulting state's membership in this compact may be terminated upon an affirmative vote of a majority of the administrators, and all rights, privileges, and benefits conferred by this compact may be terminated on the effective date of termination. A cure of the default does not relieve the offending state of obligations or liabilities incurred during the period of default;

(3) termination of membership in this compact shall be imposed only after all other means of securing compliance have been exhausted. Notice of intent to suspend or terminate shall be given by the commission to the governor of the defaulting state and to the executive officer of the defaulting state's licensing board and each of the party states;

(4) a state whose membership in this compact has been terminated is responsible for all assessments, obligations, and liabilities incurred through the effective date of termination, including obligations that extend beyond the effective date of termination;

(5) the commission shall not bear any costs related to a state that is found to be in default or whose membership in this compact has been terminated, unless agreed upon in writing between the commission and the defaulting state; and

(6) the defaulting state may appeal the action of the commission by petitioning the U.S. District Court for the District of Columbia or the federal district in which the commission has its principal offices. The prevailing party shall be awarded all costs of such litigation, including reasonable attorneys' fees.

(c) Dispute resolution:

(1) upon request by a party state, the commission shall attempt to resolve disputes related to the compact that arise among party states and between party and nonparty states;

(2) the commission shall promulgate a rule providing for both mediation and binding dispute resolution for disputes, as appropriate; and

(3) in the event the commission cannot resolve disputes among party states arising under this compact:

(i) the party states may submit the issues in dispute to an arbitration panel, which will be comprised of individuals appointed by the compact administrator in each of the affected party states and an individual mutually agreed upon by the compact administrators of all the party states involved in the dispute; and

(ii) the decision of a majority of the arbitrators shall be final and binding.

(d) Enforcement:

(1) the commission, in the reasonable exercise of its discretion, shall enforce the provisions and rules of this compact;

(2) by majority vote, the commission may initiate legal action in the U.S. District Court for the District of Columbia or the federal district in which the commission has its principal offices against a party state that is in default to enforce compliance with the provisions of this compact and its promulgated rules and bylaws. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing party shall be awarded all costs of such litigation, including reasonable attorneys' fees; and

(3) the remedies herein shall not be the exclusive remedies of the commission. The commission may pursue any other remedies available under federal or state law.

ARTICLE IX

EFFECTIVE DATE, WITHDRAWAL, AND AMENDMENT

(a) This compact shall become effective and binding on the earlier of the date of legislative enactment of this compact into law by no less than 26 states or December 31, 2018. All party states to this compact, that also were parties to the prior Nurse Licensure Compact, superseded by this compact, ("prior compact"), shall be deemed to have withdrawn from said prior compact within six months after the effective date of this compact.

(b) Each party state to this compact shall continue to recognize a nurse's multistate licensure privilege to practice in that party state issued under the prior compact until such party state has withdrawn from the prior compact.

(c) Any party state may withdraw from this compact by enacting a statute repealing the same. A party state's withdrawal shall not take effect until six months after enactment of the repealing statute.

(d) A party state's withdrawal or termination shall not affect the continuing requirement of the withdrawing or terminated state's licensing board to report adverse actions and significant investigations occurring prior to the effective date of such withdrawal or termination.

(e) Nothing contained in this compact shall be construed to invalidate or prevent any nurse licensure agreement or other cooperative arrangement between a party state and a nonparty state that is made in accordance with the other provisions of this compact.

(f) This compact may be amended by the party states. No amendment to this compact shall become effective and binding upon the party states, unless and until it is enacted into the laws of all party states.

(g) Representatives of nonparty states to this compact shall be invited to participate in the activities of the commission, on a nonvoting basis, prior to the adoption of this compact by all states.

ARTICLE X

CONSTRUCTION AND SEVERABILITY

This compact shall be liberally construed so as to effectuate the purposes thereof. The provisions of this compact shall be severable, and if any phrase, clause, sentence, or provision of this compact is declared to be contrary to the constitution of any party state or of the United States, or if the applicability thereof to any government, agency, person, or circumstance is held invalid, the validity of the remainder of this compact and the applicability thereof to any government, agency, person, or circumstance shall not be affected thereby. If this compact shall be held to be contrary to the constitution of any party state, this compact shall remain in full force and effect as to the remaining party states and in full force and effect as to the party state affected as to all severable matters.

EFFECTIVE DATE. This section is effective upon implementation of the coordinated licensure information system defined in Minnesota Statutes, section 148.2855, article V, but no sooner than July 1, 2019.

Sec. 6. **[148.2856] APPLICATION OF NURSE LICENSURE COMPACT TO EXISTING LAWS.**

(a) Section 148.2855 does not relieve employers of nurses from complying with statutorily imposed obligations.

(b) Section 148.2855 does not supersede existing state labor laws.

(c) For purposes of the Minnesota Government Data Practices Act, chapter 13, an individual not licensed as a nurse under sections 148.171 to 148.285 who practices professional or practical nursing in Minnesota under the authority of section 148.2855 is considered to be a licensee of the board.

(d) Proceedings brought against an individual's multistate privilege shall be adjudicated following the procedures listed in sections 14.50 to 14.62 and shall be subject to judicial review as provided for in sections 14.63 to 14.69.

(e) The reporting requirements of sections 144.4175, 148.263, 626.52, and 626.557 apply to individuals not licensed as registered or licensed practical nurses under sections 148.171 to 148.285 who practice professional or practical nursing in Minnesota under the authority of section 148.2855.

(f) The board may take action against an individual's multistate privilege based on the grounds listed in section 148.261, subdivision 1, and any other statute authorizing or requiring the board to take corrective or disciplinary action.

(g) The board may take all forms of disciplinary action provided for in section 148.262, subdivision 1, and corrective action provided for in section 214.103, subdivision 6, against an individual's multistate privilege.

(h) The immunity provisions of section 148.264, subdivision 1, apply to individuals who practice professional or practical nursing in Minnesota under the authority of section 148.2855.

(i) The cooperation requirements of section 148.265 apply to individuals who practice professional or practical nursing in Minnesota under the authority of section 148.2855.

(j) The provisions of section 148.283 shall not apply to individuals who practice professional or practical nursing in Minnesota under the authority of section 148.2855.

(k) Complaints against individuals who practice professional or practical nursing in Minnesota under the authority of section 148.2855 shall be handled as provided in sections 214.10 and 214.103.

EFFECTIVE DATE. This section is effective upon implementation of the coordinated licensure information system defined in Minnesota Statutes, section 148.2855, article V, but no sooner than July 1, 2019.

Sec. 7. **[148.2858] MISCELLANEOUS PROVISIONS.**

(a) For the purposes of section 148.2855, "head of the Nurse Licensing Board" means the executive director of the board.

(b) The Board of Nursing shall have the authority to recover from a nurse practicing professional or practical nursing in Minnesota under the authority of section 148.2855 the costs of investigation and disposition of cases resulting from any adverse action taken against the nurse.

EFFECTIVE DATE. This section is effective upon implementation of the coordinated licensure information system defined in Minnesota Statutes, section 148.2855, article V, but no sooner than July 1, 2019.

Sec. 8. Minnesota Statutes 2016, section 148.59, is amended to read:

148.59 LICENSE RENEWAL; LICENSE AND REGISTRATION FEES.

A licensed optometrist shall pay to the state Board of Optometry a fee as set by the board in order to renew a license as provided by board rule. No fees shall be refunded. Fees may not exceed the following amounts but may be adjusted lower by board direction and are for the exclusive use of the board:

(1) optometry licensure application, $160;

(2) optometry annual licensure renewal, ~~$135~~ $170;

(3) optometry late penalty fee, $75;

(4) annual license renewal card, $10;

(5) continuing education provider application, $45;

(6) emeritus registration, $10;

(7) endorsement/reciprocity application, $160;

(8) replacement of initial license, $12; ~~and~~

(9) license verification, $50~~.~~;

(10) jurisprudence state examination, $75;

(11) Optometric Education Continuing Education data bank registration, $20; and

(12) data requests and labels, $50.

Sec. 9. Minnesota Statutes 2016, section 148E.180, is amended to read:

148E.180 FEE AMOUNTS.

Subdivision 1. **Application fees.** Nonrefundable application fees for licensure ~~are as follows~~ may not exceed the following amounts but may be adjusted lower by board action:

(1) for a licensed social worker, ~~$45~~ $75;

(2) for a licensed graduate social worker, ~~$45~~ $75;

(3) for a licensed independent social worker, ~~$45~~ $75;

(4) for a licensed independent clinical social worker, ~~$45~~ $75;

(5) for a temporary license, $50; and

(6) for a licensure by endorsement, ~~$85~~ $115.

The fee for criminal background checks is the fee charged by the Bureau of Criminal Apprehension. The criminal background check fee must be included with the application fee as required according to section 148E.055.

Subd. 2. **License fees.** Nonrefundable license fees ~~are as follows~~ may not exceed the following amounts but may be adjusted lower by board action:

(1) for a licensed social worker, ~~$81~~ $115;

(2) for a licensed graduate social worker, ~~$144~~ $210;

(3) for a licensed independent social worker, ~~$216~~ $305;

(4) for a licensed independent clinical social worker, ~~$238.50~~ $335;

(5) for an emeritus inactive license, ~~$43.20~~ $65;

(6) for an emeritus active license, one-half of the renewal fee specified in subdivision 3; and

(7) for a temporary leave fee, the same as the renewal fee specified in subdivision 3.

If the licensee's initial license term is less or more than 24 months, the required license fees must be prorated proportionately.

Subd. 3. **Renewal fees.** Nonrefundable renewal fees for ~~licensure are as follows~~ the two-year renewal term may not exceed the following amounts but may be adjusted lower by board action:

(1) for a licensed social worker, ~~$81~~ $115;

(2) for a licensed graduate social worker, ~~$144~~ $210;

(3) for a licensed independent social worker, ~~$216~~ $305; and

(4) for a licensed independent clinical social worker, ~~$238.50~~ $335.

Subd. 4. **Continuing education provider fees.** Continuing education provider fees are ~~as follows~~ the following nonrefundable amounts:

(1) for a provider who offers programs totaling one to eight clock hours in a one-year period according to section 148E.145, $50;

(2) for a provider who offers programs totaling nine to 16 clock hours in a one-year period according to section 148E.145, $100;

(3) for a provider who offers programs totaling 17 to 32 clock hours in a one-year period according to section 148E.145, $200;

(4) for a provider who offers programs totaling 33 to 48 clock hours in a one-year period according to section 148E.145, $400; and

(5) for a provider who offers programs totaling 49 or more clock hours in a one-year period according to section 148E.145, $600.

Subd. 5. **Late fees.** Late fees are ~~as follows~~ the following nonrefundable amounts:

(1) renewal late fee, one-fourth of the renewal fee specified in subdivision 3;

(2) supervision plan late fee, $40; and

(3) license late fee, $100 plus the prorated share of the license fee specified in subdivision 2 for the number of months during which the individual practiced social work without a license.

Subd. 6. **License cards and wall certificates.** (a) The fee for a license card as specified in section 148E.095 is $10.

(b) The fee for a license wall certificate as specified in section 148E.095 is $30.

Subd. 7. **Reactivation fees.** Reactivation fees are ~~as follows~~ the following nonrefundable amounts:

(1) reactivation from a temporary leave or emeritus status, the prorated share of the renewal fee specified in subdivision 3; and

(2) reactivation of an expired license, 1-1/2 times the renewal fees specified in subdivision 3.

Sec. 10. Minnesota Statutes 2016, section 150A.06, subdivision 1a, is amended to read:

Subd. 1a. **Faculty dentists.** (a) Faculty members of a school of dentistry must be licensed in order to practice dentistry as defined in section 150A.05. The board may issue to members of the faculty of a school of dentistry a license designated as either a "limited faculty license" or a "full faculty license" entitling the holder to practice dentistry within the terms described in paragraph (b) or (c). The dean of a school of dentistry and program directors of a Minnesota dental hygiene, dental therapy, or dental assisting school accredited by the Commission on Dental Accreditation shall certify to the board those members of the school's faculty who practice dentistry but are not licensed to practice dentistry in Minnesota. A faculty member who practices dentistry as defined in section 150A.05, before beginning duties in a school of dentistry ~~or a~~, dental therapy, dental hygiene, or dental assisting ~~school,~~ shall apply to the board for a limited or full faculty license. Pursuant to Minnesota Rules, chapter 3100, and at the discretion of the board, a limited faculty license must be renewed annually and a full faculty license must be renewed biennially. The faculty applicant shall pay a nonrefundable fee set by the board for issuing and renewing the faculty license. The faculty license is valid during the time the holder remains a member of the faculty of a school of dentistry ~~or a~~, dental therapy, dental hygiene, or dental assisting ~~school~~ and subjects the holder to this chapter.

(b) The board may issue to dentist members of the faculty of a Minnesota school of dentistry, dental therapy, dental hygiene, or dental assisting accredited by the Commission on Dental Accreditation, a license designated as a limited faculty license entitling the holder to practice dentistry within the school and its affiliated teaching facilities, but only for the purposes of teaching or conducting research. The practice of dentistry at a school facility for purposes other than teaching or research is not allowed unless the dentist was a faculty member on August 1, 1993.

(c) The board may issue to dentist members of the faculty of a Minnesota school of dentistry, dental therapy, dental hygiene, or dental assisting accredited by the Commission on Dental Accreditation a license designated as a full faculty license entitling the holder to practice dentistry within the school and its affiliated ~~teaching~~ facilities ~~and elsewhere~~ if the holder of the license is employed ~~50 percent time or more~~ full time by the school in the

practice of teaching, supervising, or research, and upon successful review by the board of the applicant's qualifications as described in subdivisions 1, 1c, and 4 and board rule. The board, at its discretion, may waive specific licensing prerequisites.

Sec. 11. Minnesota Statutes 2016, section 150A.06, is amended by adding a subdivision to read:

Subd. 10. **Emeritus inactive license.** (a) A dental professional licensed under this chapter to practice dentistry, dental therapy, dental hygiene, or dental assisting who retires from active practice in the state may apply to the board for an emeritus inactive license. An applicant must apply for an emeritus inactive license on the biennial licensing form or by petitioning the board.

(b) The board shall not grant an emeritus inactive license to an applicant who is the subject of a disciplinary action resulting in the current suspension, revocation, disqualification, condition, or restriction of the applicant's license to practice dentistry, dental therapy, dental hygiene, or dental assisting.

