# House Research

## Act Summary

**Chapter:** 45 (vetoed May 12, 2017) **Session:** 2017 Regular Session

**Topic:** Omnibus health and human services bill

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**Date:** June 26, 2017

This is the initial omnibus health and human services bill for the 2017 regular legislative session.

Governor Mark Dayton vetoed this act on May 12, 2017.

### Article 1: Community Supports

## Overview

This article modifies the disability waiver rate system (DWRS), modifies home health services to conform to federal requirements, creates a new complex personal care assistance (PCA) category, modifies MnCHOICES assessments for long-term care services and supports, modernizes deaf and hard-of-hearing services, and expands an exception to the consumer-directed community-supports (CDCS) budget methodology.

**Section**

**1** **Report requirements.** Amends § 144A.351, subd. 1. Clarifies that appropriations for the gaps analysis report are available in either year of the biennium.

**2** **Applicability.** Amends § 245D.03, subd. 1. Modifies the list of services that are governed by the home and community-based services standards chapter of statutes by adding individual community living support, individualized home supports, and three new employment services. Makes the addition of individual community living support and individualized home supports effective the day following final enactment. Makes the addition of the new employment services effective upon federal approval. Requires the commissioner of human services to notify the revisor of statutes when federal approval is obtained.

**3** **Day training and habilitation (DT&H) services for adults with developmental disabilities.** Amends § 252.41, subd. 3. Modifies the list of DT&H services by removing supported employment and clarifying work-related activities are center-based. Specifies that DT&H services do not include three new employment services that are proposed to be provided under the HCBS disability waivers. Makes this section effective upon federal approval. Requires the commissioner of human services to notify the revisor of statutes when federal approval is obtained.

**4** **Self-advocacy grants.** Creates § 256.477. Requires the commissioner to make available a grant for the purposes of establishing and maintaining a statewide self-advocacy network for persons with intellectual and developmental disabilities. Lists duties of the self-advocacy network. Specifies that an organization receiving this grant must be governed by people with intellectual and developmental disabilities that administers a statewide network of disability groups in order to maintain and promote self-advocacy services and supports for persons with intellectual and developmental disabilities throughout the state. (This language codifies language in Laws 2009).

**Section**

**5** **Home health services.** Amends § 256B.0625, subd. 6a. Allows medical assistance (MA) to cover home health services provided in the community where normal life activities take the recipient.

**6** **Medical supplies and equipment.** Amends § 256B.0625, subd. 31. Adds paragraph (g), which requires an order or prescription for medical supplies, equipment, or appliances to meet certain federal requirements.

**7** **Definitions.** Amends § 256B.0653, subd. 2. Modifies the definition of "home health agency services."

**8** **Home health aide visits.** Amends § 256B.0653, subd. 3. Allows home health aide visits to be provided in the community where normal life activities take the recipient.

**9** **Skilled nurse visit services.** Amends § 256B.0653, subd. 4. Allows skilled nurse visits to be provided in the community where normal life activities take the recipient.

**10** **Home care therapies.** Amends § 256B.0653, subd. 5. Allows home care therapies to be provided in the community where normal life activities take the recipient. Home care therapies include physical therapy, occupational therapy, respiratory therapy, and speech and language pathology therapy services.

**11** **Noncovered home health agency services.** Amends § 256B.0653, subd. 6. Modifies the list of noncovered home health agency services by removing from the list home care therapies provided at a day program and adding to the list home health agency services without documentation of a face-to-face encounter.

**12** **Face-to-face encounter.** Amends § 256B.0653, subd. 7. Requires a face-to-face encounter to be completed for all home health services, except when providing a one-time perinatal visit by skilled nursing. Allows the face-to-face encounter to occur through telemedicine. Specifies when the encounter must occur and who may conduct the encounter. Lists duties of the physician responsible for ordering the services. For home health services requiring authorization, specifies that home health agencies must retain documentation of the face-to-face encounter and submit the qualifying documentation to the commissioner upon request.

**13** **Definitions.** Amends § 256B.0659, subd. 1. Defines "complex personal care assistance services." Makes this section effective July 1, 2018.

**14** **Personal care assistance services; covered services.** Amends § 256B.0659, subd. 2. Makes a conforming change to a cross-reference. Makes this section effective July 1, 2018.

**15** **Personal care assistant; requirements.** Amends § 256B.0659, subd. 11. Lists the qualifications a personal care assistant must meet to provide complex PCA services. Makes this section effective July 1, 2018.

**16** **Rate for complex personal care assistance services.** Amends § 256B.0659, by adding subd. 17a. Requires the rate paid to a provider for complex PCA services to be 110 percent of the rate paid for PCA services. Makes this section effective July 1, 2018.

**Section**

**17** **Requirements for provider enrollment of personal care assistance provider agencies.** Amends § 256B.0659, subd. 21. Modifies the list of information and documentation a PCA provider agency must provide to the commissioner to include documentation that the agency staff meet the complex PCA services requirements if complex PCA services are provided and submitted for payment.

**18** **Definitions.** Amends § 256B.0911, subd. 1a. Defines "person-centered planning" in the section of statutes governing long-term care consultation services.

**19** **MnCHOICES certified assessors.** Amends § 256B.0911, subd. 2b. Makes a grammatical correction. Removes language allowing lead agencies to contract with certified assessors. Requires certified assessors to use person-centered planning principles to conduct an interview that identifies what is important to the person, the person's needs for supports, health and safety concerns, and the person's abilities, interests, and goals. Lists certified assessor responsibilities.

**20** **Long-term care reassessments and community support plan updates.** Amends § 256B.0911, by adding subd. 3f. Requires face-to-face reassessments to be conducted annually or as required by federal and state laws and rules. Describes the purpose of reassessments.

**21** **Preadmission screening of individuals under 65 years of age.** Amends § 256B.0911, subd. 4d. Modifies language governing the timing of face-to-face assessments of individuals under age 65 who are admitted to a nursing facility under certain circumstances.

**22** **Administrative activity.** Amends § 256B.0911, subd. 5. Adds paragraph (b), which requires the commissioner of human services to work with lead agencies responsible for conducting long-term care consultation services to modify the MnCHOICES application and assessment policies to create efficiencies while ensuring federal compliance with MA and long-term services and supports eligibility criteria.

**23** **Home and community-based services incentive pool.** Amends § 256B.0921. Expands the list of activities for which an entity may receive an incentive for innovation. Removes obsolete language.

**24** **Rate stabilization adjustment.** Amends § 256B.4913, subd. 4a. Modifies the historical rate for certain day service recipients and adds a seventh year of banding. Makes the changes to the historical rate effective the day following final enactment. Makes the additional year of banding effective upon federal approval. Requires the commissioner of human services to notify the revisor of statutes when federal approval is obtained.

**25** **New services.** Amends § 256B.4913, by adding subd. 7. Specifies that a service added after January 1, 2014, is not subject to the rate stabilization adjustment. Specifies that employment support services authorized after January 1, 2018, under the new employment services definition according to the HCBS waivers for persons with disabilities are not subject to the rate stabilization adjustment. Makes this section effective the day following final enactment.

**Section**

**26** **Definitions.** Amends § 256B.4914, subd. 2. Modifies the definition of "unit of service" for certain unit-based services without programming. Makes this section effective upon federal approval. Requires the commissioner of human services to notify the revisor of statutes when federal approval is obtained.

**27** **Applicable services.** Amends § 256B.4914, subd. 3. Adds individualized home supports, independent living skills specialist services, and three employment services to the list of services that are governed by the Disability Waiver Rate System (DWRS). Makes this section effective upon federal approval, except individualized home supports are effective the day following final enactment. Requires the commissioner of human services to notify the revisor of statutes when federal approval is obtained.

**28** **Base wage index and standard component values.** Amends § 256B.4914, subd. 5. Paragraph (a) modifies various base wage calculations and adds calculations for individualized home supports services staff, independent living skills specialist staff, employment exploration services staff, and employment development services staff.

Paragraph (d) modifies certain component values for day services.

Paragraphs (e) to (g) modify certain component values for unit-based services with programming and unit-based services without programming.

Paragraphs (h) and (i) remove language requiring the commissioner to make certain inflationary adjustments every five years and require the adjustments to be made every two years beginning on January 1, 2022. Requires the commissioner to publish updated values and load them into the rate management system.

Paragraph (j) requires the commissioner to recommend to the legislature codes or items to update and replace missing component values if Bureau of Labor Statistics occupational codes or Consumer Price Index items are unavailable in the future.

Paragraph (k) requires the commissioner to ensure that wage values and component values reflect the cost to provide the service. Requires providers enrolled to provide services with rates determined under the DWRS to submit requested cost data to the commissioner to support research on the cost of providing services that have rates determined by the DWRS. Lists the cost data that must be submitted.

Paragraph (l) requires providers to submit the cost data at least once in any five-year period. Requires the commissioner to temporarily suspend payments to a provider if cost data is not received 90 days after the required submission date. Requires withheld payments to be made once data is received by the commissioner.

Paragraph (m) requires the commissioner to conduct a random audit of data submitted by providers to ensure accuracy and to analyze cost documentation and provide recommendations for adjustments to cost components.

Paragraph (n) requires the commissioner to analyze cost documentation and to submit recommendations on component values and inflationary factor adjustments to the legislative committees with jurisdiction over human services every four years beginning January 1, 2020. Requires the commissioner to release business cost data in an aggregate form.

**Section**

Paragraph (o) requires the commissioner to develop and implement a process for providing training and technical assistance necessary to support provider submission of cost documentation.

Makes the amendments to paragraphs (a) to (g) effective January 1, 2018, except the change in the absence and utilization factor for day services is effective January 1, 2019, and the addition of individualized home supports is effective the day following final enactment. Makes the amendments to paragraphs (h) to (o) effective the day following final enactment.

**29** **Payments for residential support services.** Amends § 256B.4914, subd. 6. Makes a conforming change to a cross-reference.

**30** **Payments for day programs.** Amends § 256B.4914, subd. 7. Makes a conforming change to a cross-reference.

**31** **Payments for unit-based services with programming.** Amends § 256B.4914, subd. 8. Makes conforming changes to add new services and makes a conforming change to a cross-reference. Makes this section effective the day following final enactment.

**32** **Payments for unit-based services without programming.** Amends § 256B.4914, subd. 9. Makes a conforming change to a cross-reference.

**33** **Updating payment values and additional information.** Amends § 256B.4914, subd. 10. Modifies certain analyses and evaluations the commissioner must conduct. Modifies the date of the next report to the legislature regarding the DWRS. Removes obsolete language. Beginning July 1, 2017, requires the commissioner to renew analysis and implement changes to the regional adjustment factors when certain adjustments occur. Requires the commissioner to study the underlying cost of absence and utilization for day services. Requires the commissioner to make recommendations to the legislature by January 15, 2018, for changes, if any, to the absence and utilization factor ratio component values for day services. Beginning July 1, 2017, requires the commissioner to collect transportation and trip information for all day services through the DWRS. Makes this section effective the day following final enactment.

**34** **Budget neutrality adjustments.** Amends § 256B.4914, subd. 16. Exempts individualized home support services from the budget neutrality factor effective the day following enactment.

**35** **Culturally affirmative.** Amends § 256C.23, by adding subd. 1a. Defines "culturally affirmative" in the chapter of statute governing deaf and hard-of-hearing services.

**36** **Deaf.** Amends § 256C.23, subd. 2. Updates the definition of "deaf."

**37** **Interpreting services.** Amends § 256C.23, by adding subd. 2c. Defines "interpreting services."

**38** **Real-time captioning.** Amends § 256C.23, by adding subd. 6. Defines "real-time captioning."

**Section**

**39** **Deaf and Hard-of-Hearing Services Division.** Amends § 256C.233, subd. 1. Updates the list of activities the division must address. Removes language referring to an "interagency management team" and replaces it with "interagency advisors." Updates language to be person-centered.

**40** **Responsibilities.** Amends § 256C.233, subd. 2. Updates the list of duties the division must perform. Updates language to be person-centered.

**41** **Location.** Amends § 256C.24, subd. 1. Sets a minimum number of regional service centers the division must establish. Updates language to be person-centered.

**42** **Responsibilities.** Amends § 256C.24, subd. 2. Updates the list of duties the regional service centers must perform. Updates language to be person-centered.

**43** **Services for persons who are deafblind.** Amends § 256C.261. Removes obsolete language and updates language to be person-centered. Requires consumer-directed services to be provided in whole by grant-funded providers. Prohibits the regional services centers from providing grant-funded consumer-directed services.

**44** **Expansion of CDCS budget methodology exception.** Expands the 2015 CDCS budget methodology exception. Limits the exception for persons who are currently using licensed providers for employment supports or services during the day or residential services to persons who can demonstrate that the total cost of CDCS services, including the exception, will be less than the cost of current waiver services. Makes the exception effective October 1, 2017, or upon federal approval, whichever is later. Specifies the exception to the CDCS budget methodology in Laws 2016, ch. 144, § 1, remains in effect until the exception under Laws 2015, ch. 71, art. 7, § 54, or under this section becomes effective, whichever occurs first. Requires the commissioner of human services to notify the revisor of statutes when federal approval is obtained.

**45** **Consumer-directed community supports budget methodology exception for persons leaving institutions and crisis residential settings.** By September 30, 2017, requires the commissioner to establish an institutional and crisis bed CDCS budget exception process. Lists to whom the exception process will apply. For purposes of this exception, lists the settings that are considered to be institutional. Limits the budget exception to no more than the amount of appropriate services provided in a non-institutional setting as determined by the lead agency managing the individual's HCBS waiver. Requires lead agencies to notify DHS of the budget exception. Makes this section effective the day following final enactment.

**46** **CDCS revised budget methodology report.** Requires the commissioner of human services, in consultation with others, to develop a revised CDCS budget methodology. Specifies criteria upon which the new methodology must be based. By December 15, 2018, requires the commissioner to report a revised CDCS budget methodology, including proposed legislation and funding necessary to implement the new methodology, to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services. Makes this section effective the day following final enactment.

**Section**

**47** **Federal waiver amendments.** Requires the commissioner of human services to submit necessary waiver amendments to CMS to add employment exploration services, employment development services, and employment support services to the HCBS disability waivers. Also requires the commissioner to submit necessary waiver amendments to remove community-based employment services from DT&H and prevocational services. Requires the commissioner to submit all necessary waiver amendments by October 1, 2017. Makes this section effective the day following final enactment.

**48** **Transportation study.** Requires the commissioner of human services to conduct a study to increase access to transportation services for an individual who receives HCBS. Requires the commissioner to submit a report to the legislative committees with jurisdiction over human services by January 15, 2019. Lists the information that must be included in the report. Makes this section effective the day following final enactment.

**49** **Direction to commissioner; telecommunication equipment program.** Requires the commissioner of human services to work in consultation with the Commission of Deaf, Deafblind, and Hard-of-Hearing Minnesotans to provide recommendations by January 15, 2018, to the legislative committees with jurisdiction over human services to modernize the telecommunications equipment program. Lists the items the recommendations must address.

**50** **Direction to commissioner; billing for mental health services.** By January 1, 2018, requires the commissioner of human services to report to the legislative committees with jurisdiction over deaf and hard-of-hearing services on the potential costs and benefits of the Deaf and Hard-of-Hearing Services Division billing for the cost of providing mental health services.

**51** **Direction to commissioner; MnCHOICES assessment tool.** Requires the commissioner of human services to work with lead agencies responsible for conducting long-term consultation services to modify the MnCHOICES assessment tool and related policies to: (1) reduce assessment times; (2) create efficiencies within the tool; (3) implement policy changes reducing the frequency and depth of assessment and reassessment; and (4) evaluate alternative payment methods.

**52** **Random moment time study evaluation required.** Requires the commissioner of human services to evaluate the random moment time study methodology for reimbursement of costs associated with county duties required under the long-term care consultation services. Specifies the purpose of the evaluation. Requires the commissioner to submit a report to the legislature by January 15, 2019. Specifies the information that must be included in the report.

**Section**

**53** **Repealer.** Paragraph (a) repeals Minnesota Statutes, sections 256C.23, subd. 3 (definitions; regional service center); 256C.233, subd. 4 (duties of state agencies; state commissioners); and 256C.25, subds. 1 (interpreter services; establishment) and 2 (interpreter services; duties).

Paragraph (b) repeals Minnesota Statutes, section 256B.4914, subd. 16 (budget neutrality adjustments), effective January 1, 2018.

Paragraph (c) repeals Laws 2012, ch. 247, art. 4, § 47, as amended by Laws 2014, ch. 312, art. 27, § 72, Laws 2015, ch. 71, art. 7, § 58, and Laws 2016, ch. 144, § 1 (exception to CDCS budget methodology); and Laws 2015, ch. 71, art. 7, § 54 (CDCS budget methodology exception), upon the effective date of section 44.

### Article 2: Housing

## Overview

This article modifies provisions related to home and community-based (HCBS) settings to comply with the federal HCBS setting rule, reforms corporate foster care services, creates a new housing benefit under MA, changes terminology from "group residential housing" to "housing support services," and provides for housing support supplementary rates for certain facilities.

**1** **Contents of contract.** Amends § 144D.04, subd. 2. Makes a grammatical correction. Makes this section effective the day following final enactment.

**2** **Additional contract requirements.** Amends § 144D.04, by adding subd. 2a. Adds additional housing with services contract requirements for residents receiving one or more health-related services. Allows a restriction of EW, CAC, CADI, and BI waiver recipients' rights only if determined necessary for the residents' health, safety, and well-being and requires restrictions to be documented. Lists information the contract must include. Makes this section effective the day following final enactment.