(c) An emeritus inactive licensee is prohibited from practicing dentistry, dental therapy, dental hygiene, or dental assisting. An emeritus inactive license is a formal recognition of completion of the licensee's dental career in good standing.

(d) The board shall charge a onetime fee for issuance of an emeritus inactive license, pursuant to section 150A.091.

Sec. 12. Minnesota Statutes 2016, section 150A.06, is amended by adding a subdivision to read:

Subd. 11. **Emeritus active license.** (a) A dental professional licensed to practice dentistry, dental therapy, dental hygiene, or dental assisting, pursuant to section 150A.05 and Minnesota Rules, part 3100.8500, who declares retirement from active practice in the state may apply to the board for an emeritus active license. An applicant must apply for an emeritus active license on a form as required by the board.

(b) An emeritus active licensee may engage only in pro bono or volunteer practice, paid practice not to exceed 240 hours per calendar year for the purpose of providing license supervision to meet board requirements, and paid consulting services not to exceed 240 hours per calendar year.

(c) An emeritus active licensee is prohibited from representing that the licensee is authorized to engage in any practice except as provided in paragraph (b). The board may

take disciplinary or corrective action against an emeritus active licensee as provided in section 150A.08.

(d) An emeritus active license must be renewed biennially. The renewal requirements for an emeritus active license are:

(1) completion of a renewal form as required by the board;

(2) payment of a renewal fee pursuant to section 150A.091; and

(3) reporting of 25 completed continuing education hours, which must include:

(i) courses in two required CORE areas;

(ii) one hour of credit on infection control;

(iii) for emeritus active licenses in dentistry and dental therapy, at least 15 fundamental credits and no more than ten elective credits; and

(iv) for emeritus active licenses in dental hygiene and dental assisting, at least seven fundamental credits and no more than six elective credits.

Sec. 13. Minnesota Statutes 2016, section 150A.091, is amended by adding a subdivision to read:

Subd. 19. **Emeritus inactive license.** Each applicant shall submit with an application for an emeritus inactive license a onetime, nonrefundable fee in the amount of $50.

Sec. 14. Minnesota Statutes 2016, section 150A.091, is amended by adding a subdivision to read:

Subd. 20. **Emeritus active license.** Each applicant shall submit with an application for an emeritus inactive license, and each emeritus active licensee shall submit with a renewal application, a nonrefundable fee as follows:

(1) for an emeritus active license in dentistry, $212;

(2) for an emeritus active license in dental therapy, $100;

(3) for an emeritus active license in dental hygiene, $75; and

(4) for an emeritus active license in dental assisting, $55.

Sec. 15. Minnesota Statutes 2016, section 151.15, is amended by adding a subdivision to read:

Subd. 5. **Receipt of emergency prescription orders.** A pharmacist, when that pharmacist is not present within a licensed pharmacy, may accept a written, verbal, or electronic prescription drug order from a practitioner only if:

(1) the prescription drug order is for an emergency situation where waiting for the licensed pharmacy from which the prescription will be dispensed to open would likely cause the patient to experience significant physical harm or discomfort;

(2) the pharmacy from which the prescription drug order will be dispensed is closed for business;

(3) the pharmacist has been designated to be on call for the licensed pharmacy that will fill the prescription drug order;

(4) in the case of an electronic prescription drug order, the order must be received through secure and encrypted electronic means;

(5) the pharmacist takes reasonable precautions to ensure that the prescription drug order will be handled in a manner consistent with federal and state statutes regarding the handling of protected health information; and

(6) the pharmacy from which the prescription drug order will be dispensed has relevant and appropriate policies and procedures in place and makes them available to the board upon request.

Sec. 16. Minnesota Statutes 2016, section 151.15, is amended by adding a subdivision to read:

Subd. 6. **Processing of emergency prescription orders.** A pharmacist, when that pharmacist is not present within a licensed pharmacy, may access a pharmacy prescription processing system through secure and encrypted electronic means in order to process an emergency prescription accepted pursuant to subdivision 5 only if:

(1) the pharmacy from which the prescription drug order will be dispensed is closed for business;

(2) the pharmacist has been designated to be on call for the licensed pharmacy that will fill the prescription drug order;

(3) the prescription drug order is for a patient of a long-term care facility or a county correctional facility;

(4) the prescription drug order is processed pursuant to this chapter and rules adopted under this chapter; and

(5) the pharmacy from which the prescription drug order will be dispensed has relevant and appropriate policies and procedures in place and makes them available to the board upon request.

Sec. 17. Minnesota Statutes 2016, section 151.19, subdivision 1, is amended to read:

Subdivision 1. **Pharmacy licensure requirements.** (a) No person shall operate a pharmacy without first obtaining a license from the board and paying any applicable fee specified in section 151.065. The license shall be displayed in a conspicuous place in the pharmacy for which it is issued and expires on June 30 following the date of issue. It is unlawful for any person to operate a pharmacy unless the license has been issued to the person by the board.

(b) Application for a pharmacy license under this section shall be made in a manner specified by the board.

(c) No license shall be issued or renewed for a pharmacy located within the state unless the applicant agrees to operate the pharmacy in a manner prescribed by federal and state law and according to rules adopted by the board. No license shall be issued for a pharmacy located outside of the state unless the applicant agrees to operate the pharmacy in a manner prescribed by federal law and, when dispensing medications for residents of this state, the laws of this state, and Minnesota Rules.

(d) No license shall be issued or renewed for a pharmacy that is required to be licensed or registered by the state in which it is physically located unless the applicant supplies the board with proof of such licensure or registration.

(e) The board shall require a separate license for each pharmacy located within the state and for each pharmacy located outside of the state at which any portion of the dispensing process occurs for drugs dispensed to residents of this state.

(f) The board shall not issue an initial or renewed license for a pharmacy unless the pharmacy passes an inspection conducted by an authorized representative of the board. In the case of a pharmacy located outside of the state, the board may require the applicant to pay the cost of the inspection, in addition to the license fee in section 151.065, unless the applicant furnishes the board with a report, issued by the appropriate regulatory agency of the state in which the facility is located, of an inspection that has occurred within the 24 months immediately preceding receipt of the license application by the board. The board

may deny licensure unless the applicant submits documentation satisfactory to the board that any deficiencies noted in an inspection report have been corrected.

(g) The board shall not issue an initial or renewed license for a pharmacy located outside of the state unless the applicant discloses and certifies:

(1) the location, names, and titles of all principal corporate officers and all pharmacists who are involved in dispensing drugs to residents of this state;

(2) that it maintains its records of drugs dispensed to residents of this state so that the records are readily retrievable from the records of other drugs dispensed;

(3) that it agrees to cooperate with, and provide information to, the board concerning matters related to dispensing drugs to residents of this state;

(4) that, during its regular hours of operation, but no less than six days per week, for a minimum of 40 hours per week, a toll-free telephone service is provided to facilitate communication between patients in this state and a pharmacist at the pharmacy who has access to the patients' records; the toll-free number must be disclosed on the label affixed to each container of drugs dispensed to residents of this state; and

(5) that, upon request of a resident of a long-term care facility located in this state, the resident's authorized representative, or a contract pharmacy or licensed health care facility acting on behalf of the resident, the pharmacy will dispense medications prescribed for the resident in unit-dose packaging or, alternatively, comply with section 151.415, subdivision 5.

(h) This subdivision does not apply to a manufacturer licensed under section 151.252, subdivision 1, a wholesale drug distributor licensed under section 151.47, or a third-party logistics provider, to the extent the manufacturer, wholesale drug distributor, or third-party logistics provider is engaged in the distribution of dialysate or devices necessary to perform home peritoneal dialysis on patients with end-stage renal disease, if:

(1) the manufacturer or its agent leases or owns the licensed manufacturing or wholesaling facility from which the dialysate or devices will be delivered;

(2) the dialysate is comprised of dextrose or icodextrin and has been approved by the United States Food and Drug Administration;

(3) the dialysate is stored and delivered in its original, sealed, and unopened manufacturer's packaging;

(4) the dialysate or devices are delivered only upon:

(i) receipt of a physician's order by a Minnesota licensed pharmacy; and

(ii) the review and processing of the prescription by a pharmacist licensed by the state in which the pharmacy is located, who is employed by or under contract to the pharmacy;

(5) prescriptions, policies, procedures, and records of delivery are maintained by the manufacturer for a minimum of three years and are made available to the board upon request; and

(6) the manufacturer or the manufacturer's agent delivers the dialysate or devices directly to:

(i) a patient with end-stage renal disease for whom the prescription was written or the patient's designee, for the patient's self-administration of the dialysis therapy; or

(ii) a health care provider or institution, for administration or delivery of the dialysis therapy to a patient with end-stage renal disease for whom the prescription was written.

Sec. 18. Minnesota Statutes 2016, section 151.46, is amended to read:

151.46 PROHIBITED DRUG PURCHASES OR RECEIPT.

It is unlawful for any person to knowingly purchase or receive a prescription drug from a source other than a person or entity licensed under the laws of the state, except where otherwise provided. Licensed wholesale drug distributors other than pharmacies shall not dispense or distribute prescription drugs directly to patients except for licensed facilities that dispense or distribute home peritoneal dialysis products directly to patients pursuant to section 151.19, subdivision 1, paragraph (h). A person violating the provisions of this section is guilty of a misdemeanor.

Sec. 19. Minnesota Statutes 2016, section 214.075, subdivision 1, is amended to read:

Subdivision 1. **Applications.** (a) ~~By January 1, 2018,~~ Each health-related licensing board, as defined in section 214.01, subdivision 2, shall require ~~applicants for initial licensure, licensure by endorsement, or reinstatement or other relicensure after a lapse in licensure, as defined by the individual health-related licensing boards,~~ the following individuals to submit to a criminal history records check of state data completed by the Bureau of Criminal Apprehension (BCA) and a national criminal history records check, including a search of the records of the Federal Bureau of Investigation (FBI)~~.~~:

(1) applicants for initial licensure or licensure by endorsement. An applicant is exempt from this paragraph if the applicant submitted to a state and national criminal history records check as described in this paragraph for a license issued by the same board;

(2) applicants seeking reinstatement or relicensure, as defined by the individual health-related licensing board, if more than one year has elapsed since the applicant's license or registration expiration date; or

(3) licensees applying for eligibility to participate in an interstate licensure compact.

(b) ~~An applicant must complete a criminal background check if more than one year has elapsed since the applicant last submitted a background check to the board.~~ An applicant's criminal background check results are valid for one year from the date the background check results were received by the board. If more than one year has elapsed since the results were received by the board, then an applicant who has not completed the licensure, reinstatement, or relicensure process must complete a new background check.

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

Sec. 20. Minnesota Statutes 2016, section 214.075, subdivision 4, is amended to read:

Subd. 4. **Refusal to consent.** (a) The health-related licensing boards shall not issue a license to any applicant who refuses to consent to a criminal background check or fails to submit fingerprints ~~within 90 days~~ after submission of an application for licensure. Any fees paid by the applicant to the board shall be forfeited if the applicant refuses to consent to the criminal background check or fails to submit the required fingerprints.

(b) The failure of a licensee to submit to a criminal background check as provided in subdivision 3 is grounds for disciplinary action by the respective health-related licensing board.

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

Sec. 21. Minnesota Statutes 2016, section 214.075, subdivision 5, is amended to read:

Subd. 5. **Submission of fingerprints to the Bureau of Criminal Apprehension.** The health-related licensing board or designee shall submit applicant or licensee fingerprints to the BCA. The BCA shall perform a check for state criminal justice information and shall forward the applicant's or licensee's fingerprints to the FBI to perform a check for national criminal justice information regarding the applicant or licensee. The BCA shall report to the board the results of the state and national criminal ~~justice information~~ history records checks.

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

Sec. 22. Minnesota Statutes 2016, section 214.075, subdivision 6, is amended to read:

Subd. 6. **Alternatives to fingerprint-based criminal background checks.** The health-related licensing board may require an alternative method of criminal history checks for an applicant or licensee who has submitted at least ~~three~~ two sets of fingerprints in accordance with this section that have been unreadable by the BCA or the FBI.

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

Sec. 23. Minnesota Statutes 2016, section 214.077, is amended to read:

214.077 TEMPORARY LICENSE SUSPENSION; IMMINENT RISK OF SERIOUS HARM.

(a) Notwithstanding any provision of a health-related professional practice act, when a health-related licensing board receives a complaint regarding a regulated person and has probable cause to believe that the regulated person has violated a statute or rule that the health-related licensing board is empowered to enforce, and continued practice by the regulated person presents an imminent risk of serious harm, the health-related licensing board shall issue an order temporarily suspending the regulated person's authority to practice. The temporary suspension order shall specify the reason for the suspension, including the statute or rule alleged to have been violated. The temporary suspension order shall take effect upon personal service on the regulated person or the regulated person's attorney, or upon the third calendar day after the order is served by first class mail to the most recent address provided to the health-related licensing board for the regulated person or the regulated person's attorney.

(b) The temporary suspension shall remain in effect until the health-related licensing board or the commissioner completes an investigation, holds a contested case hearing pursuant to the Administrative Procedure Act, and issues a final order in the matter as provided for in this section.

(c) At the time it issues the temporary suspension order, the health-related licensing board shall schedule a contested case hearing, on the merits of whether discipline is warranted, to be held pursuant to the Administrative Procedure Act. The regulated person shall be provided with at least ten days' notice of any contested case hearing held pursuant to this section. The contested case hearing shall be scheduled to begin no later than 30 days after the effective service of the temporary suspension order.

(d) The administrative law judge presiding over the contested case hearing shall issue a report and recommendation to the health-related licensing board no later than 30 days after the final day of the contested case hearing. If the administrative law judge's report and recommendations are for no action, the health-related licensing board shall issue a final order pursuant to sections 14.61 and 14.62 within 30 days of receipt of the administrative law judge's report and recommendations. If the administrative law judge's report and recommendations are for action, the health-related licensing board shall issue a final order pursuant to sections 14.61 and 14.62 within 60 days of receipt of the administrative law judge's report and recommendations. Except as provided in paragraph (e), if the health-related licensing board has not issued a final order pursuant to sections 14.61 and 14.62 within 30 days of receipt of the administrative law judge's report and recommendations for no action or within 60 days of receipt of the administrative law judge's report and recommendations for action, the temporary suspension shall be lifted.

(e) If the regulated person requests a delay in the contested case proceedings provided for in paragraphs (c) and (d) for any reason, the temporary suspension shall remain in effect until the health-related licensing board issues a final order pursuant to sections 14.61 and 14.62.

(f) This section shall not apply to the Office of Unlicensed Complementary and Alternative Health Practice established under section 146A.02. The commissioner of health shall conduct temporary suspensions for complementary and alternative health care practitioners in accordance with section 146A.09.

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

Sec. 24. Minnesota Statutes 2016, section 214.10, subdivision 8, is amended to read:

Subd. 8. **Special requirements for health-related licensing boards.** In addition to the provisions of this section that apply to all examining and licensing boards, the requirements in this subdivision apply to all health-related licensing boards, except the Board of Veterinary Medicine.

(a) If the executive director or consulted board member determines that a communication received alleges a violation of statute or rule that involves sexual contact with a patient or client, the communication shall be forwarded to the designee of the attorney general for an investigation of the facts alleged in the communication. If, after an investigation it is the opinion of the executive director or consulted board member that there is sufficient evidence to justify disciplinary action, the board shall conduct a disciplinary conference or hearing. If, after a hearing or disciplinary conference the board determines that misconduct involving

sexual contact with a patient or client occurred, the board shall take disciplinary action. Notwithstanding subdivision 2, a board may not attempt to correct improper activities or redress grievances through education, conciliation, and persuasion, unless in the opinion of the executive director or consulted board member there is insufficient evidence to justify disciplinary action. The board may settle a case by stipulation prior to, or during, a hearing if the stipulation provides for disciplinary action.

(b) A board member who has a direct current or former financial connection or professional relationship to a person who is the subject of board disciplinary activities must not participate in board activities relating to that case.

(c) Each health-related licensing board shall establish procedures for exchanging information with other Minnesota state boards, agencies, and departments responsible for regulating health-related occupations, facilities, and programs, and for coordinating investigations involving matters within the jurisdiction of more than one regulatory body. The procedures must provide for the forwarding to other regulatory bodies of all information and evidence, including the results of investigations, that are relevant to matters within that licensing body's regulatory jurisdiction. Each health-related licensing board shall have access to any data of the Department of Human Services relating to a person subject to the jurisdiction of the licensing board. The data shall have the same classification under chapter 13, the Minnesota Government Data Practices Act, in the hands of the agency receiving the data as it had in the hands of the Department of Human Services.

(d) Each health-related licensing board shall establish procedures for exchanging information with other states regarding disciplinary actions against licensees. The procedures must provide for the collection of information from other states about disciplinary actions taken against persons who are licensed to practice in Minnesota or who have applied to be licensed in this state and the dissemination of information to other states regarding disciplinary actions taken in Minnesota. In addition to any authority in chapter 13 permitting the dissemination of data, the board may, in its discretion, disseminate data to other states regardless of its classification under chapter 13. Criminal history record information shall not be exchanged. Before transferring any data that is not public, the board shall obtain reasonable assurances from the receiving state that the data will not be made public.

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

Sec. 25. Minnesota Statutes 2016, section 214.12, is amended by adding a subdivision to read:

Subd. 6. **Opioid and controlled substances prescribing.** (a) The Board of Medical Practice, the Board of Nursing, the Board of Dentistry, the Board of Optometry, and the Board of Podiatric Medicine shall require that licensees with the authority to prescribe controlled substances obtain at least two hours of continuing education credit on best practices in prescribing opioids and controlled substances, as part of the continuing education requirements for licensure renewal. Licensees shall not be required to complete more than two credit hours of continuing education on best practices in prescribing opioids and controlled substances before this subdivision expires. Continuing education credit on best practices in prescribing opioids and controlled substances must meet board requirements.

(b) This subdivision expires January 1, 2023.

EFFECTIVE DATE. This section is effective January 1, 2019.

Sec. 26. Minnesota Statutes 2017 Supplement, section 245G.22, subdivision 2, is amended to read:

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

(b) "Diversion" means the use of a medication for the treatment of opioid addiction being diverted from intended use of the medication.

(c) "Guest dose" means administration of a medication used for the treatment of opioid addiction to a person who is not a client of the program that is administering or dispensing the medication.

(d) "Medical director" means a physician licensed to practice medicine in the jurisdiction that the opioid treatment program is located who assumes responsibility for administering all medical services performed by the program, either by performing the services directly or by delegating specific responsibility to (1) authorized program physicians ~~and~~; (2) advanced practice registered nurses, when approved by variance by the State Opioid Treatment Authority under section 254A.03 and the federal Substance Abuse and Mental Health Services Administration; or (3) health care professionals functioning under the medical director's direct supervision.

(e) "Medication used for the treatment of opioid use disorder" means a medication approved by the Food and Drug Administration for the treatment of opioid use disorder.

(f) "Minnesota health care programs" has the meaning given in section 256B.0636.

(g) "Opioid treatment program" has the meaning given in Code of Federal Regulations, title 42, section 8.12, and includes programs licensed under this chapter.

(h) "Placing authority" has the meaning given in Minnesota Rules, part 9530.6605, subpart 21a.

(i) "Unsupervised use" means the use of a medication for the treatment of opioid use disorder dispensed for use by a client outside of the program setting.

Sec. 27. Minnesota Statutes 2016, section 256.975, subdivision 7b, is amended to read:

Subd. 7b. **Exemptions and emergency admissions.** (a) Exemptions from the federal screening requirements outlined in subdivision 7a, paragraphs (b) and (c), are limited to:

(1) a person who, having entered an acute care facility from a certified nursing facility, is returning to a certified nursing facility; or

(2) a person transferring from one certified nursing facility in Minnesota to another certified nursing facility in Minnesota.

(b) Persons who are exempt from preadmission screening for purposes of level of care determination include:

(1) persons described in paragraph (a);

(2) an individual who has a contractual right to have nursing facility care paid for indefinitely by the Veterans Administration;

(3) an individual enrolled in a demonstration project under section 256B.69, subdivision 8, at the time of application to a nursing facility; and

(4) an individual currently being served under the alternative care program or under a home and community-based services waiver authorized under section 1915(c) of the federal Social Security Act.

(c) Persons admitted to a Medicaid-certified nursing facility from the community on an emergency basis as described in paragraph (d) or from an acute care facility on a nonworking day must be screened the first working day after admission.

(d) Emergency admission to a nursing facility prior to screening is permitted when all of the following conditions are met:

(1) a person is admitted from the community to a certified nursing or certified boarding care facility during Senior LinkAge Line nonworking hours;

(2) a physician or advanced practice registered nurse has determined that delaying admission until preadmission screening is completed would adversely affect the person's health and safety;

(3) there is a recent precipitating event that precludes the client from living safely in the community, such as sustaining an injury, sudden onset of acute illness, or a caregiver's inability to continue to provide care;

(4) the attending physician or advanced practice registered nurse has authorized the emergency placement and has documented the reason that the emergency placement is recommended; and

(5) the Senior LinkAge Line is contacted on the first working day following the emergency admission.

Transfer of a patient from an acute care hospital to a nursing facility is not considered an emergency except for a person who has received hospital services in the following situations: hospital admission for observation, care in an emergency room without hospital admission, or following hospital 24-hour bed care and from whom admission is being sought on a nonworking day.

(e) A nursing facility must provide written information to all persons admitted regarding the person's right to request and receive long-term care consultation services as defined in section 256B.0911, subdivision 1a. The information must be provided prior to the person's discharge from the facility and in a format specified by the commissioner.

Sec. 28. Minnesota Statutes 2016, section 256B.0575, subdivision 1, is amended to read:

Subdivision 1. **Income deductions.** When an institutionalized person is determined eligible for medical assistance, the income that exceeds the deductions in paragraphs (a) and (b) must be applied to the cost of institutional care.

(a) The following amounts must be deducted from the institutionalized person's income in the following order:

(1) the personal needs allowance under section 256B.35 or, for a veteran who does not have a spouse or child, or a surviving spouse of a veteran having no child, the amount of an improved pension received from the veteran's administration not exceeding $90 per month;

(2) the personal allowance for disabled individuals under section 256B.36;

(3) if the institutionalized person has a legally appointed guardian or conservator, five percent of the recipient's gross monthly income up to $100 as reimbursement for guardianship or conservatorship services;

(4) a monthly income allowance determined under section 256B.058, subdivision 2, but only to the extent income of the institutionalized spouse is made available to the community spouse;

(5) a monthly allowance for children under age 18 which, together with the net income of the children, would provide income equal to the medical assistance standard for families and children according to section 256B.056, subdivision 4, for a family size that includes only the minor children. This deduction applies only if the children do not live with the community spouse and only to the extent that the deduction is not included in the personal needs allowance under section 256B.35, subdivision 1, as child support garnished under a court order;

(6) a monthly family allowance for other family members, equal to one-third of the difference between 122 percent of the federal poverty guidelines and the monthly income for that family member;

(7) reparations payments made by the Federal Republic of Germany and reparations payments made by the Netherlands for victims of Nazi persecution between 1940 and 1945;

(8) all other exclusions from income for institutionalized persons as mandated by federal law; and

(9) amounts for reasonable expenses, as specified in subdivision 2, incurred for necessary medical or remedial care for the institutionalized person that are recognized under state law, not medical assistance covered expenses, and not subject to payment by a third party.

For purposes of clause (6), "other family member" means a person who resides with the community spouse and who is a minor or dependent child, dependent parent, or dependent sibling of either spouse. "Dependent" means a person who could be claimed as a dependent for federal income tax purposes under the Internal Revenue Code.

(b) Income shall be allocated to an institutionalized person for a period of up to three calendar months, in an amount equal to the medical assistance standard for a family size of one if:

(1) a physician or advanced practice registered nurse certifies that the person is expected to reside in the long-term care facility for three calendar months or less;

(2) if the person has expenses of maintaining a residence in the community; and

(3) if one of the following circumstances apply:

(i) the person was not living together with a spouse or a family member as defined in paragraph (a) when the person entered a long-term care facility; or

(ii) the person and the person's spouse become institutionalized on the same date, in which case the allocation shall be applied to the income of one of the spouses.

For purposes of this paragraph, a person is determined to be residing in a licensed nursing home, regional treatment center, or medical institution if the person is expected to remain for a period of one full calendar month or more.

Sec. 29. Minnesota Statutes 2016, section 256B.0595, subdivision 3, is amended to read:

Subd. 3. **Homestead exception to transfer prohibition.** (a) An institutionalized person is not ineligible for long-term care services due to a transfer of assets for less than fair market value if the asset transferred was a homestead and:

(1) title to the homestead was transferred to the individual's:

(i) spouse;

(ii) child who is under age 21;

(iii) blind or permanently and totally disabled child as defined in the Supplemental Security Income program;

(iv) sibling who has equity interest in the home and who was residing in the home for a period of at least one year immediately before the date of the individual's admission to the facility; or

(v) son or daughter who was residing in the individual's home for a period of at least two years immediately before the date the individual became an institutionalized person, and who provided care to the individual that, as certified by the individual's attending physician or advanced practice registered nurse, permitted the individual to reside at home rather than receive care in an institution or facility;

(2) a satisfactory showing is made that the individual intended to dispose of the homestead at fair market value or for other valuable consideration; or

(3) the local agency grants a waiver of a penalty resulting from a transfer for less than fair market value because denial of eligibility would cause undue hardship for the individual, based on imminent threat to the individual's health and well-being. Whenever an applicant or recipient is denied eligibility because of a transfer for less than fair market value, the

local agency shall notify the applicant or recipient that the applicant or recipient may request a waiver of the penalty if the denial of eligibility will cause undue hardship. With the written consent of the individual or the personal representative of the individual, a long-term care facility in which an individual is residing may file an undue hardship waiver request, on behalf of the individual who is denied eligibility for long-term care services on or after July 1, 2006, due to a period of ineligibility resulting from a transfer on or after February 8, 2006. In evaluating a waiver, the local agency shall take into account whether the individual was the victim of financial exploitation, whether the individual has made reasonable efforts to recover the transferred property or resource, and other factors relevant to a determination of hardship. If the local agency does not approve a hardship waiver, the local agency shall issue a written notice to the individual stating the reasons for the denial and the process for appealing the local agency's decision.

(b) When a waiver is granted under paragraph (a), clause (3), a cause of action exists against the person to whom the homestead was transferred for that portion of long-term care services provided within:

(1) 30 months of a transfer made on or before August 10, 1993;

(2) 60 months if the homestead was transferred after August 10, 1993, to a trust or portion of a trust that is considered a transfer of assets under federal law;

(3) 36 months if transferred in any other manner after August 10, 1993, but prior to February 8, 2006; or

(4) 60 months if the homestead was transferred on or after February 8, 2006,

or the amount of the uncompensated transfer, whichever is less, together with the costs incurred due to the action.

Sec. 30. Minnesota Statutes 2016, section 256B.0625, subdivision 2, is amended to read:

Subd. 2. **Skilled and intermediate nursing care.** (a) Medical assistance covers skilled nursing home services and services of intermediate care facilities, including training and habilitation services, as defined in section 252.41, subdivision 3, for persons with developmental disabilities who are residing in intermediate care facilities for persons with developmental disabilities. Medical assistance must not be used to pay the costs of nursing care provided to a patient in a swing bed as defined in section 144.562, unless (1) the facility in which the swing bed is located is eligible as a sole community provider, as defined in Code of Federal Regulations, title 42, section 412.92, or the facility is a public hospital owned by a governmental entity with 15 or fewer licensed acute care beds; (2) the Centers

for Medicare and Medicaid Services approves the necessary state plan amendments; (3) the patient was screened as provided by law; (4) the patient no longer requires acute care services; and (5) no nursing home beds are available within 25 miles of the facility. The commissioner shall exempt a facility from compliance with the sole community provider requirement in clause (1) if, as of January 1, 2004, the facility had an agreement with the commissioner to provide medical assistance swing bed services.

(b) Medical assistance also covers up to ten days of nursing care provided to a patient in a swing bed if: (1) the patient's physician or advanced practice registered nurse certifies that the patient has a terminal illness or condition that is likely to result in death within 30 days and that moving the patient would not be in the best interests of the patient and patient's family; (2) no open nursing home beds are available within 25 miles of the facility; and (3) no open beds are available in any Medicare hospice program within 50 miles of the facility. The daily medical assistance payment for nursing care for the patient in the swing bed is the statewide average medical assistance skilled nursing care per diem as computed annually by the commissioner on July 1 of each year.