**3** **Licensing moratorium.** Amends § 245A.03, subd. 7. Paragraph (a) modifies the commissioner's authority to manage corporate foster care and adds new exceptions to the moratorium.

Paragraph (c) removes obsolete language.

Paragraph (e) makes conforming changes and updates terminology.

Paragraph (h) allows the commissioner to adjust capacity to address needs identified in the gaps analysis report and specifies the manner in which delicensing of settings will be accomplished.

Paragraph (i) requires the commissioner to notify a license holder when its corporate foster care or community residential setting licensed beds are reduced, state the reason for the reduction, and inform the license holder of the right to request reconsideration by the commissioner. Specifies requirements related to requesting a reconsideration. Makes this section effective the day following final enactment.

**Section**

Paragraph (j) prohibits the commissioner from issuing an initial license for children's residential treatment services for a program CMS would consider an institution for mental diseases. Exempts facilities that serve only private pay clients from the moratorium.

**4** **Policies and procedures for program administration required and enforceable.** Amends § 245A.04, subd. 14. Requires adult foster care providers that provide foster care services to EW residents to annually provide a copy of the resident termination policy to a resident covered by the policy.

**5** **Adult foster care bedrooms.** Amends § 245A.11, by adding subd. 9. Requires foster care residents to have a choice of roommates. Makes the license holder responsible for notifying residents of the right to request a change of roommate. Requires license holders to provide a lock for each resident's bedroom door, unless otherwise indicated for the resident's health, safety, or well-being. Requires documentation of restrictions on the use of the lock in the resident's individual abuse prevention plan. Requires the case manager to be part of an EW resident's interdisciplinary team. Makes this section effective the day following final enactment.

**6** **Adult foster care resident rights.** Amends § 245A.11, by adding subd. 10. Lists the information license holders must provide to a resident and a resident's legal representative at admission. Lists adult foster care resident rights. Allows restrictions on resident rights only if determined necessary to ensure the health, safety, and well-being of the resident. Requires any restriction of a resident's right to be documented in the resident's individual abuse prevention plan. Requires the case manager to be part of an EW resident's interdisciplinary team. Requires restrictions to be implemented in the least restrictive manner necessary to protect the resident. Makes this section effective the day following final enactment.

**7** **Adult foster care service termination for elderly waiver participants.** Amends § 245A.11, by adding subd. 11. Specifies adult foster care license requirements for EW residents. Requires the license holder to establish policies and procedures for service termination that promote continuity of care and service coordination. Lists requirements that the license holder must meet. Makes this section effective the day following final enactment.

**8** **Protection-related rights.** Amends § 245D.04, subd. 3. Modifies the list of protection-related rights under the home and community-based standards. Makes this section effective the day following final enactment.

**9** **Assessment and initial service planning.** Amends § 245D.071, subd. 3. Requires documentation of how the provider will support the person to have control of the person's schedule. Makes this section effective the day following final enactment.

**10** **Admission criteria.** Amends § 245D.11, subd. 4. Requires a signed and dated residency agreement between the license holder and the person or the person's legal representative. Requires the residency agreement to include service termination requirements and to be reviewed annually. Makes this section effective the day following final enactment.

**11** **Bedrooms.** Amends § 245D.24, subd. 3. Requires each person receiving services to have a choice of roommate and be allowed to lock his or her bedroom door. Requires license holders to document risk factors that require using locked doors, and the actions taken to minimize the safety risk to a person receiving services at the site.

**Section**

**12** **State agency hearings.** Amends § 256.045, subd. 3. Updates the appeal statute to allow for a state agency hearing on the termination of service for corporate foster care. Makes conforming changes to cross-references. Makes this section effective the day following final enactment.

**13** **Housing support services.** Creates § 256B.051.

**Subd. 1. Purpose.** Establishes housing support services to provide housing support services to an individual with a disability that limits the individual's ability to obtain or maintain stable housing. Specifies that services support an individual's transition to housing in the community and increase long-term stability in housing, to avoid future periods of being at risk of homelessness or institutionalization.

**Subd. 2. Definitions.** Defines the terms "at-risk of homelessness," "commissioner," "homeless," "individual with a disability," and "institution."

**Subd. 3. Eligibility.** Lists eligibility requirements an individual must meet in order to be eligible for housing support services.

**Subd. 4. Assessment requirements.** Lists the methods by which an individual's assessment of functional need must be conducted. Requires an individual to be reassessed within one year of initial assessment, and annually thereafter.

Subd. **Subd. 5. Housing support services.** Paragraph (a) specifies that housing support services include housing transition services and housing and tenancy sustaining services.

Paragraph (b) lists housing transition services.

Paragraph (c) lists housing and tenancy sustaining services.
Paragraph (d) allows a housing support to include person-centered planning for people who are not eligible to receive person-centered planning through any other service, if the person-centered planning is provided by a provider who meets certain requirements.

**Subd. 6. Provider qualifications and duties.** Lists requirements providers must meet in order to be eligible for reimbursement under this section.

**Subd. 7. Housing support supplemental service rates.** Requires supplemental service rates for individuals in specified settings to be reduced by one-half over a two-year period. Only applies the reduction to supplemental service rates for individuals eligible for housing support services under this section.

Makes subdivisions 1 to 6 effective contingent upon federal approval. Requires the commissioner of human services to notify the revisor of statutes when federal approval is obtained. Makes subdivision 7 effective contingent upon federal approval of subdivisions 1 to 6.

**Section**

**14** **Assessment and support planning.** Amends § 256B.0911, subd. 3a. Adds a new paragraph (k), which requires the certified assessor, at the time of reassessment, to: (1) assess each person receiving waiver services currently residing in a community residential setting or corporate foster care home to determine if that person would prefer to be served in a community-living setting; and (2) offer the person the option to receive alternative housing and service options.

**15** **Authority.** Amends § 256B.0915, subd. 1. Adds paragraph (b), which requires the commissioner to comply with the requirements in the federally approved transition plan for the EW waiver. Makes this section effective the day following final enactment.

**16** **Home and community-based services for developmental disabilities.** Amends § 256B.092, subd. 4. Adds paragraph (d), which requires the commissioner to comply with the requirements in the federally approved transition plan for the DD waiver. Makes this section effective the day following final enactment.

**17** **Authority.** Amends § 256B.49, subd. 11. Adds paragraph (f), which requires the commissioner to comply with the requirements in the federally approved transition plan for the CADI, CAC, and BI waivers. Makes this section effective the day following final enactment.

**18** **Coordinated service and support plan; comprehensive transitional service plan; maintenance service plan.** Amends § 256B.49, subd. 15. Removes obsolete language.

**19** **Commissioner's duties; report.** Amends § 256B.493, subd. 1. Removes language requiring the commissioner to solicit proposals to convert services for individuals residing in certain residential settings to other services in community settings. Gives the commissioner the authority to manage statewide licensed corporate foster care or community residential setting capacity. Requires the commissioner to implement a program for planned closure of licensed corporate adult foster care or community residential settings in order to: (1) respond to those individuals who want to move out of these settings; and (2) achieve budgetary savings.

**20** **Planned closure process needs determination.** Amends § 256B.493, subd. 2. Removes language requiring the commissioner to implement a program for planned closure of adult foster care homes. Requires a need determination process, managed at the state level, to be used by the commissioner to align capacity where needed.

**21** **Closure process.** Amends § 256B.493, by adding subd. 2a. Paragraph (a) requires the commissioner to work with stakeholders to establish a process for the application, review, approval, and implementation of setting closures. Specifies the information that must be included in a planned closure.

Paragraph (b) requires the commissioner to give first priority to closure plans that meet specified requirements.

Paragraph (c) requires, for each planned closure approved by the commissioner, a contract to be established between the commissioner, the counties of financial responsibility, and the participating license holder.

**22** **Temporary absence due to illness.** Amends § 256D.44, subd. 4. Makes a conforming change related to housing support services.

**Section**

**23** **Special needs.** Amends § 256D.44, subd. 5. Makes conforming changes related to housing support services. Paragraph (g) modifies the benefit amount and eligibility for housing services under MSA. Removes obsolete language. Makes paragraphs (a) to (f) effective July 1, 2017. Makes the change to the benefit amount effective July 1, 2020, and the changes in eligibility are effective July 1, 2017.

**24** **Supplementary services.** Amends § 256I.03, subd. 8. Makes conforming changes related to housing support services.

**25** **Individual eligibility requirements.** Amends § 256I.04, subd. 1. Makes conforming changes related to housing support services. Adds paragraph (c), which modifies eligibility requirements for housing support payments by including individuals receiving licensed residential crisis stabilization services and MA. Allows the individual to receive concurrent housing support payments if receiving licensed residential crisis stabilization services. Makes paragraph (c) effective October 1, 2017.

**26** **Conditions of payment; commissioner's right to suspend or terminate agreement.** Amends §256I.04, subd. 2d. Makes conforming changes related to housing support services.

**27** **Crisis shelters.** Amends § 256I.04, subd. 2g. Makes conforming changes related to housing support services.

**28** **Moratorium on development of housing support beds.** Amends § 256I.04, subd. 3. Makes conforming terminology changes. Modifies an exception to the moratorium on the development of housing support beds by increasing the number of supportive housing units that are allowed in Anoka, Dakota, Hennepin, or Ramsey County for homeless adults with a mental illness, a history of substance abuse, or HIV/AIDS.

**29** **Supplementary service rates.** Amends § 256I.05, subd. 1a. Makes conforming changes related to housing support services.

**30** **Rate increases.** Amends § 256I.05, subd. 1c. Makes conforming changes related to housing support services.

**31** **Supplementary rate for certain facilities.** Amends § 256I.05, subd. 1e. Makes conforming changes related to housing support services.

**32** **Supplementary rate for certain facilities; Crow Wing County.** Amends § 256I.05, subd. 1j. Makes a conforming terminology change.

**33** **Supplemental rate for certain facilities; Hennepin and Ramsey Counties.** Amends § 256I.05, subd. 1m. Makes conforming changes related to housing support services.

**34** **Supplementary rate; St. Louis County.** Amends § 256I.05, by adding subd. 1p. Requires a county agency to negotiate a supplemental rate, not to exceed $700 per month, including any legislatively authorized inflationary adjustments, for a housing support provider located in St. Louis County that operates a 35-bed facility that serves women who are chemically dependent, mentally ill, or both, and provides certain support services.

**Section**

**35** **Supplemental rate; Olmsted County.** Amends § 256I.05, by adding subd. 1q. Requires a county agency to negotiate a supplemental rate, not to exceed $750 per month, including any legislatively authorized inflationary adjustments, for a housing support provider located in Olmsted County that operates long-term residential facilities with a total of 104 beds that serve chemically dependent men and women and provide 24-hour-a-day supervision and other support services.

**36** **Supplemental rate; Anoka County.** Amends § 256I.05, by adding subd. 1r. Requires a county agency to negotiate a supplemental rate for 42 beds, not to exceed the standard housing support supplemental rate, including any legislatively authorized inflationary adjustments, for a housing support provider located in Anoka County that provides emergency housing on the former Anoka Regional Treatment Center campus.

**37** **Transfer of emergency shelter funds.** Amends § 256I.05, by adding subd. 11. Requires the commissioner to make a cost-neutral transfer of funding from the housing support fund to county human service agencies for emergency shelter beds removed from the housing support census under a biennial plan submitted by the county and approved by the commissioner. Lists the information that must be described in the plan, including: (1) anticipated and actual outcomes for persons experiencing homelessness; (2) improved efficiencies in administration; (3) requirements for individual eligibility; and (4) plans for quality assurance monitoring and outcomes. Requires the commissioner to review the county plan to monitor implementation and outcomes. Allows the funding to be used for room and board or supplemental services. Requires funding to be allocated annually. Requires the room and board portion of the allocation to be determined at the time of transfer. Allows the commissioner or county to return beds to the housing support fund with 180 days' notice. Makes this section effective July 1, 2017.

**38** **Time of payment.** Amends § 256I.06, subd. 2. Makes conforming terminology changes related to housing support services. Makes this section effective July 1, 2017.

**39** **Amount of housing support payment.** Amends § 256I.06, subd. 8. Establishes the housing support payment calculation for individuals who receive licensed residential crisis stabilization services. Makes this section effective October 1, 2017.

**40** **Community living infrastructure.** Creates § 256I.09. Requires the commissioner to award grants to agencies through an annual competitive process for: (1) outreach to locate and engage people who are homeless or residing in segregated settings to screen for basic needs and assist with referral to community living resources; (2) building capacity to provide technical assistance and consultation on housing and related support service resources for persons with both disabilities and low income; and (3) streamlining the administration and monitoring activities related to housing support funds. Allows agencies to collaborate and submit joint applications for funding.

**41** **Direction to commissioner; Housing support study.** Requires the commissioner, within available appropriations, to study the housing support supplementary service rates and make recommendations on the rate structure to the chairs and ranking minority members of the legislative committees with jurisdiction over human services by January 15, 2018.

**Section**

**42** **Revisor's instruction.** Instructs the revisor to change terminology from "group residential housing" to "housing support services."

### Article 3: Continuing Care

## Overview

This article modifies the nursing facility payment statutes, expands return to community initiatives, creates caregiver support grants, reforms elderly waiver, increases the monthly maximum benefit under essential community supports, modifies ICF/DD rates, extends the Alzheimer's disease working group, and provides for an electronic service delivery documentation system.

**1** **Resident assessment schedule.** Amends § 144.0724. Clarifies when a significant change in status assessment must be completed.

**2** **Penalties for late or nonsubmission.** Amends § 144.0724, subd. 6. Expands the commissioner of human services' authority to reduce penalties incurred by a nursing facility for failure to complete or submit a case mix assessment. Makes this section effective the day following final enactment.

**3** **Eligibility for license condition.** Amends § 144.562, subd. 2. Modifies the commissioner's authority to approve swing bed use above the cap by requiring patients to agree to referral to skilled nursing facilities under certain circumstances.

**4** **Consolidation of nursing facilities.** Amends § 144A.071, subd. 4d. Modifies the date for nursing facility property rate adjustments for consolidation projects to the first January or July following both the completion of the upgrades in the remaining facility and the closure of the other facility. Corrects obsolete cross-references. Makes this section effective for consolidations occurring after July 1, 2017.

**5** **Maximum charges.** Amends § 144A.74. Amends a section setting maximum charges a supplemental nursing services agency is permitted to bill or receive payments from a nursing home, to specify that a nursing home that pays for actual travel and housing costs for supplemental nursing services agency staff working at the facility is not violating the limitation on charges in this section. Makes this section effective the day following final enactment.

**6** **Consumer information and assistance and long-term care options counseling; Senior LinkAge Line.** Amends § 256.975, subd. 7. Modifies the list of services the Senior Linkage Line must provide to ensure that older adults are properly referred for counseling.

**7** **Self-directed caregiver grants.** Amends § 256.975, by adding subd. 12. Requires the Minnesota Board on Aging to administer self-directed caregiver grants to support at risk family caregivers of older adults or others eligible under the Older Americans Act of 1965, so that older adults can remain at home longer. Requires the board to give priority to consumers referred by the Senior LinkAge Line.

**Section**

**8** **Caregiver support programs.** Creates § 256.9755.

**Subd. 1. Program goals.** States the goal of all area agencies on aging and caregiver support programs is to support family caregivers of persons with Alzheimer's disease or other related dementias who are living in the community by promoting caregiver support programs and providing caregiver support services.

**Subd. 2. Authority.** Requires the Minnesota Board on Aging to allocate to the area agencies on aging the caregiver support program state and federal funds in a manner consistent with federal requirements.

**Subd. 3. Caregiver support services.** Requires funds allocated to an area agency on aging for caregiver support services to be used in a manner consistent with the National Family Caregiver Support Program to reach family caregivers of persons with Alzheimer's disease or related dementias. Requires funds to be used to provide social, nonmedical, community-based services and activities that provide respite for caregivers and social interaction for participants.

**9** **Assessment and support planning.** Amends § 256B.0911, subd. 3a. For a person being assessed for EW services, requires a provider who submitted information during the assessment process to receive a copy of the assessment, the final written community support plan when available, the case mix level, and the Residential Services Workbook. Specifies the effective date of eligibility for services under alternative care, elderly waiver, CADI, CAC, and BI waiver programs when an eligibility update is completed and documented within 90 days of the previous face-to-face assessment.

**10** **Elderly waiver cost limits.** Amends § 256B.0915, subd. 3a. Specifies the manner in which legislatively authorized service specific increases are handled. Modifies effective dates of certain increases to coincide with nursing facility payment increases.

**11** **Customized living service rate.** Amends § 256B.0915, subd. 3e. Includes a cognitive and behavioral needs factor in the payment for EW customized living services for a client determined to have certain specified needs. Modifies effective dates of certain increases to coincide with nursing facility payment increases. Corrects an obsolete a cross-reference.

Makes this section prevail over any conflicting amendments regardless of the order of enactment.

**12** **Service rate limits; 24 hour customized living services.** Amends § 256B.0915, subd. 3h. Modifies effective dates of certain increases to coincide with nursing facility payment increases. Corrects obsolete cross-references.

**Section**

**13** **Assessments and reassessments for waiver clients.** Amends § 256B.0915, subd. 5. Paragraph (a) removes language requiring client reassessments when the case manager determines there has been a significant change in a client's functioning.

Paragraph (b) contains no changes.

Paragraph (c) requires the lead agency to conduct a change-in-condition reassessment before the annual reassessment in cases where a client's condition changed due to certain specified events. Allows a change-in-condition reassessment to be initiated by the lead agency or requested by the client, or on the client's behalf by another party. Lists lead agency requirements related to conducting and completing change-in-condition reassessments.

**14** **Payment rates; application.** Amends § 256B.0915, by adding subd. 11. Applies the payment methodologies in subdivisions 12 to 16 to EW and EW customized living, alternative care, essential community supports, community access for disability inclusion customized living, brain injury customized living, EW foster care, and residential care.

**15** **Payment rates; phase-in.** Amends § 256B.0915, by adding subd. 12. Partially phases-in the new payment rate methodology for elderly waiver.

**16** **Payment rates; establishment.** Amends § 256B.0915, by adding subd. 13. Paragraph (a) requires the commissioner to use specific data to establish rates and component rates every January 1 using Minnesota-specific wages taken from job descriptions.

Paragraph (b), in creating the rates and component rates, requires the commissioner to establish base wage calculations for each service and add additional rates for certain listed factors.

**17** **Payment rates; base wage index.** Amends § 256B.0915, by adding subd. 14. Lists base wage calculations for various services. Requires the commissioner to select a new standard occupational classification (SOC) code and position that is the closest match to the previously used SOC position if any of the SOC codes and positions are no longer available.

**18** **Payment rates; factors.** Amends § 256B.0915, by adding subd. 15. Lists the factors the commissioner shall use in setting payment rates.

**19** **Payment rates; component rates.** Amends § 256B.0915, by adding subd. 16. Paragraph (a) defines "adjusted base wage."

Paragraph (b) specifies the component rate for medication setups by licensed nurse, registered nurse, and social worker services.

Paragraph (c) specifies the component rate for home management and support services, home care aide, and home health aide services.

Paragraph (d) specifies the payment rate for socialization and transportation.

Paragraph (e) specifies the 15-minute unit rate calculations for chore services and companion services.

Paragraph (f) specifies the 15-minute unit rate calculations for homemaker services and assistance with personal care, homemaker services and cleaning, and homemaker services and home management.

**Section**

Paragraph (g) specifies the 15-minute rate calculation for in-home respite care services.

Paragraph (h) specifies the daily rate calculation for in-home respite care services.

Paragraph (i) specifies the 15-minute rate calculation for out-of-home respite care services.

Paragraph (j) specifies the daily rate calculation for out-of-home respite care services.

Paragraph (k) specifies the rate calculation for individual community living support services.

Paragraph (l) specifies the rate for home delivered meals.

Paragraph (m) specifies the rate for adult day services.

Paragraph (n) specifies the 15-minute unit rate for adult day services bath service.

Paragraph (o) specifies requirements related to minimum and maximum hours for adult day services.

**20** **Evaluation of rate methodology.** Amends § 256B.0915, by adding subd. 17. Directs the commissioner of human services, in consultation with stakeholders, to conduct an evaluation of the payment rate methodology. Requires the commissioner to submit a report to the legislature on the results of the evaluation by January 1, 2019. Specifies certain information that must be included in the report.

**21** **Essential community supports.** Amends § 256B.0922, subd. 1. Increases the monthly limit for essential community supports from $400 to $600, and adds respite care and companion services to the list of services available under the essential community supports program.

**22** **Property rate adjustments and construction projects.** Amends § 256B.431, subd. 10. Modifies the date for nursing facility property rate adjustments for construction projects to the first January or July following the completion of the construction project and the submission of the provider's rate adjustment request. Makes this section effective for projects completed after January 1, 2018.

**23** **Major additions and replacements; equity incentive.** Amends § 256B.431, subd. 16. Modifies the date for nursing facility property rate adjustments for major additions or facility replacements to the first January or July following the completion of the addition or replacement. Makes this section effective for additions or replacements completed after January 1, 2018.

**24** **Bed layaway and delicensure**. Amends § 256B.431, subd. 30. Modifies the timing of property payment rate adjustments due to a bed layaway or delicensure. Updates a cross-reference. Makes this section effective for layaways occurring after July 1, 2017.

**25** **Alternate rates for nursing facilities.** Amends § 256B.434, subd. 4. Limits an inflationary adjustment to the property payment rate for rate years beginning on and after January 1, 2019, and removes obsolete language. Makes this section effective the day following final enactment.

**Section**

**26** **Construction project rate adjustments effective October 1, 2016.** Amends § 256B.434, subd. 4f. For facilities completing projects after January 1, 2018, modifies the date for nursing facility property rate adjustments resulting from certain construction projects to the first July or January following the completion of the project. Makes this section effective January 1, 2018.

**27** **Filing an appeal.** Amends § 256B.50, subd. 1b. Modifies the date by which an appeal must be received by the commissioner. Makes this section effective the day following final enactment.

**28** **Therapeutic leave days.** Amends § 256B.5012, by adding subd. 3a. Counts a vacant bed in an intermediate care facility for persons with developmental disabilities as a reserved bed when determining occupancy rates and eligibility for payment of a therapeutic leave day.

**29** **ICF/DD rate increase effective July 1, 2017; Murray County**. Amends § 256B.5012, by adding subd. 17. Effective July 1, 2017, specifies the daily rate for a specific ICF/DD located in Murray County is $400. Adds this increase to any other increase that is effective on July 1, 2017.

**30** **Administrative costs.** Amends § 256R.02, subd. 4. Modifies the definition of "administrative costs" in the chapter of statutes governing nursing facility payment rates by clarifying insurance costs and including costs incurred for travel and housing for people employed by a supplemental nursing services agency. This includes these costs in the facility's other operating payment rate. Makes this section effective October 1, 2017.

**31** **Direct care costs.** Amends § 256R.02, subd. 17. Modifies the definition of "direct care costs" by adding costs for nurse consultants, pharmacy consultants, and medical directors. Requires that salaries and payroll taxes for nurse consultants who work out of a central office be allocated proportionately to the nursing facilities served by those consultants.

**32** **Employer health insurance costs.** Amends § 256R.02, subd. 18. Clarifies the definition of "employer health insurance costs." Makes this section effective the day following final enactment.

**33** **External fixed costs.** Amends § 256R.02, subd. 19. Modifies the definition of "external fixed costs" by adding rate adjustments for compensation-related costs for minimum wage changes and by clarifying the PERA costs that are included.

**34** **Fringe benefit costs.** Amends § 256R.02, subd. 22. Clarifies the definition of "fringe benefit costs."

**35** **Raw food costs.** Amends § 256R.02, subd. 42. Includes the allocation of dietary credits in the definition of "raw food costs."

**36** **Real estate taxes.** Amends § 256R.02, by adding subd. 42a. Defines "real estate taxes."

**37** **Special assessments.** Amends § 256R.02, subd. 48a. Defines "special assessments."

**38** **Therapy costs.** Amends § 256R.02, subd. 52. Clarifies the definition of "therapy costs."

**39** **Notice to residents.** Amends § 256R.06, subd. 5. Modifies requirements related to notifying private pay residents of nursing facility rate increases.

**Section**

**40** **Electronic signature.** Amends § 256R.07, by adding subd. 6. Allows the use of an electronic signature for documentation requiring a signature under the nursing facility payment system.

**41** **Not specified allowed costs.** Amends § 256R.10, by adding subd. 7. Requires the commissioner, in consultation with stakeholders, to determine the cost category for an allowed cost item or service when the cost category for that item or service is not otherwise specified. Makes this section effective the day following final enactment.

**42** **Report by commissioner of human services.** Creates §256R.18. Beginning January 1, 2019, requires the commissioner to provide to the legislative committees with jurisdiction over nursing facility payment rates a biennial report on the effectiveness of the reimbursement system in improving quality, restraining costs, and any other features of the system as determined by the commissioner. Makes this section effective the day following final enactment.

**43** **Scholarships.** Amends § 256R.37. Removes the requirement that registered nurses and licensed practical nurses be newly graduated in order to be eligible for a scholarship under the nursing facility payment system.

**44** **Definitions.** Amends § 256R.40, subd. 1. Modifies the definition of "completion of closure" for the purposes of the planned closure rate adjustment under the nursing facility payment system.

**45** **Planned closure rate adjustment.** Amends § 256R.40, subd. 5. Modifies the timing of the planned closure rate adjustment due to the closure of a facility. Makes this section effective for closures occurring after July 1, 2017.

**46** **Single-bed room incentive.** Amends § 256R.41. Modifies the timing of the single-bed room incentive due to the delicensure of beds. Makes this section effective for closures occurring after July 1, 2017.

**47** **Rate adjustment for critical access nursing facilities.** Amends § 256R.47. Extends the suspension of this program through December 31, 2019. The current suspension expires on December 31, 2017. Makes this section effective the day following final enactment.

**48** **Rate adjustments for compensation-related costs for minimum wage changes.** Amends § 256R.49. Makes rate increases provided under this section expire after two years. Makes this section effective the day following final enactment.

**49** **Nursing facilities in border cities.** Amends § 256R.53, subd. 2. Adds nonprofit nursing facilities in Moorhead to the nursing facility payment rate exemption that already exists for Breckenridge. Requires the commissioner to make a comparison of rates by November 1 of each year and apply it to the rates to be effective on the following January 1. Exempts facilities under this subdivision from rate limits if the adjustments under this subdivision result in a rate that exceeds the limits. Makes this section effective for rate increases for facilities in Moorhead for rate years beginning January 1, 2020, and annually thereafter.

**Section**

**50** **Direction to commissioner; adult day services staffing ratios.** Requires the commissioner of human services to study the staffing ratio for adult day services clients and provide recommendations to adjust staffing ratios based on client needs by January 1, 2018, to the chairs and ranking minority members of the legislative committees with jurisdiction over adult day services.

**51** **Alzheimer's Disease Working Group.** Creates § 256.999.

**Subd. 1. Members.** Requires the Minnesota Board on Aging to appoint an Alzheimer's disease working group consisting of 16 members. Lists the organizations that must be represented on the working group. Requires the appointing authorities to complete their appointments no later than December 15, 2017. Requires the membership of the working group to reflect the diversity in Minnesota.

**Subd. 2. Duties; recommendations.** Requires the working group to review and revise the 2011 report titled "Preparing Minnesota for Alzheimer's: the Budgetary, Social and Personal Impacts." Requires the working group to consider and make recommendations and findings on several issues, including:

- trends and disparities in the state's Alzheimer's population;
- risk reduction, including health education and health promotion on risk factors, safety, and potentially avoidable hospitalizations; and
- health disparities and access to high quality dementia care.

**Subd. 3. Meetings.** Requires the Board on Aging to convene the first meeting of the working group no later than January 15, 2018. Requires meetings of the working group to be open to the public, and to the extent practicable, technological means, such as Web casts, must be used to reach the greatest number of people throughout the state. Requires the Board of Aging to designate one member to serve as chair. Limits the working group to no more than five meetings.

**Subd. 4. Compensation.** Provides that working group members serve without compensation, except for allowed expense reimbursement.

**Subd. 5. Administrative support.** Requires the Board of Aging to provide administrative support.

**Subd. 6. Report.** Requires the Board on Aging to submit a report providing the findings and recommendations of the working group to the governor and the legislature no later than January 15, 2019.

Subd. **Subd. 7. Expiration.** Provides an expiration date for the working group.

**52** **Electronic service delivery documentation system.**

**Subd. 1. Documentation; establishment.** Requires the commissioner of human services to establish implementation requirements and standards for an electronic service delivery documentation system to comply with the 21st Century Cures Act.

**Subd. 2. Definitions.** Defines the terms "electronic service delivery documentation," "electronic service delivery documentation system," and "service."

**Section**

**Subd. 3. Requirements.** Requires the commissioner to consider electronic visit verification systems and other electronic service delivery documentation methods in developing implementation requirements for an electronic service delivery documentation system. Requires the commissioner to convene impacted stakeholders to ensure that the requirements meet certain criteria, including:

- being minimally administratively and financially burdensome to a provider;
- considering existing best practices and use of electronic service delivery documentation; and
- being effective methods for preventing fraud.

Requires the commissioner to: (1) make training available to providers on the electronic service delivery documentation system requirements; (2) establish baseline measurements related to preventing fraud; and (3) establish measures to determine the effect of electronic service delivery documentation requirements on program integrity.

**Subd. 4. Legislative report.** Requires the commissioner to submit a report by January 15, 2018, to the legislative committees with jurisdiction over human services with recommendations to establish electronic service delivery documentation system requirements and standards. Lists items the report must include. Makes this section effective the day following final enactment.

53 **Direction to commissioner; ICF/DD Payment Rate Study.** Directs the commissioner, within available appropriations, to study the ICF/DD payment rates and make recommendations on the rate structure to the chairs and ranking minority members of the legislative committees with jurisdiction over human services policy and finance by January 15, 2018.

54 **Revisor's instruction.** Requires the revisor of statutes, in consultation with the House Research Department, Office of Senate Counsel, Research, and Fiscal Analysis, and the Department of Human Services to prepare legislation for the 2018 legislative session to recodify laws governing the elderly waiver. Makes this section effective the day following final enactment.

**Section**

## Article 4: Health Care

# Overview

This article contains provisions related to the Medical Assistance and MinnesotaCare programs. The article requires the legislative auditor to audit DHS programs and managed care organizations, modifies inpatient hospital payment methods for MA, increases the spenddown standard for persons who are age 65 or older, are blind, or have a disability, makes changes in the MA payment methodology for prescription drugs, modifies requirements for nonemergency medical transportation, and provides for payment for targeted case management provided by interactive video. The article also modifies and expands the integrated health partnership demonstration project, expands an existing and establishes new intergovernmental transfers, establishes a new managed care payment withhold, modifies procedures for competitive bidding, establishes a hospital outcomes program, delays capitation payments, requires studies, and modifies and adds other provisions related to state health care programs.

**1** **Audits of the Department of Human Services (DHS).** Amends § 3.972, by adding subd. 2a. (a) Directs the legislative auditor to give high priority to auditing the programs, services, and benefits administered by DHS, in order to ensure continuous legislative oversight and accountability. Requires the audits to determine whether DHS offered programs and provided services and benefits only to eligible persons and organizations, and complied with applicable legal requirements.

(b) Requires the legislative auditor, based on assessment of risk and using professional standards, no less than three times each year, to test a representative sample of MA and MinnesotaCare enrollees, to determine whether they are eligible to receive benefits under those programs. Requires the legislative auditor to report the results to the commissioner of human services and recommend corrective actions. Requires the commissioner to provide a response to the legislative auditor within 20 business days, including corrective actions to be taken and anticipated completion dates. Requires the legislative auditor to monitor implementation of corrective actions and periodically report to the legislative audit commission and the legislative committees with jurisdiction over health and human services policy and finance. Requires these reports to include recommendations for any legislative actions needed to ensure that MA and MinnesotaCare benefits are provided only to eligible persons.

**2** **Audits of managed care organizations.** Amends § 3.972 by adding subd. 2b. Requires the legislative auditor to audit each managed care and community-based purchasing plan that contracts with the Commissioner of Human Services to provide services under medical assistance and MinnesotaCare to, to determine if the organization used public money in compliance with federal and state laws and rules and the organization's contract with the commissioner.

**Section**

**3** **Classifications.** Amends § 13.69, subd. 1. Permits the Department of Public Safety to share social security numbers (which are otherwise classified as private government data) with the Department of Human Services for the purposes recovering medical assistance benefits provided to medical assistance recipients injured in motor vehicle accidents.

**4** **Health care provider price disclosures.** Adds § 62J.815. Requires health care providers to maintain a list of services or procedures that correspond with the provider's 35 most frequent CPT codes, and a list of the ten most frequent CPT codes for preventive services used for reimbursement, and the provider's charges for each of these services that the provider would charge a patient without health coverage. Requires the list to be updated annually and made available on site, and on the provider's Web site.

**5** **Rate year.** Amends § 256.9686, subd. 8. Defines "rate year" as the state fiscal year, effective with the 2012 base year. Provides an immediate effective date.

**6** **Hospital cost index.** Amends § 256.969, subd. 1. Allows automatic inflation adjustments for hospital payment rates, if authorized by this section of law. Provides a July 1, 2017, effective date.

**7** **Hospital payment rates.** Amends § 256.969, subd. 2b. The amendment to (e) extends the period by which the commissioner may make additional adjustments to rebased rates, to include the next two rebasing periods (current law allows this until the next rebasing).

The amendment to (f) provides that for determining rates for discharges in subsequent base years, the per discharge rates shall be based on Medicare cost-finding methods and allowable costs.

The amendment to (h) requires changes in costs between base years to be measured using the lower of the change in the CMS Inpatient Hospital Market Basket or the change in the case mix adjusted cost per claim.

The amendment to (i) clarifies that it is "inpatient" rates for critical access hospitals that are to be determine using the new cost-based methodology.

Provides a July 1, 2017, effective date.

**8** **Payments.** Amends § 256.969, subd. 3a. Effective for discharges on or after July 1, 2017, requires rate adjustments for long-term hospitals to be incorporated into the rates and not applied to each claim. Provides a July 1, 2017, effective date.

**9** **Unusual length of stay experience.** Amends § 256.969, subd. 8. Requires the commissioner to establish outlier payment rates for admissions that result in long length of stays (current law refers only to transfers). Provides a July 1, 2017, effective date.

**10** **Hospital residents.** Amends § 256.969, subd. 8c. Effective for discharges on or after July 1, 2017, requires payment for long stays to equal the payments established under the DRG system for unusual length of stay. Provides a July 1, 2017, effective date.

**11** **Disproportionate numbers of low-income patients served.** Amends § 256.969, subd. 9. Makes a technical change in the terminology used to refer to nonchildren's hospitals. Provides a July 1, 2017, effective date.

**Section**

**12** **Rehabilitation hospitals and distinct parts.** Amends § 256.969, subd. 12. Effective for discharges on or after July 1, 2017, requires payment to rehabilitation hospitals to be established using the DRG methodology. Provides a July 1, 2017, effective date.