Sec. 31. Minnesota Statutes 2016, section 259.24, subdivision 2, is amended to read:

Subd. 2. **Parents, guardian.** If an unmarried parent who consents to the adoption of a child is under 18 years of age, the consent of the minor parent's parents or guardian, if any, also shall be required; if either or both the parents are disqualified for any of the reasons enumerated in subdivision 1, the consent of such parent shall be waived, and the consent of the guardian only shall be sufficient; and, if there be neither parent nor guardian qualified to give such consent, the consent may be given by the commissioner. The agency overseeing the adoption proceedings shall ensure that the minor parent is offered the opportunity to consult with an attorney, a member of the clergy ~~or~~, a physician, or an advanced practice registered nurse before consenting to adoption of the child. The advice or opinion of the attorney, clergy member ~~or~~, physician, or advanced practice registered nurse shall not be binding on the minor parent. If the minor parent cannot afford the cost of consulting with an attorney, a member of the clergy ~~or~~, a physician, or an advanced practice registered nurse, the county shall bear that cost.

Sec. 32. Minnesota Statutes 2017 Supplement, section 260C.007, subdivision 6, is amended to read:

Subd. 6. **Child in need of protection or services.** "Child in need of protection or services" means a child who is in need of protection or services because the child:

(1) is abandoned or without parent, guardian, or custodian;

(2)(i) has been a victim of physical or sexual abuse as defined in section 626.556, subdivision 2, (ii) resides with or has resided with a victim of child abuse as defined in subdivision 5 or domestic child abuse as defined in subdivision 13, (iii) resides with or would reside with a perpetrator of domestic child abuse as defined in subdivision 13 or child abuse as defined in subdivision 5 or 13, or (iv) is a victim of emotional maltreatment as defined in subdivision 15;

(3) is without necessary food, clothing, shelter, education, or other required care for the child's physical or mental health or morals because the child's parent, guardian, or custodian is unable or unwilling to provide that care;

(4) is without the special care made necessary by a physical, mental, or emotional condition because the child's parent, guardian, or custodian is unable or unwilling to provide that care;

(5) is medically neglected, which includes, but is not limited to, the withholding of medically indicated treatment from an infant with a disability with a life-threatening condition. The term "withholding of medically indicated treatment" means the failure to respond to the infant's life-threatening conditions by providing treatment, including appropriate nutrition, hydration, and medication which, in the treating physician's or ~~physicians'~~ advanced practice registered nurse's reasonable medical judgment, will be most likely to be effective in ameliorating or correcting all conditions, except that the term does not include the failure to provide treatment other than appropriate nutrition, hydration, or medication to an infant when, in the treating physician's or ~~physicians'~~ advanced practice registered nurse's reasonable medical judgment:

(i) the infant is chronically and irreversibly comatose;

(ii) the provision of the treatment would merely prolong dying, not be effective in ameliorating or correcting all of the infant's life-threatening conditions, or otherwise be futile in terms of the survival of the infant; or

(iii) the provision of the treatment would be virtually futile in terms of the survival of the infant and the treatment itself under the circumstances would be inhumane;

(6) is one whose parent, guardian, or other custodian for good cause desires to be relieved of the child's care and custody, including a child who entered foster care under a voluntary placement agreement between the parent and the responsible social services agency under section 260C.227;

(7) has been placed for adoption or care in violation of law;

(8) is without proper parental care because of the emotional, mental, or physical disability, or state of immaturity of the child's parent, guardian, or other custodian;

(9) is one whose behavior, condition, or environment is such as to be injurious or dangerous to the child or others. An injurious or dangerous environment may include, but is not limited to, the exposure of a child to criminal activity in the child's home;

(10) is experiencing growth delays, which may be referred to as failure to thrive, that have been diagnosed by a physician and are due to parental neglect;

(11) is a sexually exploited youth;

(12) has committed a delinquent act or a juvenile petty offense before becoming ten years old;

(13) is a runaway;

(14) is a habitual truant;

(15) has been found incompetent to proceed or has been found not guilty by reason of mental illness or mental deficiency in connection with a delinquency proceeding, a certification under section 260B.125, an extended jurisdiction juvenile prosecution, or a proceeding involving a juvenile petty offense; or

(16) has a parent whose parental rights to one or more other children were involuntarily terminated or whose custodial rights to another child have been involuntarily transferred to a relative and there is a case plan prepared by the responsible social services agency documenting a compelling reason why filing the termination of parental rights petition under section 260C.503, subdivision 2, is not in the best interests of the child.

Sec. 33. Minnesota Statutes 2017 Supplement, section 364.09, is amended to read:

364.09 EXCEPTIONS.

(a) This chapter does not apply to the licensing process for peace officers; to law enforcement agencies as defined in section 626.84, subdivision 1, paragraph (f); to fire protection agencies; to eligibility for a private detective or protective agent license; to the licensing and background study process under chapters 245A and 245C; to the licensing and background investigation process under chapter 240; to eligibility for school bus driver endorsements; to eligibility for special transportation service endorsements; to eligibility for a commercial driver training instructor license, which is governed by section 171.35 and rules adopted under that section; to emergency medical services personnel, or to the

licensing by political subdivisions of taxicab drivers, if the applicant for the license has been discharged from sentence for a conviction within the ten years immediately preceding application of a violation of any of the following:

(1) sections 609.185 to 609.2114, 609.221 to 609.223, 609.342 to 609.3451, or 617.23, subdivision 2 or 3; or Minnesota Statutes 2012, section 609.21;

(2) any provision of chapter 152 that is punishable by a maximum sentence of 15 years or more; or

(3) a violation of chapter 169 or 169A involving driving under the influence, leaving the scene of an accident, or reckless or careless driving.

This chapter also shall not apply to eligibility for juvenile corrections employment, where the offense involved child physical or sexual abuse or criminal sexual conduct.

(b) This chapter does not apply to a school district or to eligibility for a license issued or renewed by the Professional Educator Licensing and Standards Board or the commissioner of education.

(c) Nothing in this section precludes the Minnesota Police and Peace Officers Training Board or the state fire marshal from recommending policies set forth in this chapter to the attorney general for adoption in the attorney general's discretion to apply to law enforcement or fire protection agencies.

~~(d) This chapter does not apply to a license to practice medicine that has been denied or revoked by the Board of Medical Practice pursuant to section 147.091, subdivision 1a.~~

~~(e) This chapter does not apply to any person who has been denied a license to practice chiropractic or whose license to practice chiropractic has been revoked by the board in accordance with section 148.10, subdivision 7.~~

~~(f) This chapter does not apply to any license, registration, or permit that has been denied or revoked by the Board of Nursing in accordance with section 148.261, subdivision 1a.~~

~~(g)~~ (d) This chapter does not apply to any license, registration, permit, or certificate that has been denied or revoked by the commissioner of health according to section 148.5195, subdivision 5; or 153A.15, subdivision 2.

~~(h)~~ (e) This chapter does not supersede a requirement under law to conduct a criminal history background investigation or consider criminal history records in hiring for particular types of employment.

(f) This chapter does not apply to the licensing or registration process for, or to any license, registration, or permit that has been denied or revoked by, a health licensing board listed in section 214.01, subdivision 2.

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

Sec. 34. **COUNCIL OF HEALTH BOARDS WORK GROUP.**

(a) The Council of Health Boards shall convene a work group to study and make recommendations on:

(1) increasing the use of telehealth technologies including, but not limited to, high-fidelity simulation and teleconferencing to complete portions of the clinical experiences required as part of postsecondary educational programs that relate to counseling. Clinical experiences may include supervised practicum and internship hours. The study shall include the parameters in which the proposed technology may be utilized in order to ensure that students are integrating classroom theory in a lifelike clinical setting without compromising clinical competency outcomes;

(2) increasing access to telehealth technologies for use in supervision of persons completing postdegree supervised practice work experience and training required for licensure. The study shall include the parameters in which the proposed technology may be utilized for supervision to ensure the quality and competence of the activities supervised; and

(3) increasing client access to mental health services through use of telehealth technologies.

(b) The work group must consist of representatives of:

(1) the Boards of Psychology, Social Work, Marriage and Family Therapy, and Behavioral Health and Therapy;

(2) postsecondary educational institutions that have accredited educational programs for social work, psychology, alcohol and drug counseling, marriage and family therapy, and professional counseling; and

(3) the relevant professional counseling associations, including the Minnesota Counseling Association; Minnesota Psychology Association; National Association of Social Workers, Minnesota chapter; Minnesota Association for Marriage and Family Therapy; and the Minnesota Association of Resources for Recovery and Chemical Health.

(c) By February 1, 2019, the council shall submit recommendations for using telehealth technologies to the chairs and ranking minority members of the legislative committees with jurisdiction over health occupations and higher education, and shall include a plan for implementing the recommendations and any legislative changes necessary for implementation.

Sec. 35. **REPEALER.**

Minnesota Statutes 2016, section 214.075, subdivision 8, is repealed.

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

ARTICLE 9

MISCELLANEOUS

Section 1. Minnesota Statutes 2016, section 62V.05, subdivision 2, is amended to read:

Subd. 2. **Operations funding.** ~~(a) Prior to January 1, 2015, MNsure shall retain or collect up to 1.5 percent of total premiums for individual and small group market health plans and dental plans sold through MNsure to fund the cash reserves of MNsure, but the amount collected shall not exceed a dollar amount equal to 25 percent of the funds collected under section 62E.11, subdivision 6, for calendar year 2012.~~

~~(b) Beginning January 1, 2015, MNsure shall retain or collect up to 3.5 percent of total premiums for individual and small group market health plans and dental plans sold through MNsure to fund the operations of MNsure, but the amount collected shall not exceed a dollar amount equal to 50 percent of the funds collected under section 62E.11, subdivision 6, for calendar year 2012.~~

~~(c)~~ (a) Beginning January 1, 2016, through December 31, 2018, MNsure shall retain or collect up to 3.5 percent of total premiums for individual and small group market health plans and dental plans sold through MNsure to fund the operations of MNsure, but the amount collected may never exceed a dollar amount greater than 100 percent of the funds collected under section 62E.11, subdivision 6, for calendar year 2012.

~~(d) For fiscal years 2014 and 2015, the commissioner of management and budget is authorized to provide cash flow assistance of up to $20,000,000 from the special revenue fund or the statutory general fund under section 16A.671, subdivision 3, paragraph (a), to MNsure. Any funds provided under this paragraph shall be repaid, with interest, by June 30, 2015.~~

(b) Beginning January 1, 2019, MNsure shall retain or collect up to two percent of total premiums for individual and small group health plans and dental plans sold through MNsure to fund the operations of MNsure, but the amount collected may never exceed a dollar amount greater than 25 percent of the funds collected under section 62E.11, subdivision 6, for calendar year 2012.

~~(c)~~ (c) Funding for the operations of MNsure shall cover any compensation provided to navigators participating in the navigator program.

(d) Interagency agreements between MNsure and the Department of Human Services, and the Public Assistance Cost Allocation Plan for the Department of Human Services, shall not be modified to reflect any changes to the percentage of premiums that MNsure is allowed to retain or collect under this section, and no additional funding shall be transferred from the Department of Human Services to MNsure as a result of any changes to the percentage of premiums that MNsure is allowed to retain or collect under this section.

Sec. 2. Minnesota Statutes 2016, section 62V.05, subdivision 5, is amended to read:

Subd. 5. **Health carrier and health plan requirements; participation.** (a) Beginning January 1, 2015, the board may establish certification requirements for health carriers and health plans to be offered through MNsure that satisfy federal requirements under ~~section 1311(c)(1) of the Affordable Care Act, Public Law 111-148~~ United States Code, title 42, section 18031(c)(1).

(b) Paragraph (a) does not apply if by June 1, 2013, the legislature enacts regulatory requirements that:

(1) apply uniformly to all health carriers and health plans in the individual market;

(2) apply uniformly to all health carriers and health plans in the small group market; and

(3) satisfy minimum federal certification requirements under ~~section 1311(c)(1) of the Affordable Care Act, Public Law 111-148~~ United States Code, title 42, section 18031(c)(1).

(c) In accordance with ~~section 1311(c) of the Affordable Care Act, Public Law 111-148~~ United States Code, title 42, section 18031(e), the board shall establish policies and procedures for certification and selection of health plans to be offered as qualified health plans through MNsure. The board shall certify and select a health plan as a qualified health plan to be offered through MNsure, if:

(1) the health plan meets the minimum certification requirements established in paragraph (a) or the market regulatory requirements in paragraph (b);

(2) the board determines that making the health plan available through MNsure is in the interest of qualified individuals and qualified employers;

(3) the health carrier applying to offer the health plan through MNsure also applies to offer health plans at each actuarial value level and service area that the health carrier currently offers in the individual and small group markets; and

(4) the health carrier does not apply to offer health plans in the individual and small group markets through MNsure under a separate license of a parent organization or holding company under section 60D.15, that is different from what the health carrier offers in the individual and small group markets outside MNsure.

(d) In determining the interests of qualified individuals and employers under paragraph (c), clause (2), the board may not exclude a health plan for any reason specified under ~~section 1311(e)(1)(B) of the Affordable Care Act, Public Law 111-148~~ United States Code, title 42, section 18031(e)(1)(B). ~~The board may consider:~~

~~(1) affordability;~~

~~(2) quality and value of health plans;~~

~~(3) promotion of prevention and wellness;~~

~~(4) promotion of initiatives to reduce health disparities;~~

~~(5) market stability and adverse selection;~~

~~(6) meaningful choices and access;~~

~~(7) alignment and coordination with state agency and private sector purchasing strategies and payment reform efforts; and~~

~~(8) other criteria that the board determines appropriate.~~

(e) A health plan that meets the minimum certification requirements under paragraph (c) and United States Code, title 42, section 18031(c)(1), and any regulations and guidance issued under that section, is deemed to be in the interest of qualified individuals and qualified employers. The board shall not establish certification requirements for health carriers and health plans for participation in MNsure that are in addition to the certification requirements under paragraph (c) and United States Code, title 42, section 18031(c)(1), and any regulations and guidance issued under that section. The board shall not determine the cost of, cost-sharing elements of, or benefits provided in health plans sold through MNsure.