**13** **Limitation on services.** Amends § 256B.04, subd. 12. Strikes language requiring DHS to adopt rules that would reimburse nonemergency medical transportation providers at a lower rate for additional passengers.

**14** **Excess income standard.** Amends § 256B.056, subd. 5. Increases the medical assistance spenddown standard for persons with a disability, who are blind, or who are age 65 or older, from 80 percent of federal poverty guidelines to 81 percent, effective June 1, 2019.

**15** **Payment rates.** Amends § 256B.0621, subd. 10. Adds that in assisting a client who is moving from an institutional setting to the community, a case manager may bill medical assistance for relocation targeted case management services conducted by interactive video as provided in section 256B.0924, subdivision 4a. Provides that the section is effective upon federal approval.

**16** **Telemedicine services.** Amends § 256B.0625, subd. 3b. Allows mental health practitioners, working under the general supervision of a mental health professional, to provide telemedicine services under MA. Provides an immediate effective date.

**17** **Home care nursing.** Amends § 256B.0625, subd. 7. Eliminate a cross-reference to the home care nursing interpreter-communicator service which is being repealed.

**18** **Drugs.** Amends § 256B.0625, subd. 13. Strikes the quantity limit for dispensing of over-the-counter medications.

**19** **Payment rates.** Amends § 256B.0625, subd. 13e. The amendment to paragraph (a) sets the basis for determining drug payment, effective April 1, 2017, or upon federal approval, at the lower of the ingredient cost, plus a fixed dispensing fee; or the usual and customary price charged to the public. Sets the professional dispensing fee at $11.35 for drugs that meet the federal definition of "covered outpatient drug." (The current MA dispensing fee is $3.65.) Sets the dispensing fee for certain intravenous solutions at $11.35 per bag (this varies under current law based on the product). Also sets the dispensing fee at $11.35 for over-the-counter drugs that meet the covered outpatient drug definition at $11.35, subject to pro-ration for smaller quantities. Sets the dispensing fee for over-the-counter drugs that do not meet the covered outpatient drug definition at $3.65, with pro-ration for small quantities. Requires the National Average Drug Acquisition Cost (NADAC) to be used to determine the ingredient cost of a drug. Sets the ingredient cost at wholesale acquisition cost minus two percent for drugs for which a NADAC is not reported. Sets the ingredient cost of drugs acquired through the 340B program at that program's maximum allowable cost. Requires the maximum allowable cost of a multisource drug to be comparable to the actual acquisition cost, and no higher than the NADAC of the generic product.

The amendment to paragraph (c) strikes language related to payment under a unit dose blister card system.

The amendment to paragraph (d) includes the NADAC of the generic product as one of the pricing factors for the ingredient cost of multisource drugs.

**Section**

The amendment to paragraph (f) allows the commissioner to establish maximum allowable cost rates for specialty pharmacy products that are lower than the ingredient cost formulas and sets criteria for providers of these products. Also makes conforming changes.

A new paragraph (h) requires the commissioner, for prescriptions filled on or after April 1, 2017, or upon federal approval, to increase ingredient cost reimbursement by two percent for drugs subject to the wholesale drug distributor tax under section 295.52.

States that the section is effective retroactively from April 1, 2017, or from the effective date of federal approval.

**20** **Transportation costs.** Amends § 256B.0625, subd. 17.

The amendment to paragraph (b) makes a change in terminology and clarifies that taxicabs must meet the MA requirements for nonemergency medical transportation (NEMT).

The amendment to paragraph (g) includes the securement of car seats in the list of driver-assisted services.

The amendment to paragraph (i) strikes language that prohibits implementation of the covered modes of transportation, without a new rate structure.

A new paragraph (q) requires the commissioner, when determining NEMT reimbursement rates, to exempt the covered modes of transportation from an MA rule that sets payment rates and requires pro-rating for transporting two or more persons.

**21** **Documentation required.** Amends § 256B.0625, subd. 17b. Makes a conforming change related to implementation of all modes of NEMT.

**22** **Nursing facility transports.** Amends § 256B.0625, by adding subd. 17c. Exempts from level of need determinations Minnesota health care program enrollees who are residing in, or being discharged from, a nursing facility. States that these individuals are eligible for NEMT services until they no longer reside in a nursing facility.

**23** **Managed care.** Amends § 256B.0626, subd. 18h. Lists the MA provisions related to NEMT services that managed care and county-based purchasing plans must comply with (current law specifies the provisions from which these plans are exempt). A new paragraph (b) requires NEMT providers to comply with special transportation services standards, but exempts publicly operated transit systems, volunteers, and not-for-hire vehicles from this requirement. Provides an immediate effective date.

**24** **Mental health case management.** Amends § 256B.0625, subd. 20. Provides that medical assistance and MinnesotaCare will pay for mental health case management services provided by interactive video if the interactive video contact meets the requirements of subdivision 20b. Provides that the section is effective upon federal approval.

**Section**

**25** **Mental health targeted case management through interactive video.** Amends § 256B.0625, by adding subd. 20b. Paragraph (a) provides, subject to federal approval, that medical assistance will pay for targeted case management services provided by interactive video to a person who resides in a hospital, nursing facility, or residential setting staffed 24 hours a day, seven days a week. Use of interactive video must be approved in the case plan, must be in the best interests of the person, and must be approved by the person receiving services, the case manager, and the provider operating the setting where the person resides. Provides that interactive video cannot be used for more than 50 percent of the minimum required face-to-face contacts.

Paragraph (b) allows the person receiving services the right to consent to use of interactive video and to refuse the use of interactive video at any time.

Paragraph (c) instructs the commissioner to establish criteria for providing targeted case management via interactive video, and lists possible criteria addressing client safety, policies and protocols, and quality assurance.

Paragraph (d) provides the documentation requirements for a targeted case management provider to receive medical assistance reimbursement for services provided by interactive video.

Provides that the section is effective upon federal approval.

**26** **Other clinic services.** Amends § 256B.0625, subd. 30. The amendment to paragraph (f) places a December 31, 2018, sunset on a provision that allows FQHCs and rural health clinics to be paid under a prospective payment system or an alternative payment methodology.

A new paragraph (g) allows FQHCs and rural health clinics to elect to be paid, for services provided on or after January 1, 2019, under a prospective payment system or the alternative payment methodology established in existing law (as provided in paragraph (f)), or a new alternative payment methodology established in paragraph (l).

The amendment to paragraph (i) requires FQHCs and rural health clinics to submit claims for services provided on or after July 1, 2017, directly to the commissioner for payment. Requires the commissioner to provide claims information to managed care and county-based purchasing plans.

A new paragraph (l) establishes a new alternative payment methodology for FQHCs and rural health clinics. This paragraph:

(1) requires each FQHC and rural health clinic to receive a single medical and a single dental organization rate;

(2) requires the commissioner to reimburse FQHCs and rural health clinics for allowable costs, and specifies these costs;

(3) sets criteria for base year payment rates;

(4) requires the commissioner to annually inflate payment rates and specifies the method to be used;

(5) requires payment rates to be rebased every two years, and adjusted biannually;

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(6) requires the commissioner to seek approval from the Centers for Medicare and Medicaid Services to modify payments to FQHCs and rural health clinics according to subdivision 63 (allowing payment for mental health or dental services provided on the same day as other covered services);

(7) requires the commissioner to reimburse FQHCs and rural health clinics for an additional two percent of their medical and dental rates, only if the MinnesotaCare provider tax is required to be paid;

(8) specifies criteria for FQHCs and rural health clinics seeking a change in scope of services; and

(9) specifies criteria for establishing rates for new FQHCs and rural health clinics.

This section also replaces the term "federally qualified health center" with the acronym FQHC throughout, and makes conforming changes.

**27** **Post-arrest community-based service coordination.** Amends § 256B.0625 by adding subd, 56a. Allows medical assistance to cover post arrest community- based service coordination for an individual who: has been identified as having a mental illness or substance use disorder; does not require the security of a public detention facility and is not considered an inmate of a public institution; meets eligibly requirements in section 256B.056; and has agreed to participate in postarrest community-based service coordination through a diversion contract in lieu of incarceration. Defines post-arrest community-based service coordination, specifies procedures for reimbursement, provider reporting, and avoiding duplication of services or payments. Specifies that the nonfederal share of cost for postarrest community-based service coordination services shall be provided by the recipient's county of residence.

**28** **Investigational drugs, biological products, and devices.** Amends § 256B.0625, subd. 64. Allows the EPSDT program to cover stiripentol only:

(1) when determined to be medically necessary;

(2) for enrollees with Dravet syndrome or certain children with Malignant Migrating Epilepsy in Infancy;

(3) if all other covered prescription medications have been tried without successful outcomes; and

(4) if the U.S. Food and Drug Administration has approved the treating physician's individual patient new drug application for the use of stiripentol for treatment.

Provides that the MinnesotaCare program does not cover stiripentol.

**29** **Performance reporting and quality improvement system.** Amends § 256B.072. Prohibits the assessment of patient satisfaction with pain management to be used in determining compensation or quality incentive payments under MA and MinnesotaCare. Directs the commissioner to require managed care and county-based purchasing plans, and integrated health partnerships, to comply with this prohibition as a condition of contract. States that the prohibition does not apply to: (1) assessing patient satisfaction with pain management for the purpose of quality improvement; and (2) pain management as part of a palliative care plan to treats patient with cancer or receiving hospice care.

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A new subdivision 2 requires the commissioner, by January 1, 2019, to consider and appropriately adjust quality metrics and benchmarks for providers who primarily serve socio-economically complex populations and request to be scored on these additional measures. Specifies that this requirement applies to all MA and MinnesotaCare programs and enrollees.

**30** **Implementation.** Amends § 256B.0755, subd. 1c. Changes terminology used to refer to a payment reform demonstration project from "health care delivery systems" to "integrated health partnerships" or IHPs (these changes are made throughout the statutory section). Specifies that an IHP may be customized for special needs and barriers of patient populations experiencing health disparities due to social, economic, racial, or ethnic factors. Provides a January 1, 2018, effective date.

**31** **Accountability.** Amends § 256B.0755, subd. 3. Specifies that the accountability standards for IHPs must be appropriate to the particular population served.

**32** **Payment system.** Amends § 256B.0755, subd. 4. Specifies that the payment system for IHPs must include a population-based payment that supports care coordination services for enrollees served by the IHP and is risk adjusted to reflect varying levels of care coordination intensiveness. Provides that the payment must be a per-member per-month payment paid at least on a quarterly basis and specifies that IHPs that receive this payment must continue to meet cost and quality metrics in order to maintain eligibility for the population-based payment. Specifies other criteria related to payment. Provides a January 1, 2018, effective date.

**33** **Patient incentives.** Amends § 256B.075, subd. 9. States that the commissioner may authorize an IHP to provide incentives for patients to see a primary care provider for an initial health assessment, maintain a continuous relationship with a primary care provider, and participate in ongoing health improvement and coordination of care activities.

**34** **Health care delivery systems demonstration project.** Adds § 256B.0759.

**Subd. 1. Implementation.** (a) Requires the commissioner to develop and implement a demonstration project to test delivery system payment and care models that provide services to MA and MinnesotaCare enrollees based on prospective per capita or total cost of care payments. Requires the project to be implemented in coordination with, and as an expansion of, the integrated health partnership demonstration project.

(b) Specifies criteria for the commissioner to follow in developing the project.

**Subd. 2. Requirements for health care delivery systems.** (a) Requires health care delivery systems to provide required services and care coordination, establish a process to monitor enrollment and ensure quality of care, coordinate service delivery with social services programs, provide a system for advocacy and consumer protection, and adopt innovative and cost-effective methods of care delivery and coordination.

(b) Specifies the types of health care providers that may establish a health care delivery system.

(c) Requires a health care delivery system to contract with a third-party administrator, specifies related criteria, and allows the commissioner to waive this requirement.

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**Subd. 3. Enrollment.** (a) States that individuals eligible for MA or MinnesotaCare are eligible to enroll in a health care delivery system. Allows individuals to opt-out of prepaid MA or prepaid MinnesotaCare, and receive care through a health care delivery system.

(b) Allows individuals to enroll in a health care delivery system that serves the county in which they reside, and to have a choice between delivery systems if more than one delivery system serves the county. States that enrollment in a specific health care delivery system is for 12 months, except that persons who do not maintain eligibility shall be disenrolled and persons experiencing a qualifying life event may change delivery systems or opt out of the demonstration project.

(c) Specifies criteria governing assignment of individuals to a delivery system.

**Subd. 4. Accountability.** (a) States that health care delivery systems are responsible for quality of care, and enrollee cost of care and utilization. Requires the commissioner to adjust accountability standards to take into account various barriers to care experienced by a delivery system's patient population.

(b) Requires a delivery system to contract with community health clinics, federally qualified health centers, and other specified entities, to the extent practicable.

(c) Specifies requirements for coordination of services with other providers, county agencies, and other local entities.

**Subd. 5. Payment system.** Requires the commissioner to develop a payment system for the project that includes prospective per capita payments, total cost of care benchmarks, and risk/gain sharing payment options. Also requires the payment system to include incentive payments related to quality and performance targets.

**Subd. 6. Federal waiver or approval.** Directs the commissioner to seek all federal waivers or approval necessary to implement the demonstration project, and to report to legislative committees on any federal action related to the request.

States that the section is effective January 1, 2018, or upon receipt of federal waivers or approval, whichever is later.

**35** **Targeted case management through interactive video.** Amends § 256B.0924, by adding subd. 4a. Paragraph (a) provides, subject to federal approval, that medical assistance will pay for targeted case management services provided by interactive video to a person who resides in a hospital, nursing facility, or residential setting staffed 24 hours a day, seven days a week. Use of interactive video must be approved in the case plan, must be in the best interests of the person, and must be approved by the person receiving services, the case manager, and the provider operating the setting where the person resides. Provides that interactive video cannot be used for more than 50 percent of the minimum required face-to-face contacts.

Paragraph (b) allows the person receiving services the right to consent to use of interactive active and to refuse the use of interactive video at any time.

Paragraph (c) instructs the commissioner to establish criteria for providing targeted case management via interactive video, and lists possible criteria addressing client safety, policies and protocols, and quality assurance.

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Paragraph (d) provides the documentation requirements for a targeted case management provider to receive medical assistance reimbursement for services provided by interactive video.

Provides that this section is effective upon federal approval.

**36** **Commissioner's duties.** Amends § 256B.192, subd. 2. The amendment to paragraph (d) allows ambulance services owned and operated by a governmental organization to participate in an existing intergovernmental transfer (IGT) arrangement for ambulance services that currently applies to ambulance services affiliated with Hennepin County Medical Center and the city of St. Paul. Requires the commissioner to determine an upper payment limit for these ambulance services, inform participating governmental entities of the IGTs necessary to match federal Medicaid payments available, and upon receipt of these transfers, to make supplementary payments to these entities equal to the difference between the MA payment rate and the upper payment limit. Provides that tribal governments that operate an ambulance service are not eligible to participate in the IGT arrangement for ambulance services.

A new paragraph (e) directs the commissioner to determine an upper payment limit for physicians, dentists, and other billing professionals affiliated with the University of Minnesota and University of Minnesota Physicians. Requires the commissioner to inform the University of Minnesota Medical School and School of Dentistry of the periodic intergovernmental transfers needed to match federal Medicaid payments available, in order to make supplemental payments to physicians, dentists, and other billing professionals equal to the difference between the established MA payment rate and the upper payment limit. Upon receipt of these transfers, requires the commissioner to make these supplemental payments.

A new paragraph (h) states that all data and funding transactions are between the commissioner and the governmental entities.

A new paragraph (i) defines "billing professional."

States that paragraph (d) is effective July 1, 2017, or upon federal approval, whichever is later.

**37** **Intergovernmental transfers.** Amends § 256B.196, subd. 3. Requires all intergovernmental transfer payments made by the University of Minnesota Medical School and School of Dentistry to be used to match federal payments to the University of Minnesota and the University of Minnesota Physicians under subdivision 2, paragraphs (e) and (f).

**38** **Adjustments permitted.** Amends § 256B.196, subd. 4. Adds the average commercial rates for physician and other professional services to the list of factors for which the commissioner may adjust intergovernmental transfers and payments. Adds university schools to the list of entities that the commissioner must consult with prior to making adjustments.

**39** **Managed care contracts.** Amends § 256B.69, subd. 5a. For services provided on or after January 1, 2018, through December 31, 2018, requires the commissioner to withhold two percent of capitation payments for each MA enrollee. Requires the commissioner to return the withhold, between July 1 and July 31 of the following year, for capitation payments for enrollees for whom the managed care or county-based purchasing plan has submitted to the commissioner a verification of coverage form completed and signed by the enrollee.

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Specifies requirements for the form. Requires a plan to request all enrollees to complete the form, and requires the plan to submit all completed forms to the commissioner by February 28, 2018. If a completed form for an enrollee is not received by the commissioner by that date, requires the commissioner to not return funds withheld for that enrollee, cease making capitation payments for the enrollee, and disenroll the enrollee from MA, subject to enrollee appeal.

**40** **Financial audits.** Amends § 256B.69, subd, 9e. Modifies the current financial audit language for managed care organizations by adding a cross reference to section 3.972, subd. 2b.