~~(e)~~ (f) For qualified health plans offered through MNsure on or after January 1, 2015, the board shall establish policies and procedures under paragraphs (c) and (d) for selection

of health plans to be offered as qualified health plans through MNsure by February 1 of each year, beginning February 1, 2014. The board shall consistently and uniformly apply all policies and procedures and any requirements, standards, or criteria to all health carriers and health plans. For any policies, procedures, requirements, standards, or criteria that are defined as rules under section 14.02, subdivision 4, the board may use the process described in subdivision 9.

~~(f) For 2014, the board shall not have the power to select health carriers and health plans for participation in MNsure. The board shall permit all health plans that meet the certification requirements under section 1311(c)(1) of the Affordable Care Act, Public Law 111-148, to be offered through MNsure.~~

(g) Under this subdivision, the board shall have the power to verify that health carriers and health plans are properly certified to be eligible for participation in MNsure.

(h) The board has the authority to decertify health carriers and health plans that fail to maintain compliance with ~~section 1311(c)(1) of the Affordable Care Act, Public Law 111-148~~ United States Code, title 42, section 18031(c)(1).

(i) For qualified health plans offered through MNsure beginning January 1, 2015, health carriers must use the most current addendum for Indian health care providers approved by the Centers for Medicare and Medicaid Services and the tribes as part of their contracts with Indian health care providers. MNsure shall comply with all future changes in federal law with regard to health coverage for the tribes.

Sec. 3. Minnesota Statutes 2016, section 62V.05, subdivision 10, is amended to read:

Subd. 10. **Limitations; risk-bearing.** (a) The board shall not bear insurance risk or enter into any agreement with health care providers to pay claims.

(b) Nothing in this subdivision shall prevent MNsure from providing insurance for its employees.

(c) The commissioner of human services shall not bear insurance risk or enter into any agreement with providers to pay claims for any health coverage administered by the commissioner that is made available for purchase through the MNsure Web site as an alternative to purchasing a qualifying health plan through MNsure or an individual health plan offered outside of MNsure.

(d) Nothing in this subdivision shall prohibit:

(1) the commissioner of human services from administering the medical assistance program under chapter 256B and the MinnesotaCare program under chapter 256L, as long as health coverage under these programs is not purchased by the individual through the MNsure Web site; and

(2) employees of the Department of Human Services from obtaining insurance from the state employee group insurance program.

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

Sec. 4. Minnesota Statutes 2016, section 169.345, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) For the purpose of section 168.021 and this section, the following terms have the meanings given them in this subdivision.

(b) "Health professional" means a licensed physician, licensed physician assistant, advanced practice registered nurse, licensed physical therapist, or licensed chiropractor.

(c) "Long-term certificate" means a certificate issued for a period greater than 12 months but not greater than 71 months.

(d) "Organization certificate" means a certificate issued to an entity other than a natural person for a period of three years.

(e) "Permit" refers to a permit that is issued for a period of 30 days, in lieu of the certificate referred to in subdivision 3, while the application is being processed.

(f) "Physically disabled person" means a person who:

(1) because of disability cannot walk without significant risk of falling;

(2) because of disability cannot walk 200 feet without stopping to rest;

(3) because of disability cannot walk without the aid of another person, a walker, a cane, crutches, braces, a prosthetic device, or a wheelchair;

(4) is restricted by a respiratory disease to such an extent that the person's forced (respiratory) expiratory volume for one second, when measured by spirometry, is less than one liter;

(5) has an arterial oxygen tension (PaO_2) of less than 60 mm/Hg on room air at rest;

(6) uses portable oxygen;

(7) has a cardiac condition to the extent that the person's functional limitations are classified in severity as class III or class IV according to standards set by the American Heart Association;

(8) has lost an arm or a leg and does not have or cannot use an artificial limb; or

(9) has a disability that would be aggravated by walking 200 feet under normal environmental conditions to an extent that would be life threatening.

(g) "Short-term certificate" means a certificate issued for a period greater than six months but not greater than 12 months.

(h) "Six-year certificate" means a certificate issued for a period of six years.

(i) "Temporary certificate" means a certificate issued for a period not greater than six months.

Sec. 5. Minnesota Statutes 2016, section 243.166, subdivision 4b, is amended to read:

Subd. 4b. **Health care facility; notice of status.** (a) For the purposes of this subdivision~~,~~:

(1) "health care facility" means a facility:

~~(1)~~ (i) licensed by the commissioner of health as a hospital, boarding care home or supervised living facility under sections 144.50 to 144.58, or a nursing home under chapter 144A;

~~(2)~~ (ii) registered by the commissioner of health as a housing with services establishment as defined in section 144D.01; or

~~(3)~~ (iii) licensed by the commissioner of human services as a residential facility under chapter 245A to provide adult foster care, adult mental health treatment, chemical dependency treatment to adults, or residential services to persons with disabilities; and

(2) "home care provider" has the meaning given in section 144A.43.

(b) Prior to admission to a health care facility or home care services from a home care provider, a person required to register under this section shall disclose to:

(1) the health care facility employee or the home care provider processing the admission the person's status as a registered predatory offender under this section; and

(2) the person's corrections agent, or if the person does not have an assigned corrections agent, the law enforcement authority with whom the person is currently required to register, that ~~inpatient~~ admission will occur.

(c) A law enforcement authority or corrections agent who receives notice under paragraph (b) or who knows that a person required to register under this section is planning to be admitted and receive, or has been admitted and is receiving health care at a health care facility or home care services from a home care provider, shall notify the administrator of the facility or the home care provider and deliver a fact sheet to the administrator or provider containing the following information: (1) name and physical description of the offender; (2) the offender's conviction history, including the dates of conviction; (3) the risk level classification assigned to the offender under section 244.052, if any; and (4) the profile of likely victims.

(d) Except for a hospital licensed under sections 144.50 to 144.58, if a health care facility receives a fact sheet under paragraph (c) that includes a risk level classification for the offender, and if the facility admits the offender, the facility shall distribute the fact sheet to all residents at the facility. If the facility determines that distribution to a resident is not appropriate given the resident's medical, emotional, or mental status, the facility shall distribute the fact sheet to the patient's next of kin or emergency contact.

(e) If a home care provider receives a fact sheet under paragraph (c) that includes a risk level classification for the offender, the provider shall distribute the fact sheet to any individual who will provide direct services to the offender before the individual begins to provide the service.

Sec. 6. **HUMAN SERVICES DEPARTMENT RESTRUCTURING WORKING GROUP.**

Subdivision 1. **Establishment; membership.** (a) A working group to consider restructuring the Department of Human Services is established.

(b) The working group shall include 17 members as follows:

(1) two members of the house of representatives, one appointed by the speaker of the house and one appointed by the minority leader of the house of representatives;

(2) two members of the senate, one appointed by the senate majority leader and one appointed by the senate minority leader;

(3) the legislative auditor or a designee;

(4) the commissioner of administration or a designee;

(5) two representatives from county social services agencies, appointed by the commissioner of human services;

(6) two representatives from tribal social services agencies, appointed by the commissioner of human services;

(7) two representatives from organizations that represent people served by programs administered by the Department of Human Services, appointed by the commissioner of human services;

(8) two representatives from organizations that represent service providers that are either licensed or reimbursed by the Department of Human Services, appointed by the commissioner of human services;

(9) one member representing the Cultural and Ethnic Communities Leadership Council, appointed by the commissioner of human services; and

(10) two representatives of labor organizations, who must be full-time employees of the Department of Human Services working in facilities located in different geographic regions of the state, appointed by the governor.

(c) The appointing authorities under this subdivision must complete their appointments no later than July 1, 2018.

Subd. 2. **Duties.** The working group shall review the current structure of the Department of Human Services and programs administered by that agency and propose a restructuring of the agency to provide for better coordination and control of programs, accountability, and continuity. In making recommendations, the working group must consider:

(1) how human services agencies are structured in other states;

(2) transferring duties to other state agencies;

(3) the effect of a restructuring on clients and counties;

(4) administrative efficiencies;

(5) various analytical methods to evaluate efficiencies, including but not limited to zero-based budgeting;

(6) budget and policy priorities;

(7) program funding sources;

(8) avoiding conflicting agency roles;

(9) the extent to which the agency should provide direct services to clients;

(10) eliminating any duplication of services; and

(11) staffing issues.

Subd. 3. **Meetings.** The legislative auditor or a designee shall convene the first meeting of the working group no later than August 1, 2018. The legislative auditor or a designee shall serve as the chair of the working group. Meetings of the working group are open to the public.

Subd. 4. **Compensation.** Members of the working group shall serve without compensation or reimbursement for expenses.

Subd. 5. **Administrative support.** The Legislative Coordinating Commission shall provide administrative support for the working group and arrange for meeting space.

Subd. 6. **Report.** By March 1, 2019, the working group must submit a report with findings, recommendations, and draft legislation to the chairs and ranking minority members of the legislative committees with jurisdiction over human services policy and finance. The report must include a discussion of the costs and benefits associated with any proposed restructuring.

Subd. 7. **Expiration.** The working group expires March 2, 2019, or the day after the working group submits the report required under subdivision 6, whichever is earlier.

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

Sec. 7. **RATES FOR INDIVIDUAL MARKET HEALTH AND DENTAL PLANS FOR 2019.**

(a) Health carriers must take into account the reduction in the premium withhold percentage under Minnesota Statutes, section 62V.05, subdivision 2, applicable beginning in calendar year 2019 for individual market health plans and dental plans sold through MNsure when setting rates for individual market health plans and dental plans for calendar year 2019.

(b) For purposes of this section, "dental plan," "health carrier," "health plan," and "individual market" have the meanings given in Minnesota Statutes, section 62V.02.

ARTICLE 10

FORECAST ADJUSTMENTS

Section 1. **HUMAN SERVICES APPROPRIATION.**

The dollar amounts shown in the columns marked "Appropriations" are added to or, if shown in parentheses, are subtracted from the appropriations in Laws 2017, First Special

Session chapter 6, article 18, from the general fund or any fund named to the Department of Human Services for the purposes specified in this article, to be available for the fiscal year indicated for each purpose. The figures "2018" and "2019" used in this article mean that the appropriations listed under them are available for the fiscal years ending June 30, 2018, or June 30, 2019, respectively. "The first year" is fiscal year 2018. "The second year" is fiscal year 2019. "The biennium" is fiscal years 2018 and 2019.

		APPROPRIATIONS	
		Available for the Year	
		Ending June 30	
		2018	**2019**
Sec. 2. **COMMISSIONER OF HUMAN SERVICES**			
Subdivision 1. **Total Appropriation**		**$ (208,963,000)**	**$ (88,363,000)**
Appropriations by Fund			
General Fund	(210,083,000)	(103,535,000)	
Health Care Access Fund	7,620,000	9,258,000	
Federal TANF	(6,500,000)	5,914,000	
Subd. 2. **Forecasted Programs**			
(a) **MFIP/DWP**			
Appropriations by Fund			
General Fund	(3,749,000)	(11,267,000)	
Federal TANF	(7,418,000)	4,565,000	
(b) **MFIP Child Care Assistance**		(7,995,000)	(521,000)
(c) **General Assistance**		(4,850,000)	(3,770,000)
(d) **Minnesota Supplemental Aid**		(1,179,000)	(821,000)
(e) **Housing Support**		(3,260,000)	(3,038,000)
(f) **Northstar Care for Children**		(5,168,000)	(6,458,000)
(g) **MinnesotaCare**		7,620,000	9,258,000
These appropriations are from the health care access fund.			
(h) **Medical Assistance**			
Appropriations by Fund			

General Fund	(199,817,000)	(106,124,000)
Health Care Access Fund	-0-	-0-

(i) **Alternative Care Program** -0- -0-

(j) **CCDTF Entitlements** 15,935,000 28,464,000

Subd. 3. **Technical Activities** 918,000 1,349,000

These appropriations are from the federal TANF fund.

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

ARTICLE 11

HEALTH AND HUMAN SERVICES APPROPRIATIONS

Section 1. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are added to or, if shown in parentheses, subtracted from the appropriations in Laws 2017, First Special Session chapter 6, article 18, to the agencies and for the purposes specified in this article. The appropriations are from the general fund and are available for the fiscal years indicated for each purpose. The figures "2018" and "2019" used in this article mean that the addition to or subtraction from the appropriation listed under them is available for the fiscal year ending June 30, 2018, or June 30, 2019, respectively. Base adjustments mean the addition to or subtraction from the base level adjustment set in Laws 2017, First Special Session chapter 6, article 18. Supplemental appropriations and reductions to appropriations for the fiscal year ending June 30, 2018, are effective the day following final enactment unless a different effective date is explicit.

	APPROPRIATIONS	
	Available for the Year	
	Ending June 30	
	2018	**2019**

Sec. 2. **COMMISSIONER OF HUMAN SERVICES**

Subdivision 1. **Total Appropriation** **$** **-0-** **$** **19,865,000**

Subd. 2. **Central Office; Operations** -0- 5,779,000

(a) **Foster Care Recruitment Models.** $75,000 in fiscal year 2019 is from the general fund for a grant to Hennepin County to establish and promote family foster care recruitment models. The county shall use the grant funds for the purpose of increasing foster care providers through administrative simplification, nontraditional recruitment models, and family incentive options, and develop a strategic planning model to recruit family foster care providers. This is a onetime appropriation.

(b) **Transfer; Advisory Council on Rare Diseases.** $150,000 in fiscal year 2019 is from the general fund for transfer to the Board of Regents of the University of Minnesota for the advisory council on rare diseases under Minnesota Statutes, section 137.68.

(c) **Transfer; Study and Report on Health Insurance Rate Disparities between Geographic Rating Areas.** $251,000 in fiscal year 2019 is from the general fund for transfer to the Legislative Coordinating Commission for the Office of the Legislative Auditor to study and report on disparities between geographic rating areas in individual and small group market health insurance rates. This is a onetime appropriation.

(d) **Substance Abuse Recovery Services Provided through Minnesota Recovery Corps.** $450,000 in fiscal year 2019 is from the general fund for transfer to ServeMinnesota under Minnesota Statutes, section 124D.37, for purposes of providing

evidenced-based substance abuse recovery services through Minnesota Recovery Corps. Funds shall be used to support training, supervision, and deployment of AmeriCorps members to serve as recovery navigators. The Minnesota Commission on National and Community Service shall include in the commission's report to the legislature under Minnesota Statutes, section 124D.385, subdivision 3, an evaluation of program data to determine the efficacy of the services promoting sustained substance abuse recovery, including but not limited to stable housing, relationship-building, employment skills, or a year of AmeriCorps service. This is a onetime appropriation.