**41** **Competitive bidding and procurement.** Amends § 256B.69, by adding subd. 36.

(a) For managed care organization contracts effective on or after January 1, 2019, requires the commissioner to utilize a competitive price and technical bidding program on a regional basis for nonelderly adults and children who are not eligible based on a disability and are enrolled in MA and MinnesotaCare. Requires the commissioner to establish geographic regions, and to not implement competitive bidding for more than 40 percent of the regions during each procurement. Requires the commissioner to ensure there is an adequate choice of managed care organizations, in a manner consistent with section 256B.694 (which allows sole-source contracting with county-based purchasing plans). Requires the commissioner to operate competitive bidding by region, but to award contracts by county and allow partial bids within a region based on counties served. Defines managed care organization.

(b) Requires the commissioner to provide the scoring weight of selection criteria in the request for proposals. Requires substantial weight to be given to county board resolutions and priority areas identified by counties, when that input meets federal conflict of interest requirements.

(c) Requires that each responding managed care organization be given the opportunity to submit a best and final offer, if a best and final offer is requested.

(d) Requires the commissioner to consider network adequacy for dental and other services when evaluating proposals.

(e) Requires the commissioner to meet with any responder upon request to discuss individual results. Prohibits the provision of evaluation materials in writing until final contracts are signed.

(f) Requires the commissioner to provide information on the goals and objectives of the procurement prior to any publication of a request for proposals.

(g) Allows a managed care organization to appeal the commissioner's selection decision using a three-person mediation panel, but states that the panel recommendation is binding on the commissioner.

(h) Requires the commissioner to contract for an independent evaluation of the competitive bidding process. Requires the contractor to solicit recommendations for improving the competitive bidding process. Requires the commissioner to make evaluation results available on the department's Web site.

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**42** **Hospital outpatient reimbursement.** Amends § 256B.75. Specifies the method for determining outpatient payment rates for critical access hospitals. Requires Medicare cost report information to be used until DHS finalizes the MA cost reporting process for critical access hospitals. Specifies components of the outpatient rate. Provides a July 1, 2017, effective date.

**43** **Reimbursement for evidence-based public health nurse home visits.** Adds § 256B.7635. For services provided on or after January 1, 2018, sets MA payment rates for prenatal and post-partum follow-up home visits provided by a public health nurse, or a registered nurse supervised by a public health nurse, using evidence-based models, at $140 per visit. Requires follow-up home visits to be administered by home visiting programs that meet specified criteria. Requires home visits to target mothers and their children beginning with prenatal visits through age three for the child.

**44** **Reimbursement for basic health care services.** Amends § 256B.766. Effective for items provided on or after January 1, 2016, sets the MA payment rate for non-pressure support ventilators at the lower of the submitted charge or the Medicare fee schedule rate, and sets the MA payment rate for pressure support ventilators at the lower of the submitted charge or 47 percent above the Medicare fee schedule rate. Also specifies that categories of medical supplies may be individually priced. Provides a retroactive effective date of January 1, 2016.

**45** **Definitions.** Adds § 256B.90. Defines terms.

**46** **Medical assistance outcomes-based payment program.** Adds § 256B.91.

**Subd. 1. Generally.** Requires the commissioner to establish a hospital outcomes program to provide hospitals with information and incentives to reduce potentially avoidable events.

**Subd. 2. Potentially avoidable event methodology.** Requires the commissioner to select a methodology for identifying potentially avoidable events and associated costs, and for measuring hospital performance with respect to these events. Requires the commissioner to develop definitions for each potentially avoidable event. Requires the methodology, to the extent possible, to be one that has been used by other Medicaid programs or by commercial payers, and specifies other criteria.

**Subd. 3. Medical assistance system waste.** Requires the commissioner to analyze state databases to identify waste in the MA system. Requires the analysis to identify potentially avoidable events in MA and associated costs. Specifies related requirements.

**47** **Hospital outcomes program.** Adds § 256B.92.

**Subd. 1. Generally.** Requires the hospital outcomes program to: (1) target reduction of potentially avoidable readmissions and complications; (2) apply to all state acute care hospitals participating in MA; and (3) be implemented in two phases—performance reporting and outcomes-based financial incentives.

**Subd. 2. Phase 1; performance reporting.** Requires the commissioner to develop and maintain a reporting system to provide each hospital with reports on its performance for potentially avoidable readmissions and potentially avoidable

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complications. Specifies duties for the commissioner. Allows a hospital to share information in the outcome performance reports with health care providers to foster coordination and cooperation in the hospital's outcome improvement and waste reduction initiatives.

**Subd. 3. Phase 2; outcomes-based financial incentives.** Requires the commissioner, 12 months after implementation of performance reporting, to establish financial incentives for a hospital to reduce potentially avoidable readmissions and potentially avoidable complications.

**Subd. 4. Rate adjustment methodology.** Requires the commissioner to adjust hospital reimbursement based on the hospital's performance on outcome results. Specifies criteria for the rate methodology.

**Subd. 5. Amendment of contracts.** Requires the commissioner to amend hospital contracts as necessary to incorporate the financial incentives.

**Subd. 6. Budget neutrality.** Requires the program to be implemented in a budget-neutral manner for aggregate Medicaid hospital expenditures.

**48** **Capitation payment delay.** Delays the capitation payment to managed care plans and county-based purchasing plans due in May 2019, and the payment due in April 2019 for special needs basic care until July 1, 2019. Also delays the capitation payment due in May 2021 and the payment due in April 2021 for special needs basic care until July 1, 2021.

**49** **Commissioner duty to seek federal approval.** Instructs the commissioner to seek federal approval necessary to implement the provisions related to interactive video contact.

**50** **Legislative commission on managed care.** Establishes a legislative commission to study and make recommendations on issues relating to the competitive bidding program and procurement process for the medical assistance and MinnesotaCare contracts with managed care plans and county-based purchasing plans for nonelderly, nondisabled adults and children. Specifies membership of the commission and criteria for the study and recommendations. Requires the commission to report recommendations by February 15, 2018 to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance. Provides that this section is expires June 30, 2018.

**51** **Health care access fund assessment.** Requires the Commissioner of Human Services to assess any federal health care reform legislation passed at the federal level on its effect on the MinnesotaCare program and the need for the health care access fund as its continued source of funding. Requires the commissioner to report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance.

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**52** **Opioid use and acupuncture study.** Requires the Human Services Policy Committee to study and compare the use of opiates for the treatment of chronic pain conditions when acupuncture services are also part of the treatment for chronic pain, to opiate use by the MA recipients who are not receiving acupuncture. Requires the commissioner to report findings to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by February 15, 2018.

**53** **Encounter reporting of 340B eligible drugs.** (a) By January 1, 2018, requires the Commissioner of Human Services, in consultation with specified entities, to develop a process to identify and report at point of sale 340B drugs dispensed to enrollees of managed care organizations who are patients of an FQHC, in order to exclude these claims from the Medicaid drug rebate program. Requires the commissioner to ensure that FQHCs are allowed to utilize 340B drug discounts if a FQHC utilizes a contract pharmacy for a patient enrolled in the prepaid medical assistance program, and to also ensure that duplicate discounts for drugs do not occur.

(b) Requires the commissioner, by January 1, 2018, to notify the chairs and ranking minority members of the legislative committees with jurisdiction over MA when the process required by paragraph (a) was developed, or to report why the process was not developed.

**54** **Rate-setting analysis report.** Requires the commissioner of human services to analyze and report on the current rate-setting methodology for outpatient, professional, and physician services that do not have a cost-based, federally mandated, or contracted rate. Requires the report to include recommendations for changes to the existing Resource-Based Relative Value System fee schedule, and alternative payment methodologies for services that do not have relative values, to simplify the rate structure and improve consistency and transparency. Requires the commissioner to consult with outside experts in Medicaid financing when developing the report. Requires the commissioner to report the analysis to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services finance by November 1, 2019.

**55** **Study of payment rates for durable medical equipment and supplies.** Requires the commissioner of human services to study the impact of basing MA payment for durable medical equipment and supplies on Medicare payments, as limited by the federal 21st Century Cures Act, on access by MA enrollees to these items. Requires the study to include recommendations for ensuring and improving access by MA enrollees to durable medical equipment and supplies. Requires the commissioner to report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance, by February 1, 2018.

**56** **Revisor's instruction.** Requires the Revisor to change the term "health care delivery system" to "integrated health partnership" where it appears in section 256B.0755.

**57** **Repealer.** Repeals the home care nursing interpreter-communicator service (section 256B.64).

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## Article 5: Health Insurance

# Overview

This article exempts health plans from requirements to include certain standard provisions in their policies; modifies provisions governing continuation coverage for current spouses, former spouses, and dependents; modifies requirements for pharmacy benefit filings; exempts Affordable Care Act compliant plans from certain requirements in chapter 62E; establishes notice requirements for conversions of nonprofit health care entities; and modifies two provisions in the premium subsidy program.

**1** **Reference.** Amends § 62A.04, subd. 1. Lists provisions from a section establishing standard provisions for accident and sickness or accident and health insurance that do not apply to health plans.

**2** **Continuation privilege.** Amends § 62A.21, subd. 2a. In a subdivision authorizing continuation of insurance coverage for former spouses and dependent children, specifies that continuation of coverage only applies to a former spouse who was covered on the day before the entry of a valid dissolution decree. Also adds a cross-reference regarding dependent children whose coverage may be continued.

**3** **Cancer chemotherapy treatment coverage.** Amends § 62A.3075. Requires a health plan company with a health plan covering cancer chemotherapy treatment to indicate, in its pharmacy benefit filing with the commissioner, the level of coverage for orally administered anticancer medication.

**4** **Coverage of current spouse, former spouse, and children.** Amends § 62D.105. In a section on health maintenance agreement coverage of an enrollee's spouse and dependent children, specifies that continuation of coverage for former spouses only applies to a former spouse who was covered on the day before the entry of a valid dissolution decree. Also adds a cross-reference regarding dependent children whose coverage may be continued.

**5** **Affordable Care Act compliant plans.** Amends § 62E.04, subd. 11. Provides that section 62E.04, requiring insurers to file policies with the commissioner that meet the standards of a qualified plan, does not apply to policies of accident and health insurance that are subject to the Affordable Care Act.

**6** **Certification.** Amends § 62E.05, subd. 1. Provides that section 62E.05, which establishes certification and annual reporting requirements for policies filed with the commissioner as a qualified plan, does not apply to policies of accident and health insurance that are subject to the Affordable Care Act.

**7** **Affordable Care Act compliant plans.** Adds subd. 5 to § 62E.06. Provides that section 62E.06, which establishes minimum benefits for qualified plans, does not apply to policies of accident and health insurance that are subject to the Affordable Care Act.

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**8** **When required.** Amends § 317A.811, subd. 1. Requires health maintenance organizations and service plan corporations to notify the attorney general of their intent to dissolve, merge, or consolidate or transfer all or substantially all of their assets.

**9** **Nonprofit health care entity; notice required.** Adds subd. 1a to § 317A.811. Requires health maintenance organizations and service plan corporations to give notice to the attorney general under section 317A.814, before entering into a conversion transaction.

**10** **Nonprofit health care entity conversions.** Adds § 317A.814. Establishes notice requirements for nonprofit health care entity conversions, and prohibits private inurement related to a conversion transaction.

**Subd. 1. Definitions.** Defines terms: commissioner, conversion benefit entity, conversion transaction or transaction, family member, nonprofit health care entity, public benefit assets, and related organization.

**Subd. 2. Private inurement.** Prohibits a nonprofit health care entity from entering into a conversion transaction if an officer, director, or other executive of the nonprofit health care entity or a related organization:

1. has received or will receive any compensation or financial benefit in connection with the transaction;
2. has held or will hold an ownership stake, stock, securities, investment, or other financial interest in, or receive any onetime compensation or benefit from, an entity to which the nonprofit health care entity transfers public benefit assets in a conversion transaction; or
3. has held or will hold an ownership stake, stock, securities, investment, or other financial interest in, or receive any compensation or benefit from, an entity that has or will have a business relationship with an entity to which the nonprofit health care entity transfers public benefit assets in a conversion transaction.

**Subd. 3. Attorney general notice required.** Requires a nonprofit health care entity to notify the attorney general before entering into a conversion transaction, and requires the notice to include an itemization of the nonprofit health care entity's public benefit assets and their valuation, a proposed distribution plan for those assets to a conversion benefit entity, and other information the attorney general considers necessary. Also requires the notice and other information to be given to the commissioner of health for HMOs and the commissioner of commerce for service plan corporations.

**Subd. 4. Review elements.** Lists factors the attorney general may consider in exercising its powers under chapter 317A.

**Subd. 5. Conversion benefit entity requirements.** Lists elements an entity must satisfy in order to be a conversion benefit entity:

1. be a nonprofit, 501(c)(3) corporation;
2. have policies that prohibit conflicts of interest; and
3. have a charitable purpose and grant-making functions that are dedicated to meeting the health care needs of people in Minnesota.

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**Subd. 6. Public comment.** Allows the attorney general to solicit public comments and hold public meetings regarding the proposed conversion transaction.

**Subd. 7. Relation to other law.** Provides that this section does not limit the powers, remedies, or responsibilities of a health maintenance organization, service plan corporation, conversion benefit entity, the attorney general, or a commissioner under chapter 317A, 62C, 62D, or 501B, or other law.

**11** **Sunset.** Amends Laws 2017, chapter 2, article 1, section 5. Modifies the sunset date for chapter 2, article 1, which established the premium subsidy program. The article now sunsets August 31, 2018, except that provisions on audits and data sharing do not sunset.

**12** **Appropriations.** Amends Laws 2017, chapter 2, article 1, section 7. Modifies a section appropriating money for the premium subsidy program, by making the appropriation available through August 31, 2018 (instead of June 30, 2018), and requiring any unexpended funds to be transferred to the budget reserve by August 31, 2018 (instead of July 1, 2018).

### Article 6: Direct Care and Treatment

## Overview

This article makes changes to civil commitment administrative requirements, imposes term limits for the civil commitment review board, and requires a review of and report on state-operated group homes housing one person.

**1** **Administrative requirements.** Amends § 253B.10, subd. 1. Requires that treatment facility staff receive civil commitment documents and information consistently and in a timely manner.

**2** **Establishment.** Amends § 253B.22, subd. 1. Imposes term limits on the members of the review board under the civil commitment act.

**3** **Review of alternatives to state-operated group homes housing one person.** Requires the commissioner to review alternatives to state-operated on-person group homes and report back to legislative committees by January 15, 2018.

### Article 7: Children and Families

## Overview

This article makes changes to welfare data practices provisions, child care assistance programs and program integrity provisions, child care licensing, TEFRA parental fees, MFIP, and foster care. This article also requires a report on compliance with the Indian Child Welfare Act and establishes mobile food shelf grants, the birth to 8 pilot project, and the pathways to prosperity pilot project.

**1** **Access by welfare system.** Amends § 13.32, by adding subd. 12. Allows county personnel with the welfare system to request access to education data in order to coordinate services for

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a student or family. Specifies the manner in which the request must be submitted. Allows education data to be released only if the parent or legal guardian gives informed consent to the release.

**2** **Definitions.** Amends § 13.46, subd. 1. Modifies the definitions of "program" and "welfare system" in the chapter of statutes governing data practices.

**3** **General.** Amends § 13.46, subd. 2. Provides that entities within the welfare system may disclose data to (1) the chief administrative officer of a school for purposes of coordinating services for a student and family; and (2) county correctional agencies to the extent necessary to coordinate services.

**4** **Disclosure.** Amends § 13.84, subd. 5. Provides that private or confidential court services data may be disclosed to personnel in the county welfare system.

**5** **Authorization with a secondary provider.** Creates § 119B.097. Requires a parent to choose one primary provider and one secondary provider per child that can be paid by child care assistance if a child uses certain combinations of providers paid by child care assistance. Limits the amount of child care authorized with the secondary provider and the total amount of child care authorized with both providers. Makes this section effective April 23, 2018.

**6** **Subsidy restrictions.** Amends § 119B.13, subd. 1. Modifies child care assistance program maximum rates by setting the maximum rate for child care providers who are located within the boundaries of a city located in two or more of the counties of Benton, Sherburne, and Stearns at the maximum rate paid in the county with the highest maximum reimbursement rates or the provider's charge, whichever is less. Limits maximum payments if a child uses two providers. Makes technical and conforming changes.

Makes paragraph (a) effective July 1, 2018. Makes paragraphs (d) to (i) effective April 23, 2018.

**7** **Application of coverage.** Amends § 245.814, subd. 2. Removes liability insurance restriction, allowing for insurance to cover property owned by an individual foster home provider and damage caused intentionally by a person over 12 years old.

**8** **Compensation provisions.** Amends § 245.814, subd. 3. Raises the amount the state is required to compensate for property damage caused or sustained by foster children or adults from $250 to $1,000 for each occurrence.

**9** **Exemption from positive support strategies requirements.** Proposes coding for § 245A.23. Paragraph (a) exempts licensed family day care programs, licensed group family day care facilities, and licensed child care centers from Minnesota Rules, chapter 9544, the positive supports rule.

Paragraph (b) prohibits licensed family day care programs, licensed group family day care facilities, and licensed child care centers from using chemical restraints, mechanical restraints, manual restraints, time out, seclusion, or any other aversive or deprivation procedure.

Makes this section effective the day following final enactment.

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**10** **Sudden unexpected infant death and abusive head trauma training.** Amends § 245A.50, subd. 5. Exempts from the sudden unexpected infant death and abusive head trauma training relatives of the license holder if the relative is only involved in the care of the license holder's own infant or child.

**11** **Contribution amount.** Amends § 252.27, subd. 2a. Reduces TEFRA parental fees by 25 percent.

**12** **Allocation of money.** Amends § 256E.30, subd. 2. Modifies the allocation of money to community action agencies.

**13** **MFIP transitional standard.** Amends § 256J.24, subd. 5. Provides a $13 increase in the cash portion of the MFIP grant effective March 1, 2018.