(e) **Base Adjustment.** The general fund base is increased $6,136,000 in fiscal year 2020 and $6,145,000 in fiscal year 2021.

Subd. 3. **Central Office; Children and Families** -0- 1,420,000

(a) **Task Force on Childhood Trauma-Informed Policy and Practices.** $55,000 in fiscal year 2019 is from the general fund for the task force on childhood trauma-informed policy and practices. This is a onetime appropriation.

(b) **Child Welfare Training Academy.** $786,000 in fiscal year 2019 is from the general fund for the child welfare training academy, which shall provide training to county and tribal child welfare workers, county and tribal child welfare supervisors, and staff at agencies providing out-of-home placement services.

(c) **Child Welfare Caseload Study.** $400,000 in fiscal year 2019 is from the general fund for a child welfare caseload study.

(d) **Minn-LInK Study.** $150,000 in fiscal year 2019 is from the general fund for the Minn-LInK study under Minnesota Statutes, section 260C.81.

Subd. 4. **Central Office; Health Care** -0- 1,836,000

(a) **Encounter Reporting of 340B Eligible Drugs.** $35,000 in fiscal year 2019 is from the general fund for development of recommendations for a process to identify 340B eligible drugs and report them at the point of sale. This is a onetime appropriation.

(b) **Base Adjustment.** The general fund base is increased $2,235,000 in fiscal year 2020 and $2,255,000 in fiscal year 2021.

Subd. 5. **Central Office; Continuing Care** -0- 1,200,000

(a) **Regional Ombudsmen.** $612,000 in fiscal year 2019 is from the general fund to fund five additional regional ombudsman in the Office of Ombudsman for Long-Term Care, to perform the duties in Minnesota Statutes, section 256.9742.

(b) **Live Well At Home Grants.** Of the fiscal year 2019 general fund appropriation in Laws 2017, First Special Session chapter 6, article 18, section 2, subdivision 6: (1) $50,000 shall be used to provide a live well at home grant under Minnesota Statutes, section 256B.0917, to an organization that provides block nurse services to the elderly in the city of McGregor; and (2) if an organization providing block nurse services to the elderly in the city of

Grove City does not receive a live well at home grant award by November 1, 2018, $120,000 shall be used to provide a live well at home grant under Minnesota Statutes, section 256B.0917, to that organization.

(c) **Base Adjustment.** The general fund base is increased $746,000 in fiscal year 2020 and $746,000 in fiscal year 2021.

Subd. 6. **Central Office; Community Supports**	-0-	4,571,000

Base Adjustment. The general fund base is increased $4,127,000 in fiscal year 2020 and $4,012,000 in fiscal year 2021.

Subd. 7. **Forecasted Programs; Medical Assistance**	-0-	8,495,000
Subd. 8. **Forecasted Programs; Alternative Care**	-0-	(28,000)
Subd. 9. **Forecasted Programs; Chemical Dependency Treatment Fund**	-0-	(14,243,000)
Subd. 10. **Grant Programs; Child and Economic Support Grants**	-0-	1,900,000

(a) **Community Action Grants.** $750,000 in fiscal year 2019 is from the general fund for community action grants under Minnesota Statutes, sections 256E.30 to 256E.32. This is a onetime appropriation.

(b) **Mobile food shelf grants.** (1) $750,000 in fiscal year 2019 is from the general fund for mobile food shelf grants to be awarded by Hunger Solutions. Of this appropriation, $375,000 is for sustaining existing mobile food shelf programs and $375,000 is for creating new mobile food shelf programs.

(2) Hunger Solutions shall award grants on a priority basis under clause (4). A grant to sustain an existing mobile food shelf program shall not exceed $25,000. A grant to create a

new mobile food shelf program shall not exceed $75,000.

(3) An applicant for a mobile food shelf grant must provide the following information to Hunger Solutions:

(i) the location of the project;

(ii) a description of the mobile program, including the program's size and scope;

(iii) evidence regarding the unserved or underserved nature of the community in which the program is located;

(iv) evidence of community support for the program;

(v) the total cost of the program;

(vi) the amount of the grant request and how funds will be used;

(vii) sources of funding or in-kind contributions for the program that may supplement any grant award;

(viii) the applicant's commitment to maintain the mobile program; and

(ix) any additional information requested by Hunger Solutions.

(4) In evaluating applications and awarding grants, Hunger Solutions must give priority to an applicant who:

(i) serves unserved or underserved areas;

(ii) creates a new mobile program or expands an existing mobile program;

(iii) serves areas where a high level of need is identified;

(iv) provides evidence of strong support for the program from residents and other institutions in the community;

(v) leverages funding for the program from other private and public sources; and

(vi) commits to maintaining the program on a multiyear basis.

(5) This is a onetime appropriation.

(c) **Project Legacy.** $400,000 in fiscal year 2019 is from the general fund for a grant to Project Legacy to provide counseling and outreach to youth and young adults from families with a history of generational poverty. Money from this appropriation must be spent for mental health care, medical care, chemical dependency interventions, housing, and mentoring and counseling services for first generation college students. This is a onetime appropriation.

Subd. 11. **Grant Programs; Disabilities Grants**	-0-	7,740,000

Disability grants. $7,740,000 in fiscal year 2019 is from the general fund for the home and community-based services innovation pool under Minnesota Statutes, section 256B.0921; disability waiver rate system transition grants under Laws 2017, First Special Session chapter 6, article 18, section 2, subdivision 29; and competitive workforce sustainability grants under article 5, section 18. These funds shall be provided to home and community-based waiver service providers that are projected to be negatively impacted due to the transition to rates calculated under Minnesota Statutes, section 256B.4914. The

commissioner may transfer funds from this appropriation to budget activity 52, other long-term care grants, as necessary. This is a onetime appropriation.

Subd. 12. **Grant Programs; Child Mental Health Grants** -0- 250,000

School-Linked Mental Health Services Delivered by Telemedicine. $250,000 in fiscal year 2019 is from the general fund for grants for four pilot projects to deliver school-linked mental health services by telemedicine. The grants are for new or existing providers and must be two pilot projects in greater Minnesota, one in the seven-county metropolitan area excluding Minneapolis and St. Paul, and one in Minneapolis or St. Paul. No later than six months after the funds are expended, the commissioner shall report to the legislative committees with jurisdiction over mental health issues on the effectiveness of the pilot projects. This is a onetime appropriation and is available until June 30, 2021.

Subd. 13. **Grant Programs; Chemical Dependency Treatment Support Grants** -0- 945,000

Student Health Initiative to Limit Opioid Harm. $945,000 in fiscal year 2019 is from the general fund for the student health initiative to limit opioid harm. This is a onetime appropriation.

Sec. 3. **COMMISSIONER OF HEALTH**

Subdivision 1. **Total Appropriation** **$** **-0-** **$** **11,565,000**

Appropriations by Fund

	2018	2019
General	-0-	11,481,000

State Government
Special Revenue -0- 84,000

Subd. 2. **Health Improvement** -0- 8,505,000

(a) **Health Professional Education Loan Forgiveness Program.** $1,000,000 in fiscal year 2019 is from the general fund for the health professional education loan forgiveness program under Minnesota Statutes, section 144.1501.

(b) **Transfer; Minnesota Biomedicine and Bioethics Innovation Grants.** $2,897,000 in fiscal year 2019 is from the general fund for transfer to the Board of Regents of the University of Minnesota for Minnesota biomedicine and bioethics innovation grants under Minnesota Statutes, section 137.67. This appropriation is available until June 30, 2021. The general fund base for this program is $30,000 in fiscal year 2020 and $30,000 in fiscal year 2021.

(c) **Addressing Disparities in Prenatal Care Access and Utilization.** $613,000 in fiscal year 2019 is from the general fund for grants under Minnesota Statutes, section 145.928, subdivision 7, paragraph (a), clause (2), to decrease racial and ethnic disparities in access to and utilization of high-quality prenatal care. This is a onetime appropriation.

(d) **Information on Congenital Cytomegalovirus.** $127,000 in fiscal year 2019 is from the general fund for the development and dissemination of information about congenital cytomegalovirus according to Minnesota Statutes, section 144.064.

(e) **Older Adult Social Isolation Working Group.** $85,000 in fiscal year 2018 is from the general fund for the older adult social isolation working group, for costs related to the salary of an independent, professional facilitator, printing and duplicating costs, and expenses related to meeting management for the working group. This is a onetime appropriation.

(f) **Transfer; Mental Health and Substance Use Disorder Parity Work Group.** $75,000 in fiscal year 2019 is from the general fund for transfer to the commissioner of commerce for the mental health and substance use disorder parity work group.

(g) **The TAP Program.** $10,000 in fiscal year 2019 is from the general fund for a grant to the TAP in St. Paul to support mental health in disability communities through spoken art forms, community supports, and community engagement. This is a onetime appropriation.

(h) **Statewide Tobacco Cessation Services.** $291,000 in fiscal year 2019 is from the general fund for statewide tobacco cessation services under Minnesota Statutes, section 144.397. The general fund base for this appropriation is $1,550,000 in fiscal year 2020 and $2,955,000 in fiscal year 2021.

(i) **Opioid Abuse Prevention Pilot Project.** $2,000,000 in fiscal year 2019 is from the general fund for opioid abuse prevention pilot projects under Laws 2017, First Special Session chapter 6, article 10, section 144. Of this amount: (1) $1,400,000 is for the opioid abuse prevention pilot project through CHI

St. Gabriel's Health Family Medical Center, also known as Unity Family Health Care; and (2) $600,000 is for Project Echo through CHI St. Gabriel's Health Family Medical Center for e-learning sessions centered around opioid case management and best practices for opioid abuse prevention. This is a onetime appropriation.

(j) **Opioid Overdose Reduction Pilot Program.** $1,000,000 in fiscal year 2019 is from the general fund for the opioid overdose reduction pilot program, which provides grants to ambulance services to fund community paramedic teams. Of this appropriation, the commissioner may use up to $50,000 to administer the program. This is a onetime appropriation and is available until June 30, 2021.

(k) **Prescription Drug Deactivation and Disposal Products.** (1) $1,104,000 in fiscal year 2019 is from the general fund to provide grants to pharmacists and other prescription drug dispensers, health care providers, local law enforcement and emergency services personnel, and local health and human services departments to purchase at-home prescription drug deactivation and disposal products that render drugs and medications inert and irretrievable. The grants must be awarded on a competitive basis and targeted toward geographic areas of the state with the highest rates of overdose deaths.

(2) Grant recipients must provide these deactivation and disposal products free of charge to members of the public. Grant

recipients, and the vendors providing deactivation and disposal products to grant recipients, shall provide information necessary to evaluate the effectiveness of the grant program to the commissioner of health, in the form and manner specified by the commissioner. At a minimum, a grant recipient must provide the commissioner with the number of deactivation and disposal products the grant recipient provided to members of the public under this program, and an estimate of the total number of dosages that may have been deactivated and disposed of using the products. The commissioner may contract with a third party to conduct the evaluation.

(3) This is a onetime appropriation.

(l) **Base Adjustments.** The general fund base is increased $4,677,000 in fiscal year 2020 and $6,082,000 in fiscal year 2021.

Subd. 3. **Health Protection**

Appropriations by Fund		
General	-0-	2,976,000
State Government Special Revenue	-0-	84,000

(a) **Technology Upgrades.** $1,250,000 in fiscal year 2019 is from the general fund for technology upgrades at the Office of Health Facility Complaints. These technology upgrades must be provided by an external vendor selected on a competitive basis by the commissioner of administration. The commissioner shall not transfer this appropriation or use the appropriated funds for any other purpose. This is a onetime

appropriation and is available until June 30, 2022.

(b) **Base Adjustments.** The general fund base is increased $980,000 in fiscal year 2020 and $933,000 in fiscal year 2021. The state government special revenue fund base is increased $365,000 in fiscal year 2020 and $77,000 in fiscal year 2021.

Sec. 4. **HEALTH-RELATED BOARDS**

Subdivision 1. **Total Appropriation**	**$**	**-0-**	**$** **216,000**

Unless otherwise noted, this appropriation is from the state government special revenue fund. The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **Board of Dentistry**	-0-	5,000

This is a onetime appropriation.

Subd. 3. **Board of Nursing**	-0-	162,000

(a) **Nurse Licensure Compact.** $157,000 in fiscal year 2019 is for implementation of Minnesota Statutes, section 148.2855.

(b) **Base Adjustments.** The state government special revenue fund base is increased by $6,000 in fiscal year 2020 and $6,000 in fiscal year 2021.

Subd. 4. **Board of Nursing Home Administrators**	-0-	25,000

Council of Health Boards Work Group. $25,000 in fiscal year 2019 is for the administrative services unit to convene a Council of Health Boards work group to study and make recommendations on the use of telehealth technologies. This is a onetime appropriation.

Subd. 5. **Board of Optometry** -0- 5,000

This is a onetime appropriation.

Subd. 6. **Board of Pharmacy** -0- 14,000

Base Adjustments. The state government special revenue fund base is increased by $12,000 in fiscal year 2020 and $12,000 in fiscal year 2021.

Subd. 7. **Board of Podiatric Medicine** -0- 5,000

This is a onetime appropriation.

Sec. 5. **EMERGENCY MEDICAL SERVICES REGULATORY BOARD** **$** **-0-** **$** **35,000**

Base Adjustment. The general fund base is increased by $15,000 in fiscal year 2020 only.

Sec. 6. Minnesota Statutes 2016, section 256.01, is amended by adding a subdivision to read:

Subd. 17a. **Transfers for routine administrative operations.** (a) The commissioner may only transfer money from the general fund to any other fund for routine administrative operations and may not transfer money from the general fund to any other fund without approval from the commissioner of management and budget unless specifically authorized by law. If the commissioner of management and budget determines that a transfer proposed by the commissioner is necessary for routine administrative operations of the Department of Human Services, the commissioner may approve the transfer. If the commissioner of management and budget determines that the transfer proposed by the commissioner is not necessary for routine administrative operations of the Department of Human Services, the commissioner may not approve the transfer unless the requirements of paragraph (b) are met.

(b) If the commissioner of management and budget determines that a transfer under paragraph (a) is not necessary for routine administrative operations of the Department of Human Services, the commissioner may request approval of the transfer from the Legislative Advisory Commission under section 3.30. To request approval of a transfer from the Legislative Advisory Commission, the commissioner must submit a request that includes the amount of the transfer, the budget activity and fund from which money would be transferred and the budget activity and fund to which money would be transferred, an

explanation of the administrative necessity of the transfer, and a statement from the commissioner of management and budget explaining why the transfer is not necessary for routine administrative operations of the Department of Human Services. The Legislative Advisory Commission shall review the proposed transfer and make a recommendation within 20 days of the request from the commissioner. If the Legislative Advisory Commission makes a positive recommendation or no recommendation, the commissioner may approve the transfer. If the Legislative Advisory Commission makes a negative recommendation or a request for more information, the commissioner may not approve the transfer. A recommendation of the Legislative Advisory Commission must be made by a majority of the commission and must be made at a meeting of the commission unless a written recommendation is signed by a majority of the commission members required to vote on the question. If the commission makes a negative recommendation or a request for more information, the commission may subsequently withdraw or change its recommendation.

Sec. 7. Laws 2017, First Special Session chapter 6, article 18, section 3, subdivision 2, is amended to read:

Subd. 2. **Health Improvement**

	Appropriations by Fund	
General	81,438,000	78,100,000
State Government Special Revenue	6,215,000	6,182,000
Health Care Access	36,643,000	36,258,000
Federal TANF	11,713,000	11,713,000

(a) **TANF Appropriations.** (1) $3,579,000 of the TANF fund each year is for home visiting and nutritional services listed under Minnesota Statutes, section 145.882, subdivision 7, clauses (6) and (7). Funds must be distributed to community health boards according to Minnesota Statutes, section 145A.131, subdivision 1.

(2) $2,000,000 of the TANF fund each year is for decreasing racial and ethnic disparities in infant mortality rates under Minnesota Statutes, section 145.928, subdivision 7.

(3) $4,978,000 of the TANF fund each year is for the family home visiting grant program according to Minnesota Statutes, section 145A.17. $4,000,000 of the funding must be distributed to community health boards according to Minnesota Statutes, section 145A.131, subdivision 1. $978,000 of the funding must be distributed to tribal governments according to Minnesota Statutes, section 145A.14, subdivision 2a.

(4) $1,156,000 of the TANF fund each year is for family planning grants under Minnesota Statutes, section 145.925.

(5) The commissioner may use up to 6.23 percent of the funds appropriated each year to conduct the ongoing evaluations required under Minnesota Statutes, section 145A.17, subdivision 7, and training and technical assistance as required under Minnesota Statutes, section 145A.17, subdivisions 4 and 5.

(b) **TANF Carryforward.** Any unexpended balance of the TANF appropriation in the first year of the biennium does not cancel but is available for the second year.

(c) ~~**Evidence-Based**~~ **Home Visiting to Pregnant Women and Families with Young Children.** $6,000,000 in fiscal year 2018 and $6,000,000 in fiscal year 2019 are from the general fund to start up or expand ~~evidence-based~~ home visiting programs to pregnant women and families with young children. The commissioner shall award grants to community health boards, nonprofits, or tribal nations in urban and rural areas of the

state. Grant funds must be used to start up or expand evidence-based or targeted home visiting programs in the county, reservation, or region to serve families, such as parents with high risk or high needs, parents with a history of mental illness, domestic abuse, or substance abuse, or first-time mothers prenatally until the child is four years of age, who are eligible for medical assistance under Minnesota Statutes, chapter 256B, or the federal Special Supplemental Nutrition Program for Women, Infants, and Children. For fiscal year 2019, the commissioner shall allocate at least 75 percent of the grant funds not yet awarded to evidence-based home visiting programs and up to 25 percent of the grant funds not yet awarded to other targeted home visiting programs in order to promote innovation and serve high-need families. Priority for grants to rural areas shall be given to community health boards, nonprofits, and tribal nations that expand services within regional partnerships that provide the ~~evidence-based~~ home visiting programs. This funding shall only be used to supplement, not to replace, funds being used for evidence-based or targeted home visiting services as of June 30, 2017. Up to seven percent of the appropriation may be used for training, technical assistance, evaluation, and other costs to administer the grants. The general fund base for this program is $16,500,000 in fiscal year 2020 and $16,500,000 in fiscal year 2021.

(d) **Safe Harbor for Sexually Exploited Youth Services.** $250,000 in fiscal year 2018

and $250,000 in fiscal year 2019 are from the general fund for trauma-informed, culturally specific services for sexually exploited youth. Youth 24 years of age or younger are eligible for services under this paragraph.

(e) **Safe Harbor Program Technical Assistance and Evaluation.** $200,000 in fiscal year 2018 and $200,000 in fiscal year 2019 are from the general fund for training, technical assistance, protocol implementation, and evaluation activities related to the safe harbor program. Of these amounts:

(1) $90,000 each fiscal year is for providing training and technical assistance to individuals and organizations that provide safe harbor services and receive funds for that purpose from the commissioner of human services or commissioner of health;

(2) $90,000 each fiscal year is for protocol implementation, which includes providing technical assistance in establishing best practices-based systems for effectively identifying, interacting with, and referring sexually exploited youth to appropriate resources; and

(3) $20,000 each fiscal year is for program evaluation activities in compliance with Minnesota Statutes, section 145.4718.

(f) **Promoting Safe Harbor Capacity.** In funding services and activities under paragraphs (d) and (e), the commissioner shall emphasize activities that promote capacity-building and development of resources in greater Minnesota.

(g) **Administration of Safe Harbor Program.** $60,000 in fiscal year 2018 and $60,000 in fiscal year 2019 are for administration of the safe harbor for sexually exploited youth program.

(h) **Palliative Care Advisory Council.** $44,000 in fiscal year 2018 and $44,000 in fiscal year 2019 are from the general fund for the Palliative Care Advisory Council under Minnesota Statutes, section 144.059. This is a onetime appropriation.

(i) **Transfer; Minnesota Biomedicine and Bioethics Innovation Grants.** $2,500,000 in fiscal year 2018 is from the general fund for transfer to the Board of Regents of the University of Minnesota for Minnesota biomedicine and bioethics innovation grants under Minnesota Statutes, section 137.67. The full amount of the appropriation is for grants, and the University of Minnesota shall not use any portion for administrative or monitoring expenses. The steering committee of the University of Minnesota and Mayo Foundation partnership must submit a preliminary report by April 1, 2018, and a final report by April 1, 2019, on all grant activities funded under Minnesota Statutes, section 137.67, to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services finance. This is a onetime appropriation and is available until June 30, 2021.

(j) **Statewide Strategic Plan for Victims of Sex Trafficking.** $73,000 in fiscal year 2018 is from the general fund for the development

of a comprehensive statewide strategic plan and report to address the needs of sex trafficking victims statewide. This is a onetime appropriation.

(k) **Home and Community-Based Services Employee Scholarship Program.** $500,000 in fiscal year 2018 and $500,000 in fiscal year 2019 are from the general fund for the home and community-based services employee scholarship program under Minnesota Statutes, section 144.1503.

(l) **Comprehensive Advanced Life Support Educational Program.** $100,000 in fiscal year 2018 and $100,000 in fiscal year 2019 are from the general fund for the comprehensive advanced life support educational program under Minnesota Statutes, section 144.6062. This is a onetime appropriation.

(m) **Opioid Abuse Prevention.** $1,028,000 in fiscal year 2018 is to establish and evaluate accountable community for health opioid abuse prevention pilot projects. $28,000 of this amount is for administration. This is a onetime appropriation and is available until June 30, 2021.

(n) **Advanced Care Planning.** $250,000 in fiscal year 2018 and $250,000 in fiscal year 2019 are from the general fund for a grant to a statewide advanced care planning resource organization that has expertise in convening and coordinating community-based strategies to encourage individuals, families, caregivers, and health care providers to begin conversations regarding end-of-life care

choices that express an individual's health care values and preferences and are based on informed health care decisions. Of this amount, $9,000 each year is for administration. This is a onetime appropriation.

(o) **Health Professionals Clinical Training Expansion Grant Program.** $526,000 in fiscal year 2018 and $526,000 in fiscal year 2019 are from the general fund for the primary care and mental health professions clinical training expansion grant program under Minnesota Statutes, section 144.1505. Of this amount, $26,000 each year is for administration.

(p) **Federally Qualified Health Centers.** $500,000 in fiscal year 2018 and $500,000 in fiscal year 2019 are from the general fund to provide subsidies to federally qualified health centers under Minnesota Statutes, section 145.9269. This is a onetime appropriation.

(q) **Base Level Adjustments.** The general fund base is $87,656,000 in fiscal year 2020 and $87,706,000 in fiscal year 2021. The health care access fund base is $36,858,000 in fiscal year 2020 and $36,258,000 in fiscal year 2021.

Sec. 8. Laws 2017, First Special Session chapter 6, article 18, section 16, subdivision 2, is amended to read:

Subd. 2. **Administration.** Subject to Minnesota Statutes, section 256.01, subdivision 17a, positions, salary money, and nonsalary administrative money may be transferred within the Departments of Health and Human Services as the commissioners consider necessary, with the advance approval of the commissioner of management and budget. The commissioner shall inform the chairs and ranking minority members of the senate Health and Human Services Finance and Policy Committee, the senate Human Services Reform

Finance and Policy Committee, and the house of representatives Health and Human Services Finance Committee quarterly about transfers made under this subdivision.

Sec. 9. **TRANSFERS.**

By June 30, 2018, the commissioner of management and budget shall transfer:

(1) $14,000,000 from the systems operations account in the special revenue fund to the general fund;

(2) $2,000,000 from the system long-term care options product account in the special revenue fund to the general fund; and

(3) $2,400,000 from the direct care and treatment special health care receipts account in the special revenue fund to the general fund.

Sec. 10. **EXPIRATION OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires on June 30, 2019, unless a different expiration date is explicit.

Sec. 11. **EFFECTIVE DATE.**

This article is effective July 1, 2018, unless a different effective date is specified.

APPENDIX
Article locations in HF3138-1

62A.65 INDIVIDUAL MARKET REGULATION.

Subd. 7a. **Short-term coverage; applicability.** Notwithstanding subdivision 3, paragraph (g), and subdivision 7, paragraph (c), short-term coverage is not subject to section 62A.021.

144A.45 REGULATION OF HOME CARE SERVICES.

Subd. 6. **Home care providers; tuberculosis prevention and control.** (a) A home care provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines.

(b) Written compliance with this subdivision must be maintained by the home care provider.

144A.481 HOME CARE LICENSING IMPLEMENTATION FOR NEW LICENSEES AND TRANSITION PERIOD FOR CURRENT LICENSEES.

Subdivision 1. **Temporary home care licenses and changes of ownership.** (a) Beginning January 1, 2014, all temporary license applicants must apply for either a temporary basic or comprehensive home care license.

(b) Temporary home care licenses issued beginning January 1, 2014, shall be issued according to sections 144A.43 to 144A.4798, and the fees in section 144A.472. Temporary licensees must comply with the requirements of this chapter.

(c) No temporary license applications will be accepted nor temporary licenses issued between December 1, 2013, and December 31, 2013.

(d) Beginning October 1, 2013, changes in ownership applications will require payment of the new fees listed in section 144A.472. Providers who are providing nursing, delegated nursing, or professional health care services, must submit the fee for comprehensive home care providers, and all other providers must submit the fee for basic home care providers as provided in section 144A.472. Change of ownership applicants will be issued a new home care license based on the licensure law in effect on June 30, 2013.

Subd. 2. **Current home care licensees with licenses as of December 31, 2013.** (a) Beginning July 1, 2014, department licensed home care providers must apply for either the basic or comprehensive home care license on their regularly scheduled renewal date.

(b) By June 30, 2015, all home care providers must either have a basic or comprehensive home care license or temporary license.

Subd. 3. **Renewal application of home care licensure during transition period.** (a) Renewal and change of ownership applications of home care licenses issued beginning July 1, 2014, will be issued according to sections 144A.43 to 144A.4798 and, upon license renewal or issuance of a new license for a change of ownership, providers must comply with sections 144A.43 to 144A.4798. Prior to renewal, providers must comply with the home care licensure law in effect on June 30, 2013.

(b) The fees charged for licenses renewed between July 1, 2014, and June 30, 2016, shall be the lesser of 200 percent or $1,000, except where the 200 percent or $1,000 increase exceeds the actual renewal fee charged, with a maximum renewal fee of $6,625.

(c) For fiscal year 2014 only, the fees for providers with revenues greater than $25,000 and no more than $100,000 will be $313 and for providers with revenues no more than $25,000 the fee will be $125.

146B.02 ESTABLISHMENT LICENSE PROCEDURES.

Subd. 7a. **Supervisors.** (a) Only a technician who has been licensed as a body artist for at least two years in Minnesota or in a jurisdiction with which Minnesota has reciprocity may supervise a temporary technician.

(b) Any technician who agrees to supervise more than two temporary technicians during the same time period must provide to the commissioner a supervisory plan that describes how the technician will provide supervision to each temporary technician in accordance with section 146B.01, subdivision 28.

(c) The commissioner may refuse to approve as a supervisor a technician who has been disciplined in Minnesota or in another jurisdiction after considering the criteria described in subdivision 10, paragraph (b).

151.55 CANCER DRUG REPOSITORY PROGRAM.

Subdivision 1. **Definitions.** (a) For the purposes of this section, the terms defined in this subdivision have the meanings given.

(b) "Board" means the Board of Pharmacy.

(c) "Cancer drug" means a prescription drug that is used to treat:

(1) cancer or the side effects of cancer; or

(2) the side effects of any prescription drug that is used to treat cancer or the side effects of cancer.

(d) "Cancer drug repository" means a medical facility or pharmacy that has notified the board of its election to participate in the cancer drug repository program.

(e) "Cancer supply" or "supplies" means prescription and nonprescription cancer supplies needed to administer a cancer drug.

(f) "Dispense" has the meaning given in section 151.01, subdivision 30.

(g) "Distribute" means to deliver, other than by administering or dispensing.

(h) "Donor" means an individual and not a drug manufacturer or wholesale drug distributor who donates a cancer drug or supply according to the requirements of the cancer drug repository program.

(i) "Medical facility" means an institution defined in section 144.50, subdivision 2.

(j) "Medical supplies" means any prescription and nonprescription medical supply needed to administer a cancer drug.

(k) "Pharmacist" has the meaning given in section 151.01, subdivision 3.

(l) "Pharmacy" means any pharmacy registered with the Board of Pharmacy according to section 151.19, subdivision 1.

(m) "Practitioner" has the meaning given in section 151.01, subdivision 23.