**14** **General information.** Amends § 256J.45, subd. 2. Adds to the list of information that must be presented during the MFIP orientation by including information about certain income exclusions. Makes this section effective December 1, 2018.

**15** **Support for adoptive, foster, and kinship families.** Proposes coding for § 256N.261.

**Subd. 1. Program established.** Instructs the commissioner to design and implement a program to reduce the need for placement changes of children and youth in foster care, adoptive placements, and permanent physical and legal custody kinship placements, to improve the functioning and stability of these families. Requires the commissioner, to the extent funds are available, to ensure that placements are trauma-informed and child and family-centered, and to provide services as follows:

(1) Information, referrals, parent-to-parent support, peer support for youth, family activities, respite care, crisis services, educational support, and mental health services to children, youth, and families;

(2) Training for adoptive, foster, and kinship families, and the professionals who serve them, on the effects of trauma, common disabilities of children in placements, and other challenges; and

(3) Periodic evaluation of these services.

**Subd. 2. Definitions.** Defines "child and family-centered" and "trauma-informed."

**16** **Exempted individuals.** Amends § 256P.06, subd. 2. Adds to the list of exempted members of an assistance unit for purposes of MFIP and the child care assistance programs. Makes this section effective December 1, 2018.

**17** **Reentering foster care and accessing services after 18 years of age and up to 21 years of age.** Amends § 260C.451, subd. 6. Adds a requirement for the responsible social services agency to provide foster care or other services, with a plan specific to the individual's needs, to an individual over 18 years old who was not under the guardianship of the commissioner and who asks to reenter foster care, if the individual left foster care within six months before his or her 18th birthday.

**18** **Minnesota Birth to Age Eight Pilot Project.**

**Subd. 1. Authorization.** Requires the commissioner of human services to award a grant to Dakota County to develop and implement pilots that will evaluate the impact of

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a coordinated systems and service delivery approach on key developmental milestones and outcomes that lead to reading proficiency by age eight. Specifies the pilot project is from July 1, 2017, to June 30, 2021.

**Subd. 2. Pilot design and goals.** Requires the pilot to develop five key milestone markers from birth to age eight. Requires enrollees to be developmentally assessed and tracked by a technology solution that tracks developmental milestones. Requires the coordinated service system to focus on areas of concern, mobilize appropriate supportive services, and offer services to children whose progress falls below established milestones and their families.

**Subd. 3. Program participants in phase 1 target population.** Pilot program participants must: (1) be enrolled in WIC; (2) be participating in a family home visiting program, or nurse family practice, or Healthy Families America; (3) be children and families qualifying for and participating in early language learners in the school district in which they reside; and (4) opt-in and provide parental consent to participate in the pilot project.

**19 Minnesota Pathways to Prosperity Pilot Project.**

**Subd. 1. Authorization.** Allows the commissioner of human services to develop a pilot project to test an alternative financing model for the distribution of publicly funded benefits and to work with interested counties to develop the pilot and determine the waivers that are necessary to implement the pilot project based on the design and outcome measures.

**Subd. 2. Pilot project goals.** Specifies the goals of the pilot project.

**Subd. 3. Project participants.** Allows the commissioner to require certain requirements for participation in the pilot.

**Subd. 4. Outcomes.** Lists the outcome measures that must be included in the pilot project.

**20 Indian Child Welfare Act Compliance System Review.** Requires the Commissioner of Human Services to report back to the legislature by February 1, 2018, on a system for the review of cases reported by counties for aid payments under section 477A.0126 for compliance with the Indian Child Welfare Act and the Minnesota Indian Family Preservation Act.

**21 Mobile Food Shelf Grants.**

**Subd. 1. Grant amount.** Requires Hunger Solutions to award grants on a priority basis. Limits grant amounts for sustaining existing mobile programs and creating new mobile programs.

**Subd. 2. Application contents.** Lists the information that grant applicants must provide to Hunger Solutions.

**Subd. 3. Awarding grants.** Requires Hunger Solutions to give priority to certain applicants when evaluating applications and awarding grants.

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**22** **Child care correction order posting guidelines.** Requires commissioner to develop guidelines, consulting with stakeholders, for posting public licensing data for licensed child care providers, by November 1, 2017.

**23** **Repealer.** Repeals Minnesota Statutes 2016, sections 13.468 (data sharing); 179A.50; 179A.51; 179A.52; 179A.53 (authorizing child care provider unionization); and 256J.626, subd. 5 (MFIP innovation grants).

### Article 8: Chemical and Mental Health

## Overview

This article establishes a mental health innovation grant program, modifies the statutes relating to the Ombudsman for Mental Health and Developmental Disabilities, updates terminology and cross-references throughout the substance use disorder statutes, creates a new substance use disorder chapter, and adds new services. It also increases payment rates for certain treatment services, modifies provisions related to psychiatric residential treatment facility services for children, and requires analyses and reports for children's mental health and substance use disorder residential treatment.

**1** **Grant program; mental health innovation.** Proposes coding for § 245.4662.

**Subd. 1. Definitions.** Defines the following terms: community partnership, eligible applicant, intensive residential treatment services, and metropolitan area.

"Eligible applicant" includes a county, Indian tribe, mental health center, hospital, and community partnership.

**Subd. 2**. **Grants authorized.** Authorizes the commissioner to award grants to eligible applicants to plan, establish, or operate programs to improve community-based outpatient mental health services. Specifies that half of grant funds will be awarded to applicants in the metropolitan area, and half outside the area.

**Subd. 3. Allocation of grants.** Specifies application deadlines and what applications must contain. Lists guidelines for the commissioner to establish criteria, and relevant factors for the commissioner to consider. Lists grant award purposes: intensive residential treatment services, mental health urgent care centers, crisis residential services, new or expanded community mental health services, supportive housing, and other innovative projects.

**Subd. 4. Report to legislature.** Requires the commissioner to provide a report on program outcomes to the legislature by December 1, 2019. Requires grantees to provide information to the commissioner for the report.

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**2** **Establishment and authority.** Amends § 245.4889, subd. 1. Allows children's mental health grants to be used for start-up funding to establish new children's mental health programs to support providers to meet program requirements and begin operations, and for transportation to school-linked mental health services. Makes clause (17) effective the day following final enactment.

**3** **Facility or program.** Amends § 245.91, subd. 4. Specifies that a "facility" or "program" includes any entity required to be licensed, certified, or registered, providing services or treatment for mental illness, developmental disabilities, chemical dependency, or emotional disturbance.

Makes section effective the day following final enactment.

**4** **Serious injury.** Amends § 245.91, subd. 6. Adds to the list of serious injuries for reporting to the ombudsman for mental health and developmental disabilities:

(1) head injuries with loss of consciousness or potential for a closed head injury or concussion without loss of consciousness requiring a medical assessment, whether or not further medical attention was sought;

(2) attempted suicide; and

(3) all other incidents considered serious by a health care professional, including self-harm, medication error requiring medical treatment, delay of medical treatment, and complications related to treatment and injury.

Makes section effective the day following final enactment

**5** **Powers.** Amends § 245.94, subd. 1.

Paragraph (b) clarifies that the ombudsman for mental health and developmental disabilities is a health oversight agency under federal regulations, and may access patient records.

Paragraph (d) allows the ombudsman to investigate to promote the health, safety, and welfare of clients, including those in acute care facilities receiving services through private funding.

Paragraph (e) allows the ombudsman to gather and analyze data upon receiving information or a complaint relating to the rights of one or more clients who may not be capable of requesting assistance.

Paragraph (f) allows the ombudsman to gather records on behalf of one or more clients, and specifies that the ombudsman is not required to obtain consent for access to private data for individuals in the Minnesota Sex Offender Program. Allows the ombudsman to take photos or video evidence while investigating, with client consent. Adds chemical dependency to the services for which the ombudsman may access private data on deceased clients without consent.

Paragraph (i) expands ombudsman's power to attend meetings and access private client data without consent.

Paragraph (j) instructs the ombudsman to gather private data regarding services for clients with developmental disabilities and those served by the Minnesota Sex Offender Program.

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Paragraph (l) states that the Office of the Ombudsman must provide the services of the Civil Commitment Training and Resource Center.

Makes section effective the day following final enactment.

**6** **Terms, compensation, and removal.** Amends § 245.97, subd. 6. Changes the membership, compensation, and removal terms for the Ombudsman Committee.

Makes section effective the day following final enactment.

**7** **Exclusion from licensure.** Amends § 245A.03, subd. 2. Updates terminology to refer to substance use disorder and cross-references to new chapter established in this article. Adds county (as eligible vendor of care coordination and assessment) and recovery community organization to exclusions. Makes section effective January 1, 2018.

**8** **Provider eligibility for payments from the chemical dependency consolidated treatment fund.** Amends § 245A.191. Updates terminology and cross-references. Makes section effective January 1, 2018.

**9 to 30** **§ 9. Definitions; § 10. Applicability; § 11. Licensing requirements; § 12. Initial services plan; § 13. Comprehensive assessment and assessment summary; § 14. Individual treatment plan; § 15. Treatment service; § 16. Medical services; § 17. Client records; § 18. Staff requirements; § 19. Staff qualifications; § 20. Provider policies and procedures; § 21. Provider personnel policies; § 22. Service initiation and termination policies; § 23. Client rights protection; § 24. Behavioral emergency procedures; § 25. Evaluation; § 26. License holders serving adolescents; § 27. License holders serving clients with children; § 28. License holders serving persons with co-occurring disorders; § 29. Requirements for licensed residential treatment; § 30. Opioid treatment programs.**
Proposing coding for 245G.01, 245G.02, 245G.03, 245G.04, 245G.05, 245G.06, 245G.07, 245G.08, 245G.09, 245G.10, 245G.11, 245G.12, 245G.13, 245G.14, 245G.15, 245G.16, 245G.17, 245G.18, 245G.19, 245G.20, 245G.21, 245G.22. These sections establish the standards for the substance use disorder services in a new chapter, 245G. A majority of the language in these sections is existing rule, and is being codified in this new chapter. New language in section 15 includes the expansion of services, which are peer recovery support services and care coordination, subject to federal approval. The existing provisions related to opioid treatment programs are consolidated in this chapter in section 30.

Sections effective January 1, 2018.

**31** **Collections deposited in the general fund.** Amends § 246.18, subd. 4. Requires receipts from collection efforts for regional treatment centers and community behavioral health hospitals (county payments) to be deposited in the mental health innovation account, according to section 32.

**32** **Mental health innovation account.** Amends § 246.18 by adding a subdivision. Establishes the mental health innovation account. Requires $2,000,000 of revenue generated by collection efforts from to regional treatment centers and community behavioral health hospitals to be deposited into the account in fiscal year 2018 and fiscal year 2019, and $2,500,000 beginning fiscal year 2020. Specifies that money deposited into this account is for the mental health innovation grant program.

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**33** **Public Policy.** Amends § 254A.01. Modifies the public policy statement related to drug and alcohol addiction. Makes section effective January 1, 2018.

**34** **Approved treatment program.** Amends § 254A.02, subd. 2. Updates terminology and strikes obsolete references. Makes section effective January 1, 2018.

**35** **Comprehensive program.** Amends § 254A.02, subd. 3. Updates terminology and strikes obsolete references. Makes section effective January 1, 2018.

**36** **Drug dependent person.** Amends § 254A.02, subd. 5. Updates terminology and strikes obsolete references. Makes section effective January 1, 2018.

**37** **Facility.** Amends § 254A.02, subd. 6. Updates terminology and strikes obsolete references. Makes section effective January 1, 2018.

**38** **Substance misuse.** Amends § 254A.02 by adding subd. 6a. Defines the term "substance misuse." Makes section effective January 1, 2018.

**39** **Other drugs.** Amends § 254A.02, subd. 8. Updates terminology and strikes obsolete references. Makes section effective January 1, 2018.

**40** **State authority.** Amends § 254A.02, subd. 10. Updates terminology and strikes obsolete references. Makes section effective January 1, 2018.

**41** **Substance use disorder.** Amends § 254A.02 by adding subd. 10a. Defines the term "substance use disorder." Makes section effective January 1, 2018.

**42** **State authority on alcohol and drug abuse.** Amends § 254A.03. Updates the statute delegating authority to the alcohol and drug abuse section in DHS, by incorporating the new services and updating terminology.

> **Subd. 3** specifies that upon federal approval or on July 1, 2018, whichever is later, of a comprehensive assessment as a Medicaid benefit, an eligible vendor may determine and approve the appropriate level of substance use disorder treatment for a recipient of public assistance. 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 publicly funded placements in treatment.

Makes section effective January 1, 2018.

**43** **Establishment.** Amends § 254A.035, subd. 1. Updates terminology. Makes section effective January 1, 2018.

**44** **Citizens advisory council.** Amends § 254A.04. Updates terminology. Makes section effective January 1, 2018.

**45** **Detoxification centers.** Amends § 254A.08. Updates terminology and incorporates references to rules. Makes section effective January 1, 2018.

**46** **Confidentiality of records.** Amends § 254A.09. Updates terminology. Makes section effective January 1, 2018.

**47** **Financial conflicts of interest.** Amends § 254A.19, subd. 3. Adds paragraph specifying that an eligible vendor conducting a comprehensive assessment shall approve the nature, intensity, and duration of treatment services, but an individual may access any enrolled and licensed

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provider to provide the treatment services, and must comply with any requirements of a prepaid health plan, if applicable. Makes section effective January 1, 2018.

**48** **Substance use disorder.** Amends § 254B.01, subd. 3. Updates terminology by changing "chemical dependency" to "substance use disorder." Makes section effective January 1, 2018.

**49** **Recovery community organization.** Amends § 254B.01 by adding subd. 8. Defines the term "recovery community organization." Makes section effective January 1, 2018.

**50** **Chemical dependency fund payment.** Amends § 254B.03, subd. 2. Updates terminology and prohibits a vendor from requiring clients to use their public benefits to offset the cost of services paid under this section. Clarifies that SNAP benefits belong to the client. Makes section effective January 1, 2018.

**51** **Eligibility.** Amends § 254B.04, subd. 1. Modifies the chemical dependency fund services by striking obsolete language. Makes section effective January 1, 2018.

**52** **Eligibility for placement in opioid treatment programs.** Amends § 254B.04, subd. 2b. Modifies the chemical dependency fund services by striking obsolete language. Makes section effective January 1, 2018.

**53** **Licensure required.** Amends § 245B.05, subd. 1. Provides that on July 1, 2018, or upon federal approval, whichever is later, licensed professionals in private practice and counties are eligible vendors of comprehensive assessment and assessment summary services, under new paragraphs (b) and (c). Counties are also eligible providers of care coordination services. Paragraph (d) provides that on July 1, 2018, or upon federal approval, whichever is later, a recovery community organization is an eligible vendor of peer support services. Updates terminology and references. Makes section effective January 1, 2018.

**54** **Room and board provider requirements.** Amends § 254B.05, subd. 1a. Updates cross-references to new chapter 245G. Makes section effective January 1, 2018.

**55** **Rate requirements.** Amends § 254B.05, subd. 5. Requires the commissioner to establish rates for the new eligible services (comprehensive assessments, care coordination, peer recovery support services, and withdrawal management services) under this section, effective July 1, 2018, or upon federal approval, whichever is later. Updates references to the new chapter 245G. Makes section effective January 1, 2018.

**56** **Substance use disorder treatment effectiveness.** Amends § 254B.051. Updates terminology. Makes section effective January 1, 2018.

**57** **Third party liability.** Amends § 254B.07. Updates terminology. Makes section effective January 1, 2018.

**58** **Federal waivers.** Amends § 254B.08. Updates terminology. Makes section effective January 1, 2018.

**59** **Indian reservation allocation of chemical dependency fund.** Amends § 254B.09. Updates terminology. Makes section effective January 1, 2018.

**60** **Payment methodology for highly specialized vendors.** Amends § 254B.12, subd 2. Updates terminology. Makes section effective January 1, 2018.

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**61** **Chemical dependency provider rate increase.** Amends § 254B.12 by adding subd. 3. Provides for a 3 percent rate increase for chemical dependency services listed in section 254B.05, subdivision 5 provided on or after July 1, 2017.

**62** **Eligibility for navigator pilot program.** Amends § 254B.13, subd 2a. Updates cross-references. Makes section effective January 1, 2018.

**63** **Psychiatric residential treatment facility services for persons under 21 years of age.** Amends § 256B.0625, subd. 45a. Clarifies that MA coverage of psychiatric residential treatment facility services must be provided according to section 256B.0941, and makes conforming and technical changes. Makes section effective the day following final enactment.

**64** **Psychiatric residential treatment facility for persons under 21 years of age.** Proposes coding for § 256B.0941.

**Subd. 1. Eligibility.** (a) States that individuals eligible for mental health treatment services in a psychiatric residential treatment facility must meet all of the following criteria:

(1) before admission, the services are determined to be medically necessary by the state's medical review agent;

(2) be younger than age 21 at the time of admission, with services continuing until the individual meets discharge criteria or reaches age 22, whichever occurs first;

(3) has a mental health diagnosis, and clinical evidence of severe aggression or a finding that the individual is a risk to self or others;

(4) has a functional impairment and a history of difficulty in functioning safely and successfully, an inability to adequately care for one's physical needs, or caregiver, guardians, and family members are unable to safely fulfill the individual's needs;

(5) requires psychiatric residential treatment under the direction of a physician;

(6) utilized and exhausted other community-based mental health services, or clinical evidence indicates that these services cannot provide the needed level of care; and

(7) referred to residential treatment by a qualified mental health professional.

(b) Requires the mental health professional making a referral to submit specified documentation to the state's medical review agent, within 180 days of admission.