(n) "Prescription drug" means a legend drug as defined in section 151.01, subdivision 17.

(o) "Side effects of cancer" means symptoms of cancer.

(p) "Single-unit-dose packaging" means a single-unit container for articles intended for administration as a single dose, direct from the container.

(q) "Tamper-evident unit dose packaging" means a container within which a drug is sealed so that the contents cannot be opened without obvious destruction of the seal.

Subd. 2. **Establishment.** The Board of Pharmacy shall establish and maintain a cancer drug repository program, under which any person may donate a cancer drug or supply for use by an individual who meets the eligibility criteria specified under subdivision 4. Under the program, donations may be made on the premises of a medical facility or pharmacy that elects to participate in the program and meets the requirements specified under subdivision 3.

Subd. 3. **Requirements for participation by pharmacies and medical facilities.** (a) To be eligible for participation in the cancer drug repository program, a pharmacy or medical facility must be licensed and in compliance with all applicable federal and state laws and administrative rules.

(b) Participation in the cancer drug repository program is voluntary. A pharmacy or medical facility may elect to participate in the cancer drug repository program by submitting the following information to the board, in a form provided by the board:

(1) the name, street address, and telephone number of the pharmacy or medical facility;

(2) the name and telephone number of a pharmacist who is employed by or under contract with the pharmacy or medical facility, or other contact person who is familiar with the pharmacy's or medical facility's participation in the cancer drug repository program; and

(3) a statement indicating that the pharmacy or medical facility meets the eligibility requirements under paragraph (a) and the chosen level of participation under paragraph (c).

(c) A pharmacy or medical facility may fully participate in the cancer drug repository program by accepting, storing, and dispensing or administering donated drugs and supplies, or may limit its participation to only accepting and storing donated drugs and supplies. If a pharmacy or facility chooses to limit its participation, the pharmacy or facility shall distribute any donated drugs to a fully participating cancer drug repository according to subdivision 8.

(d) A pharmacy or medical facility may withdraw from participation in the cancer drug repository program at any time upon notification to the board. A notice to withdraw from participation may be given by telephone or regular mail.

Subd. 4. **Individual eligibility requirements.** Any Minnesota resident who is diagnosed with cancer is eligible to receive drugs or supplies under the cancer drug repository program. Drugs and supplies shall be dispensed or administered according to the priority given under subdivision 6, paragraph (d).

Subd. 5. **Donations of cancer drugs and supplies.** (a) Any one of the following persons may donate legally obtained cancer drugs or supplies to a cancer drug repository, if the drugs or supplies meet the requirements under paragraph (b) or (c) as determined by a pharmacist who is employed by or under contract with a cancer drug repository:

(1) an individual who is 18 years old or older; or

(2) a pharmacy, medical facility, drug manufacturer, or wholesale drug distributor, if the donated drugs have not been previously dispensed.

(b) A cancer drug is eligible for donation under the cancer drug repository program only if the following requirements are met:

(1) the donation is accompanied by a cancer drug repository donor form described under paragraph (d) that is signed by the person making the donation or that person's authorized representative;

(2) the drug's expiration date is at least six months later than the date that the drug was donated;

(3) the drug is in its original, unopened, tamper-evident unit dose packaging that includes the drug's lot number and expiration date. Single-unit dose drugs may be accepted if the single-unit-dose packaging is unopened; and

(4) the drug is not adulterated or misbranded.

(c) Cancer supplies are eligible for donation under the cancer drug repository program only if the following requirements are met:

(1) the supplies are not adulterated or misbranded;

(2) the supplies are in their original, unopened, sealed packaging; and

(3) the donation is accompanied by a cancer drug repository donor form described under paragraph (d) that is signed by the person making the donation or that person's authorized representative.

(d) The cancer drug repository donor form must be provided by the board and shall state that to the best of the donor's knowledge the donated drug or supply has been properly stored and that the drug or supply has never been opened, used, tampered with, adulterated, or misbranded. The board shall make the cancer drug repository donor form available on the Board of Pharmacy's Web site.

(e) Controlled substances and drugs and supplies that do not meet the criteria under this subdivision are not eligible for donation or acceptance under the cancer drug repository program.

(f) Drugs and supplies may be donated on the premises of a cancer drug repository to a pharmacist designated by the repository. A drop box may not be used to deliver or accept donations.

(g) Cancer drugs and supplies donated under the cancer drug repository program must be stored in a secure storage area under environmental conditions appropriate for the drugs or supplies being stored. Donated drugs and supplies may not be stored with nondonated inventory.

Subd. 6. **Dispensing requirements.** (a) Drugs and supplies must be dispensed by a licensed pharmacist pursuant to a prescription by a practitioner or may be dispensed or administered by a practitioner according to the requirements of chapter 151 and within the practitioner's scope of practice.

(b) Cancer drugs and supplies shall be visually inspected by the pharmacist or practitioner before being dispensed or administered for adulteration, misbranding, and date of expiration. Drugs or supplies that have expired or appear upon visual inspection to be adulterated, misbranded, or tampered with in any way may not be dispensed or administered.

(c) Before a cancer drug or supply may be dispensed or administered to an individual, the individual must sign a cancer drug repository recipient form provided by the board acknowledging that the individual understands the information stated on the form. The form shall include the following information:

(1) that the drug or supply being dispensed or administered has been donated and may have been previously dispensed;

(2) that a visual inspection has been conducted by the pharmacist or practitioner to ensure that the drug has not expired, has not been adulterated or misbranded, and is in its original, unopened packaging; and

(3) that the dispensing pharmacist, the dispensing or administering practitioner, the cancer drug repository, the Board of Pharmacy, and any other participant of the cancer drug repository program cannot guarantee the safety of the drug or supply being dispensed or administered and that the pharmacist or practitioner has determined that the drug or supply is safe to dispense or administer based on the accuracy of the donor's form submitted with the donated drug or supply and the visual inspection required to be performed by the pharmacist or practitioner before dispensing or administering.

The board shall make the cancer drug repository form available on the Board of Pharmacy's Web site.

(d) Drugs and supplies shall only be dispensed or administered to individuals who meet the eligibility requirements in subdivision 4 and in the following order of priority:

(1) individuals who are uninsured;

(2) individuals who are enrolled in medical assistance, MinnesotaCare, Medicare, or other public assistance health care; and

(3) all other individuals who are otherwise eligible under subdivision 4 to receive drugs or supplies from a cancer drug repository.

Subd. 7. **Handling fees.** A cancer drug repository may charge the individual receiving a drug or supply a handling fee of no more than 250 percent of the medical assistance program dispensing fee for each cancer drug or supply dispensed or administered.

Subd. 8. **Distribution of donated cancer drugs and supplies.** (a) Cancer drug repositories may distribute drugs and supplies donated under the cancer drug repository program to other repositories if requested by a participating repository.

(b) A cancer drug repository that has elected not to dispense donated drugs or supplies shall distribute any donated drugs and supplies to a participating repository upon request of the repository.

(c) If a cancer drug repository distributes drugs or supplies under paragraph (a) or (b), the repository shall complete a cancer drug repository donor form provided by the board. The completed form and a copy of the donor form that was completed by the original donor under subdivision 5 shall be provided to the fully participating cancer drug repository at the time of distribution.

Subd. 9. **Resale of donated drugs or supplies.** Donated drugs and supplies may not be resold.

Subd. 10. **Record-keeping requirements.** (a) Cancer drug repository donor and recipient forms shall be maintained for at least five years.

(b) A record of destruction of donated drugs and supplies that are not dispensed under subdivision 6 shall be maintained by the dispensing repository for at least five years. For each drug or supply destroyed, the record shall include the following information:

(1) the date of destruction;

(2) the name, strength, and quantity of the cancer drug destroyed;

(3) the name of the person or firm that destroyed the drug; and

(4) the source of the drugs or supplies destroyed.

Subd. 11. **Liability.** (a) The manufacturer of a drug or supply is not subject to criminal or civil liability for injury, death, or loss to a person or to property for causes of action described in clauses (1) and (2). A manufacturer is not liable for:

(1) the intentional or unintentional alteration of the drug or supply by a party not under the control of the manufacturer; or

(2) the failure of a party not under the control of the manufacturer to transfer or communicate product or consumer information or the expiration date of the donated drug or supply.

(b) A medical facility or pharmacy participating in the program, a pharmacist dispensing a drug or supply pursuant to the program, a practitioner dispensing or administering a drug or supply pursuant to the program, or a donor of a cancer drug or supply as defined in subdivision 1 is immune from civil liability for an act or omission that causes injury to or the death of an individual to whom the cancer drug or supply is dispensed and no disciplinary action shall be taken against a pharmacist or practitioner so long as the drug or supply is donated, accepted, distributed, and dispensed according to the requirements of this section. This immunity does not apply if the act or omission involves reckless, wanton, or intentional misconduct, or malpractice unrelated to the quality of the cancer drug or supply.

214.075 HEALTH-RELATED LICENSING BOARDS; CRIMINAL BACKGROUND CHECKS.

Subd. 8. **Instructions to the board; plans.** The health-related licensing boards, in collaboration with the commissioner of human services and the BCA, shall establish a plan for completing criminal background checks of all licensees who were licensed before the effective date requirement under subdivision 1. The plan must seek to minimize duplication of requirements for background checks of licensed health professionals. The plan for background checks of current licensees shall be developed no later than January 1, 2017, and may be contingent upon the implementation of a system by the BCA or FBI in which any new crimes that an applicant or licensee commits after an initial background check are flagged in the BCA's or FBI's database and reported back to the board. The plan shall include recommendations for any necessary statutory changes.

256.021 VULNERABLE ADULT MALTREATMENT REVIEW PANEL.

Subdivision 1. **Creation.** (a) The commissioner of human services shall establish a review panel for purposes of reviewing lead investigative agency determinations regarding maltreatment of a vulnerable adult in response to requests received under section 626.557, subdivision 9d, paragraph (b). The panel shall hold quarterly meetings for purposes of conducting reviews under this section.

(b) The review panel consists of:

(1) the commissioners of health and human services or their designees;

(2) the ombudsman for long-term care and ombudsman for mental health and developmental disabilities, or their designees;

(3) a member of the board on aging, appointed by the board; and

(4) a representative from the county human services administrators appointed by the commissioner of human services or the administrator's designee.

Subd. 2. **Review procedure.** (a) If a vulnerable adult or an interested person acting on behalf of the vulnerable adult requests a review under this section, the panel shall review the request at its next quarterly meeting. If the next quarterly meeting is within ten days of the panel's receipt of the request for review, the review may be delayed until the next subsequent meeting. The panel shall review the request and the investigation memorandum and may review any other data on the

investigation maintained by the lead investigative agency that are pertinent and necessary to its review of the final disposition. If more than one person requests a review under this section with respect to the same final disposition, the review panel shall combine the requests into one review. The panel shall submit its written request for the case file and other documentation relevant to the review to the supervisor of the investigator conducting the investigation under review.

(b) Within 30 days of the review under this section, the panel shall notify the director or manager of the lead investigative agency and the vulnerable adult or interested person who requested the review as to whether the panel concurs with the final disposition or whether the lead investigative agency must reconsider the final disposition. If the panel determines that the lead investigative agency must reconsider the final disposition, the panel must make specific recommendations to the director or manager of the lead investigative agency. The recommendation must include an explanation of the factors that form the basis of the recommendation to reconsider the final disposition and must specifically identify the disputed facts, the disputed application of maltreatment definitions, the disputed application of responsibility for maltreatment, and the disputed weighing of evidence, whichever apply. Within 30 days the lead investigative agency shall conduct a review and report back to the panel with its determination and the specific rationale for its final disposition. At a minimum, the specific rationale must include a detailed response to each of the factors identified by the panel that formed the basis for the recommendations of the panel.

(c) Upon receiving the report of reconsideration from the lead investigative agency, the panel shall communicate the decision in writing to the vulnerable adult or interested person acting on behalf of the vulnerable adult who requested the review. The panel shall include the specific rationale provided by the lead investigative agency as part of the communication.

Subd. 3. **Report.** By January 15 of each year, the panel shall submit a report to the committees of the legislature with jurisdiction over section 626.557 regarding the number of requests for review it receives under this section, the number of cases where the panel requires the lead investigative agency to reconsider its final disposition, and the number of cases where the final disposition is changed, and any recommendations to improve the review or investigative process.

Subd. 4. **Data.** Data of the review panel created or received as part of a review under this section are private data on individuals as defined in section 13.02.

256B.0705 PERSONAL CARE ASSISTANCE SERVICES; MANDATED SERVICE VERIFICATION.

Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have the meanings given them.

(b) "Personal care assistance services" or "PCA services" means services provided according to section 256B.0659.

(c) "Personal care assistant" or "PCA" has the meaning given in section 256B.0659, subdivision 1.

(d) "Service verification" means a random, unscheduled telephone call made for the purpose of verifying that the individual personal care assistant is present at the location where personal care assistance services are being provided and is providing services as scheduled.

Subd. 2. **Verification schedule.** An agency that submits claims for reimbursement for PCA services under this chapter must develop and implement administrative policies and procedures by which the agency verifies the services provided by a PCA. For each service recipient, the agency must conduct at least one service verification every 90 days. If more than one PCA provides services to a single service recipient, the agency must conduct a service verification for each PCA providing services before conducting a service verification for a PCA whose services were previously verified by the agency. Service verification must occur on an ongoing basis while the agency provides PCA services to the recipient. During service verification, the agency must speak with both the PCA and the service recipient or recipient's authorized representative. Only qualified professional service verifications are eligible for reimbursement. An agency may substitute a visit by a qualified professional that is eligible for reimbursement under section 256B.0659, subdivision 14 or 19.

Subd. 3. **Documentation of verification.** An agency must fully document service verifications in a legible manner and must maintain the documentation on site for at least five years from the date of documentation. For each service verification, documentation must include:

(1) the names and signatures of the service recipient or recipient's authorized representative, the PCA and any other agency staff present with the PCA during the service verification, and the staff person conducting the service verification; and

(2) the start and end time, day, month, and year of the service verification, and the corresponding PCA time sheet.

Subd. 4. **Variance.** The Office of Inspector General at the Department of Human Services may grant a variance to the service verification requirements in this section if an agency uses an electronic monitoring system or other methods that verify a PCA is present at the location where services are provided and is providing services according to the prescribed schedule. A decision to grant or deny a variance request is final and not subject to appeal under chapter 14.