**Subd. 2. Services.** Requires psychiatric residential treatment facility services providers to offer and have the capacity to provide the following:

(1) development of the individual plan of care, review of the plan every 30 days, and discharge planning;

(2) any services provided by a psychiatrist or physician for purposes of the services required in clause (1);

(3) active treatment seven days per week;

(4) individual therapy, at least twice per week;

(5) family engagement activities, at least once per week;

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(6) consultation with other professionals;

(7) coordination of educational services between local and resident school districts and the facility;

(8) 24-hour nursing; and

(9) direct care and supervision, supportive services for daily living and safety, and positive behavior management.

**Subd. 3. Per diem rate.** (a) Requires the commissioner to establish a statewide per diem rate for facility services for individuals 21 years of age or younger. Specifies criteria for the rate and the reporting of costs.

(b) Specifies rate components.

(c) Allows a facility to submit a claim for payment outside of the per diem for professional services, and specifies related criteria.

(d) Requires Medicaid to reimburse for concurrent services as approved by the commissioner to support continuity of care and successful discharge. Defines concurrent services and specifies related criteria.

(e) Excludes the costs of the following services from payment rates: educational services, acute medical care or specialty services for other conditions, dental services, and pharmacy drug costs.

(f) Provides a definition of "actual cost."

**Subd. 4. Leave days.** Provides medical assistance coverage for therapeutic and hospital leave days, and specifies requirements for payment and payment levels.

Makes section effective the day following final enactment.

**65** **Exception to excluded services.** Amends § 256B.0943, subd. 13. Adds a psychiatric residential treatment facility to the list of facilities for which payment can be made under MA for children's therapeutic services and supports. Strikes obsolete language. Makes section effective the day following final enactment.

**66** **Covered services.** Amends § 256B.0945, subd. 2. Provides that MA covers mental health services provided to children with severe emotional disturbance in a residential facility determined by CMS to be an institution for mental diseases (IMD), except for room and board, using state-only MA funding.

**67** **Payment rates.** Amends § 256B.0945, subd. 4. Provides that payments to counties, for services provided to children with severe emotional disturbance by a residential facility that is determined to be an IMD, shall be equivalent to the federal share of the payment that would have been made were the facility not an IMD. Requires the portion of payment representing what would be the nonfederal share to be paid by the county. Specifies other payment criteria and makes conforming changes.

**68** **Critical access mental health rate increase.** Amends § 256B.763. Requires the MA payment rate to mental health clinics and centers that are not designated as essential community

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providers under section 62Q.19 to be the same as the payment rate for those facilities that are designated as essential community providers, for the following services:

(1) Group skills training as a component of mental health services;

(2) Medication education services provided by adult rehabilitative mental health services providers;

(3) Mental health behavioral aide services provided by children's therapeutic services and support providers; and

(4) Individual and family skills training provided by children's therapeutic services and support providers.

Requires a provider to demonstrate a commitment to serve low-income and underserved populations in order to receive increased payments by charging for services on a sliding fee schedule based on poverty guidelines and not restricting access or services because of financial limitations.

**69** **Children's mental health report and recommendations.** Requires the commissioner to conduct a comprehensive analysis of Minnesota's continuum of intensive mental health services and develop recommendations for a sustainable and community-driven continuum of care for children with serious mental health needs, including children in residential treatment. Lists criteria for the analysis and requires extensive stakeholder engagement. Requires the commissioner to present the report with specific recommendations and implementation timelines to legislative committees by November 15, 2018.

**70** **Residential treatment and payment rate reform.** Requires the commissioner to contract with an outside expert to develop a substance use disorder residential treatment program model that is not subject to the federal IMD exclusion, and that is financially sustainable and improves treatment outcomes. Requires analysis to include recommendations and a timeline for providers to transition to the new models of care. Requires report to legislative committees by December 15, 2018.

**71** **Revisor's instruction.** Instructs the revisor to make necessary cross-reference changes due to terminology and structural changes in this section.

**72** **Repealer.** Repeals obsolete statutes and rules due to new chapter 245G; repeals section related to chemical dependency provider rate. Provides effective dates for repealers.

### Article 9: Operations

## Overview

This article modifies and adds several provisions relating to child care licensing and corrective actions, requires a report to the legislature on child care, and transfers investigation responsibilities for reports of maltreatment in juvenile correctional facilities regulated by the Department of Corrections to the Department of Human Services.

**1** **Annual or annually.** Amends § 245A.02, subd. 2b. Adds an exception.

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**2** **Annual or annually; family child care training requirements.** Amends § 245A.02 by adding subd. 2c. Specifies that "annual" or "annually" for the purposes of section 245A.50 (family child care training requirements) means the 12 month period beginning on the license anniversary and ending the day prior to the anniversary.

**3** **Inspections; waiver.** Amends § 245A.04, subd. 4. Requires a licensing agency to offer a child care license holder an exit interview to discuss violations observed during inspection and offer technical assistance to help the license holder comply, before completing a licensing inspection. Allows commissioner to issue a correction order or negative action for violations not discussed in an exit interview, or if the license holder does not participate in an exit interview. Makes section effective October 1, 2017.

**4** **Reconsideration of correction orders.** Amends § 245A.06, subd. 2. Modifies the reconsideration process of DHS licensing correction orders for licensed family child care providers, to allow for expedited review under certain circumstances.

**5** **Requirement to post correction order.** Amends § 245A.06, subd. 8. Requires the commissioner to issue an amended correction order and requires the license holder to post the amended order, if the commissioner reverses or rescinds a violation in a correction order upon reconsideration. Requires the license holder to remove the original posted correction order if the correction order is rescinded or reversed in full upon reconsideration.

**6** **Child care correction order quotas prohibited.** Adds subd. 9 to § 245A.06. Prohibits the commissioner and county licensing agencies from mandating or suggesting quotas for issuing correction orders to any person responsible for licensing or inspecting child care centers or family child care facilities.

**7** **Child care fix-it ticket.** Proposes coding for § 245A.065. (a) Requires the commissioner to issue a "fix-it ticket" to a child care license holder if:

(1) the license holder failed to comply with statute or rule that is eligible for a fix-it ticket;

(2) the violation does not imminently endanger the health, safety, or welfare of anyone the program serves;

(3) the license holder did not receive a fix-it ticket or correction order for the same violation at the previous inspection;

(4) the violation can be corrected at the time of inspection or within 48 hours; and

(5) the license holder in fact corrects the violation at the time of inspection, or agrees to correct the violation within 48 hours.

(b) Specifies that the fix-it ticket must state:

(1) the conditions that led to violation;

(2) the specific law or rule violated; and

(3) that the violation was corrected, or will be corrected within 48 hours.

(c) States that a fix-it ticket will not be available on a public Web site.

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(d) Requires the child care license holder to correct the violation within 48 hours of receiving the ticket, and to submit evidence to the county licensing agency showing the correction.

(e) Allows commissioner to issue a correction order if the violation on the fix-it ticket is not corrected at the time of inspection or within 48 hours, or if the evidence the license holder submits is not sufficient to establish that the violation has been corrected.

(f) Requires commissioner to issue a report by October 1, 2017, identifying violations of statute and rule that are eligible for a fix-it ticket, and to provide the report to county agencies and legislative committees, and post the report online.

Makes the section effective October 1, 2017.

**8** **License suspension, revocation, or fine.** Amends § 245A.07, subd. 3. Modifies the DHS licensing act by imposing a $5,000 fine on a license holder following the determination of serious maltreatment. Imposes a $1,000 fine for each determination of maltreatment for a program operating out of the license holder's home and licensed under Minnesota Rules, part 9502.0300 to 0502.0495. Makes section effective August 1, 2017.

**9** **Information for child care license holders.** Proposes coding for § 245A.1434. Adds the commissioner's duty to timely inform family child care and child care center license holders of changes in federal and state statute, rule, regulation, or policy, relating to child care, child care assistance, child care quality rating and improvement, and licensing functions, in order to promote license holder compliance with changes. Allows notice via electronic means, requires the commissioner to make the notice available online.

**10** **Report to legislature on the status of child care.** Proposes coding for § 245A.153.

**Subd. 1. Reporting requirements.** Requires the commissioner to provide a report on the status of child care in Minnesota to the legislative committees with jurisdiction over child care by February 1, 2018, and each year thereafter.

**Subd. 2. Contents of report.** Requires that the child care report include the following:

(1) summary data on trends in child care capacity and availability;

(2) description of any changes to statutes, rules, or policies and procedures;

(3) description of actions DHS has taken to address or implement the recommendations of the Legislative Task Force on Access to Affordable Child Care, including:

(i) encouraging uniformity in implementing and interpreting statutes, rules, policies, and procedures relating to child care licensing;

(ii) improving communication with county licensors and child care providers;

(iii) providing notice to child care providers before issuing correction orders or negative licensing actions relating to recently changed statutes, rules, or policies;

(iv) implementing confidential communication processes for provider questions;

(v) streamlining processes to reduce training and paperwork requirement overlap and duplication; and

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(vi) compiling and distributing information detail trends in violations resulting in correction orders and negative licensing actions;

(4) description of DHS efforts to cooperate with counties;

(5) summary data on CCAP, including state funding and number of families served

(6) summary data on child care correction orders.

**Subd. 3. Sunset.** Section expires February 2, 2020.

11 **Local welfare agency, Department of Human Services or Department of Health responsible for assessing or investigating reports of maltreatment.** Amends § 626.556, subd. 3c. Requires that investigations of maltreatment occurring in children's residential facilities licensed by the Commissioner of Corrections be conducted by the Department of Human Services Licensing Division.

## Article 10: Health Department

# Overview

This article creates or modifies programs operated by the Minnesota Department of Health. It makes changes to the chapter governing wells and borings, creates an advisory council, modifies an existing loan forgiveness program and a physician residency grant program, establishes two new grant programs for health occupations, authorizes administration of a statewide tobacco quitline, authorizes licensure of prescribed pediatric extended care centers, modifies abortion reporting requirements, modifies the commissioner's authority to re-register and discipline medical cannabis manufacturers, repeals the Minnesota Radon License Act, and authorizes pilot programs and studies regarding brain health, safety and quality improvement practices for long-term care services, the home care nursing workforce shortage, and opioid abuse prevention.

1 **Duties.** Amends § 103I.101, subd. 2. In a subdivision specifying duties of the commissioner of health related to regulating wells and borings, specifies that monitoring well contractors are licensed, not registered. Makes other minor changes.

2 **Commissioner to adopt rules.** Amends § 103I.101, subd. 5. In a subdivision authorizing rulemaking relating to wells and borings, changes registration to license or certification, as applicable.

3 **Unsealed wells and borings are public health nuisances.** Amends § 103I.111, subd. 6. Clarifies that unsealed borings, in addition to unsealed wells that are required to be sealed, are a public health nuisance that may be abated.

4 **Local license fees prohibited.** Amends § 103I.111, subd. 7. Removes a reference to registration in a subdivision prohibiting local fees for well contractors.

5 **Municipal regulation of drilling.** Amends § 103I.111, subd. 8. Changes a reference from shaft to boring, in a subdivision authorizing municipalities to regulate certain types of drilling.

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**6** **Well and boring construction.** Amends § 103I.205. Adds borings to a section governing well construction. Also changes registration to license, for well contractors.

**7** **Well and boring sealing requirements.** Amends § 103I.301. Adds borings to a sections governing well sealing requirements, and removes a reference to registered.

**8** **Licensing and regulation of wells and borings.** Amends § 103I.501. Removes a reference to register, in a section governing the commissioner's authority to license and regulate activities related to wells and borings.

**9** **Reciprocity of licenses and certifications.** Amends § 103I.505. In a section governing reciprocity for persons licensed or certified in other states, replaces registration with certification.

**10** **Licenses not transferrable.** Amends § 103I.515. In a section on transferability of licenses and similar authorizations, replaces registration with certification.

**11** **Certification examination.** Amends § 103I.535, subd. 3. Amends a subdivision headnote.

**12** **Certification renewal.** Adds subd. 3b to § 103I.535. Establishes requirements to apply for certification renewal for representatives of elevator boring contractors.

**13** **License fee.** Amends § 103I.535, subd. 6. In a subdivision establishing license fees for certain licenses, changes the name of the license from elevator shaft contractor's license to elevator boring contractor's license.

**14** **Monitoring well contractor's license; representative's certification.** Amends § 103I.541. In a section governing representatives of monitoring well contractors, changes registration to certification and removes references to registration. Clarifies that a representative must file an application and a renewal application to renew the certification and must include information that the certified representative has met continuing education requirements. Also clarifies that if a person employs a certified representative, submits the required bond and pays the required license fee for a monitoring well contractor's license, the commissioner shall issue a monitoring well contractor's license.

**15** **Drilling machine.** Amends § 103I.545, subd. 1. In a subdivision governing the use of drilling machines, removes a reference to registration.

**16** **Hoist.** Amends § 103I.545, subd. 2. In a subdivision governing the use of hoists, removes a reference to registration.

**17** **Impoundment.** Amends § 103I.711, subd. 1. In a subdivision authorizing the commissioner to seek impoundment of drilling machines and hoists, changes shaft to boring and removes a reference to registration.

**18** **Gross misdemeanor.** Amends § 103I.715, subd. 2. In a subdivision establishing penalties for violations of chapter 103I, changes shafts to borings.

**19** **Palliative Care Advisory Council.** Adds § 144.059. Establishes an 18-member Palliative Care Advisory Council to advise the commissioner of health on palliative care initiatives in the state. Specifies the council's membership, and requires at least six members to reside outside counties in and surrounding the Twin Cities metro area. Establishes requirements for meetings and terms, and provides that public members of the council shall not receive

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compensation or reimbursement for expenses. Directs the council to consult with and advise the commissioner on palliative care initiatives in the state, and requires the council to submit an annual report on the availability of palliative care, barriers, and recommendations for legislative action. Requires the report to also be published on MDH's Web site. Requires the council to comply with open meeting laws, and sunsets the council January 1, 2025.

**20** **Authorization to use certain handheld dental x-ray equipment.** Adds § 144.1215. Allows the use of handheld dental x-ray equipment that meet the requirements of this section.

**Subd. 1. Definition; handheld dental x-ray equipment.** Defines handheld dental x-ray equipment.

**Subd. 2. Use authorized.** Allows a facility to use handheld dental x-ray equipment if the equipment has been approved for human use by the FDA and is being used consistent with that approval and uses a backscatter shield that meets the listed requirements. Prohibits use of the equipment if its backscatter shield is broken or not permanently affixed to the system. Prohibits limiting the use of handheld equipment to situations when it is impractical to transfer a patient to a stationary system. Allows the system's tube housing and position-indicating device to be handheld during exposure. Requires the equipment to be securely stored when not in use and establishes calibration requirements.

**Subd. 3. Exemptions from certain shielding requirements.** Exempts handheld equipment from the following requirements in Minnesota Rules: shielding requirements and requirements for the location of the x-ray console or use of a protective barrier.

**Subd. 4. Compliance with rules.** Requires handheld dental x-ray equipment to otherwise comply with Minnesota Rules, chapter 4732, which governs sources of ionizing radiation.

**21** **License, permit, and survey fees.** Amends § 144.122. Specifies that fees collected to license hospitals, nursing homes, outpatient surgical centers, boarding care homes, and supervised living facilities are nonrefundable even if received before July 1, 2017, for licenses issued effective July 1, 2017 or later.

**22** **Creation of account.** Amends § 144.1501, subd. 2. Expands the category of nurses eligible for loan forgiveness through the health professional education loan forgiveness program to include nurses who agree to practice in a housing with services establishment or practice with a home care provider.

**23** **Senior care workforce innovation grant program.** Adds § 144.1504. Establishes a senior care workforce innovation grant program.

**Subd. 1. Establishment.** Establishes a grant program to fund new pilot programs or expand existing programs that increase the pool of caregivers providing senior care services.

**Subd. 2. Competitive grants.** Directs the commissioner to make competitive grants, to expand the senior care services workforce.

**Subd. 3. Eligibility.** Specifies that applicants eligible for a grant under this section must (1) recruit and train individuals to work primarily with people 65 years of age and

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older and (2) provide services in a home and community-based setting, in an adult day care setting, through home care, or in a nursing home.

**Subd. 4. Application.** Requires applicants to apply for grants on forms and according to timelines established by the commissioner. Requires applicants to propose a project to expand the number of workers in the senior care services field, and specifies what proposals must include.

**Subd. 5. Commissioner's duties; requests for proposals; grantee selections.** Requires the commissioner to annually publish a request for proposals (RFP) for the grant program. Requires the commissioner to give priority to proposals that target employment of individuals who have multiple employment barriers, have been unemployed long-term, or are veterans. Directs the commissioner to determine maximum grant awards and to make grant selections.

**Subd. 6. Grant funding.** Specifies that grant awards do not lapse until the grant agreement expires.

**Subd. 7. Reporting requirements.** Establishes reporting requirements for grant recipients and the commissioner of health. Authorizes the commissioner to collect information from grant recipients as necessary to evaluate the grant program.

**24** **Health professionals clinical training expansion grant program.** Adds § 144.1505. Establishes a program administered by the commissioner of health to provide grants to physician assistant (PA), advanced practice registered nurse (APRN), pharmacy, dental therapy, and mental health professional training programs, to expand clinical training for these professions.

**Subd. 1. Definitions.** Defines terms: eligible advanced practice registered nurse program; eligible dental therapy program; eligible mental health professional program; eligible physician assistant program; eligible pharmacy program; mental health professional; and project.

**Subd. 2. Program.** Directs the commissioner of health to award grants to eligible programs training advanced practice registered nurses, physician assistants, pharmacists, dental therapists, advanced dental therapists, or mental health professionals, to plan and implement expanded clinical training for these professions. Establishes limits for planning and training grants and lists purposes for which grant funds may be used.

**Subd. 3. Applications.** Directs eligible PA, APRN, pharmacy, dental therapy, and mental health professional programs seeking a grant to apply to the commissioner and lists required content for applications.

**Subd. 4. Consideration of applications.** Directs the commissioner to review and score applications and specifies factors the commissioner must use to score applications.

**Subd. 5. Program oversight.** Directs the commissioner to determine grant amounts for eligible programs based on their application scores. Specifies that appropriations do not cancel and are available until expended and allows the commissioner to collect from programs information necessary for evaluation.

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**25** **Physician residency expansion grant program.** Amends § 144.1506. Renames the primary care residency expansion grant program as the physician residency expansion grant program. Expands the types of residency training programs eligible to receive grants under this section, to include obstetrics and gynecology programs and programs that train medical residents in other physician specialties if the program incorporates rural training components.

**26** **Statewide tobacco quitline services.** Adds § 144.397. Directs the commissioner of health to administer or contract for administration of a statewide tobacco quitline service to help Minnesotans quit using tobacco products. Also requires statewide awareness activities to notify the public about the service. Lists services to be provided, and requires services to be evidence-based best practices and to be coordinated with other tobacco prevention and cessation services.

**27** **Restricted construction or modification.** Amends § 144.551, subd. 1. Current law prohibits the construction of a new hospital and any hospital construction that increases hospital bed capacity or increases or redistributes hospital beds in the state. This section establishes an exception, to allow PrairieCare's inpatient psychiatric hospital for children and adolescents in Brooklyn Park to add 21 new beds to that facility. This section is effective the day following final enactment.

**28** **Minnesota biomedicine and bioethics innovation grants.** Adds § 144.88. Establishes a Minnesota biomedicine and bioethics innovation grant program to be used to fund biomedical and bioethical research and related clinical translation and commercialization activities in the state. Lists criteria for the commissioner of health, in consultation with interested parties, to consider in awarding grants. Specifies parties with whom the commissioner must consult when awarding grants.

**29** **Remedies available.** Amends § 144.99, subd. 1. Allows the Minnesota Department of Health to enforce section 144.1215 (authorizing the use of handheld dental x-ray equipment) using the tools of the Health Enforcement Consolidation Act (HECA; sections 144.99 to 144.993; these sections include provisions on correction orders, administrative penalty orders, injunctive relief, cease and desist orders, actions related to licenses, contested case hearings, and penalty amounts).

**30** **Fees; application, change of ownership, and renewal.** Amends § 144A.472, subd. 7. Specifies that home care provider license fees are nonrefundable even if received before July 1, 2017, for licenses issued effective July 1, 2017 or later.

**31** **Fines.** Amends § 144A.474, subd. 11. Requires the revenue from fines collected from home care providers to be used by the commissioner of health for special projects to improve home care in Minnesota, as recommended by the home care provider advisory council. (Current law permits, but does not require, the revenue to be used for these special projects.)

**32** **Duties.** Amends § 144A.4799, subd. 3. Directs the home care provider advisory council to annually review the balance in the account that holds fines collected from home care providers, and to make recommendations to the legislature regarding uses of those funds for special projects to improve home care.

**33** **Nurse.** Adds subd. 4a to § 144A.70. Defines "nurse" for purposes of statutes regulating supplemental nursing services agencies, to mean an LPN or an RN.

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**34** **Supplemental nursing services agency.** Amends § 144A.70, subd. 6. Amends the definition of supplemental nursing services agency, by removing "other licensed health professionals" from the list of health professionals an agency may provide for temporary employment in a health care facility. With this language removed, a supplemental nursing services agency that is regulated by the commissioner of health is an agency that provides nurses, nursing assistants, nurse aides, and orderlies for temporary employment in health care facilities.

**35** **Other laws.** Amends § 144D.06. Exempts housing with services establishments from being required to obtain a lodging license under chapter 157.

**36** **Definitions.** Adds § 144H.01. Defines terms for a new chapter licensing prescribed pediatric extended care centers: basic services, commissioner, licensee, medically complex or technologically dependent child, owner, prescribed pediatric extended care center, and supportive services or contracted services.

**37** **Licensure required.** Adds § 144H.02. Prohibits a person from owning or operating a prescribed pediatric extended care center, or PPEC center, unless the center is licensed by the commissioner of health under this chapter.

**38** **Exemptions.** Adds § 144H.03. Exempts facilities operated by a federal agency and facilities licensed under chapters 144 (hospitals and supervised living facilities) and 144A (nursing homes, boarding care homes, and hospices) from the licensing requirements of this chapter.

**39** **License application and renewal.** Adds § 144H.04. Establishes a procedure and requirements for seeking licensure and for license renewal. Specifies that PPEC center licenses are not transferrable.

**40** **Fees.** Adds § 144H.05. Specifies fees for initial license applications, license renewal, late submission of a renewal application, and change of ownership. Provides that fees are not refundable.

**41** **Application of rules for hospice services and residential hospice facilities.** Adds § 144H.06. Provides that rules for hospice services and residential hospice facilities, administered by the commissioner of health, also apply to PPEC centers, except that the rules listed in clauses (1) to (11) do not apply.

**42** **Services; limitations.** Adds § 144H.07. Requires PPEC centers to provide basic services to medically complex and technologically dependent children, based on a protocol of care established for each child. Allows a PPEC center to provide care up to 24 hours a day and up to seven days a week. Prohibits a child from attending a PPEC center more than 14 hours in a 24-hour period. Prohibits a PPEC center from providing other services besides services to medically complex or technologically dependent children. Specifies that the maximum capacity for a PPEC center is 45 children.

**43** **Administration and management.** Adds § 144H.08. Provides that the owner of a PPEC center has the full legal authority and responsibility for operation of the center, and requires the owner to designate an administrator who is responsible for overall management of the center. Lists duties for center administrators.

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**44** **Admission, transfer, and discharge policies; consent form.** Adds § 144H.09. Requires a PPEC center to have written policies for admitting, transferring, and discharging children, and requires a parent or guardian to sign a consent form before admitting a child to a PPEC center. Also requires notice of discharge to a parent or guardian at least ten days before a child's discharge.

**45** **Medical director.** Adds § 144H.10. Requires a PPEC center to have a medical director who is a physician licensed in Minnesota and certified by the American Board of Pediatrics.

**46** **Nursing services.** Adds § 144H.11. Requires a PPEC center to have a nursing director who is a registered nurse licensed in Minnesota and who has specified expertise. Also establishes requirements that registered nurses, licensed practical nurses, and other direct care personnel (including nursing assistants and individuals trained in the fields of education, social services, or child care) must meet in order to be employed by a PPEC center.

**47** **Total staffing for nursing services and direct care personnel.** Adds § 144H.12. Requires a minimum of one staff person providing direct care for every three children at a PPEC center.

**48** **Medical record; protocol of care.** Adds § 144H.13. Requires a medical record and individualized nursing protocol of care to be developed, maintained, and appropriately signed for each child admitted to a PPEC center.

**49** **Quality assurance program.** Adds § 144H.14. Requires PPEC centers to have a quality assurance program.

**50** **Inspections.** Adds § 144H.15. Allows the commissioner of health to inspect PPEC centers and center records at reasonable times to ensure compliance with this chapter and rules that apply to PPEC centers, and before issuing or renewing a license.

**51** **Compliance with other laws.** Adds § 144H.16. Requires PPEC centers to:

- develop procedures for reporting suspected child maltreatment; and
- comply with crib safety requirements in section 245A.146, to the extent they are applicable.

**52** **Denial, suspension, revocation, refusal to renew a license.** Adds § 144H.17. Specifies grounds for denying, suspending, revoking, and refusing to renew a PPEC center license, and provides for a contested case hearing before suspending, revoking, or refusing to renew a license.

**53** **Fines; corrective action plans.** Adds § 144H.18.

**Subd. 1. Corrective action plans.** Authorizes the commissioner to require a PPEC center to submit a corrective action plan to remedy violations found by the commissioner.

**Subd. 2. Fines.** Authorizes the commissioner to issue a fine to a PPEC center, employee, or contractor, and lists factors for the commissioner to consider in determining fine amounts.

**Subd. 3. Fines for violations of other statutes.** Directs the commissioner to impose a fine of $250 for violating the Maltreatment of Minors Act or crib safety requirements.

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**54** **Closing a PPEC center.** Adds § 144H.19. If a PPEC center voluntarily closes, requires a PPEC center to provide notice to the parents and guardians of children attending the center at least 30 days before the center closes.

**55** **Physical environment.** Adds § 144H.20. Requires PPEC centers to conform with the physical environment requirements in this section, and otherwise with requirements that apply to day care facilities in Minnesota Rules, chapter 9502. Establishes specific requirements for center entrances, treatment rooms, isolation procedures, outdoor and indoor spaces, and application of the building code.

**56** **Forms.** Amends § 145.4131, subd. 1. Requires a physician or facility performing an abortion to include in abortion data reports submitted to the commissioner of health, the facility code for the patient and the facility code for the physician, if the abortion was performed via telemedicine. This section is effective January 1, 2018.

**57** **Duties of director.** Amends § 145.4716, subd. 2. Authorizes the commissioner of health to manage funds that were used or intended to be used to commit a crime related to prostitution or sex trafficking, were subject to forfeiture under state law, and were deposited in the safe harbor for youth account. The commissioner may use these funds for distribution to crime victims services organizations that serve sexually exploited youth.

**58** **Opioid prescriber education and public awareness grants.** Adds § 145.9263. Directs the commissioner of health, in coordination with the commissioner of human services, to award grants to nonprofit organizations to expand prescriber education, public awareness, and outreach on the opioid epidemic and overdose prevention programs.

**59** **Reports.** Amends § 145.928, subd. 13. Clarifies that the commissioner of health's annual report on public health grants made to decrease racial and ethnic disparities in infant mortality rates must be released to the public. Also requires the report to include an itemized list specifying how each grantee used the grant funds and the amount expended for each use.

**60** **Grants to local communities.** Amends § 145.986, subd. 1a. Requires the commissioner of health to award at least two statewide health improvement program (SHIP) grants to be used to confront the opioid addiction and overdose epidemic.

**61** **Audiologist biennial licensure fee.** Amends § 148.5194, subd. 7. In a subdivision establishing license fees for audiologists, separates the license fee for initial applicants from the renewal license fee (the license fee amounts are unchanged).

**62** **Medical cannabis manufacturer registration.** Amends § 152.25, subd. 1. Prohibits the commissioner of health from renewing a medical cannabis manufacturer's registration if an officer, director, or controlling person of the manufacturer pleads or is found guilty of intentionally diverting medical cannabis to a person other than allowed by law.

**63** **Revocation, nonrenewal, or denial of consent to transfer a medical cannabis manufacturer registration.** Adds subd. 1a to § 152.25. If the commissioner of health intends to revoke, not renew, or deny consent to transfer a medical cannabis manufacturer registration, requires the commissioner to notify a manufacturer in writing and give the manufacturer a chance to request a contested case hearing. Allows the commissioner to proceed without a

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hearing if the manufacturer does not request a hearing. Specifies a registration is revoked on the date specified in the commissioner's notice of revocation.

**64** **Temporary suspension proceedings.** Adds subd. 1b to § 152.25. Establishes a process for the commissioner to temporarily suspend a medical cannabis manufacturer's registration.

**65** **Notice to patients.** Adds subd. 1c to § 152.25. If a manufacturer's registration is revoked, not renewed, or temporarily suspended, requires the commissioner to provide written notice to patients and their designated caregivers, parents, or legal guardians about the proceeding and alternative registered manufacturers. Requires this notice to be provided at least two business days before the revocation, nonrenewal, or suspension.

**66** **Intentional diversion outside the state; penalties.** Adds subd. 1a to § 152.33. Requires the commissioner to levy a fine of $500,000 against a manufacturer and immediately initiate proceedings to revoke a manufacturer's registration if an officer, director, or controlling person of the manufacturer: (1) pleads or is found guilty of intentionally transferring medical cannabis to a person other than allowed by law; and (2) in transferring medical cannabis to a person other than allowed by law, transported or directed the transport of medical cannabis outside the state.

**67** **License required annually.** Amends § 157.16, subd. 1. Specifies that license fees collected under chapter 157 must be deposited in the state government special revenue fund.

**68** **Prescribed pediatric extended care centers.** Adds subd. 65 to § 256B.0625. Provides that medical assistance covers services provided at prescribed pediatric extended care centers.

**69** **Prescribed pediatric extended care centers.** Adds § 256B.7651. Directs the commissioner of human services to set payment rates for PPEC centers at 85 percent of the rate for one hour of complex home care nursing services.

**70** **Fees, manufactured home parks and recreational camping areas.** Amends § 327.15, subd. 3. Requires fees collected under section 327.15 for manufactured home parks and recreational camping areas to be deposited in the state government special revenue fund.

**71** **Disposition of money; prostitution.** Amends § 609.5315, subd. 5c. Transfers authority to distribute the forfeited funds used or intended to be used to commit a prostitution or sex trafficking crime, from the commissioner of public safety to the commissioner of health.

**72 to 75** Amends § 626.556, subds. 2, 3, 3c, 10d. Adds references to PPEC centers in section 626.556, the Maltreatment of Minors Act, to make PPEC centers subject to the reporting requirements and standards in that section.

**76** **Brain health pilot programs.** Directs the commissioner to award grants to up to five pilot programs to improve brain health in youth sports, using a request for proposal process. Requires working group members to be included in scoring proposals unless the member has a financial interest in the proposal. Requires at least one program to be funded in each area of the state. Requires programs to be funded for one year, and requires the commissioner to report to the health care policy and finance committees in the legislature on the progress and outcomes of the programs.

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**77** **Recommendations for safety and quality improvement practice for long-term care services and supports.** Directs the commissioner of health to consult with interested stakeholders to explore and make recommendations on how to apply safety and quality improvement practices to long-term care services and supports. Lists interested stakeholders who must be consulted and what the recommendations must include. Requires the recommendations and any necessary implementing legislation to be submitted to the legislature by July 15, 2018.

**78** **Study and report on home care nursing workforce shortage.** Requires house and senate chairs and ranking minority members of the listed health and human services committees to convene a working group to study and report on the shortage of RNs and LPNs available to provide low-complexity regular home care services to clients. Specifies working group membership, who will convene the first meeting, and who will provide support, meeting space, technical assistance, and recommendations to the working group. Lists working group duties, and requires the working group to submit a report and draft legislation by January 15, 2018.

**79** **Opioid abuse prevention pilot projects.** (a) Requires the commissioner of health to establish opioid abuse prevention pilot projects in geographic areas throughout the state, to reduce opioid abuse through the use of controlled substance care teams and community-wide coordination of abuse-prevention initiatives. Allows the commissioner to award grants to health care providers, health plan companies, local units of government, or other entities.

(b) Provides that each pilot project must:

(1) be designed to reduce emergency room use and health care provider visits resulting from opioid use or abuse, and reduce rates of opioid addiction;

(2) establish multidisciplinary controlled substance care teams;

(3) deliver health care services and care coordination, through controlled substance care teams, to reduce the inappropriate use of opioids and rates of opioid addiction;

(4) address unmet social service needs that create barriers to managing pain and obtaining optimal health outcomes;

(5) provide prescriber and dispenser education and assistance to reduce the inappropriate prescribing and dispensing of opioids;

(6) promote best practices for opioid disposal and reducing illegal access to opioids; and

(7) engage partners outside of the health care system, to address root causes of opioid abuse and addiction at the community level.

(c) Requires the commissioner to contract with an accountable community for health that operates an opioid abuse prevention project and can document reductions in opioid use through the use of controlled substance care teams, to assist the commissioner in administering this section and to provide technical assistance to the commissioner and entities selected to operate a pilot project.

(d) Requires the accountable community for health under contract to evaluate the extent to which pilot projects were successful in reducing the inappropriate use of opioids. Specifies

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requirements for the evaluation and requires results to be reported to the chair and ranking minority members of specified legislative committees by December 15, 2019.

**80** **Safe harbor for all; statewide sex trafficking victims strategic plan.** Directs the commissioner of health to consult with the commissioners of public safety and human services and develop a statewide strategic plan, by October 1, 2018, to address the needs of sex trafficking victims. Directs the commissioner of health to seek recommendations and input from a range of organizations and individuals. Requires the strategic plan to include recommendations regarding the expansion of the safe harbor law to adult victims. Requires the commissioner to report, by January 15, 2019, to the chairs and ranking minority members of the relevant legislative committees on the plan and recommendations for legislation and funding.

**81** **Direction to commissioner of health.** Directs the commissioner of health to evaluate whether existing laws for certain health care providers and facilities protect the health and safety of persons with dementia.

**82** **Palliative care advisory council.** Requires first appointments to be made to the palliative care advisory council by October 1, 2017, and requires the first meeting to be convened by November 15, 2017.

**83** **Youth sports concussion working group.** Directs the commissioner of health to establish a working group to assess the causes and incidence of brain injuries in youth sports and best practices for preventing, evaluating, identifying, and treating brain injuries in youth sports.

**Subd. 1. Working group established; duties and membership.** Directs the commissioner of health to establish a youth sports concussion working group of up to 30 members. Directs the group to be formed through nominations of individuals with specified experience, and specifies what the working group must study and evaluate. Requires the working group to be geographically and professionally diverse, and provides that working group members shall not be compensated.

**Subd. 2. Working group goals defined.** Lists specific tasks for the working group, including gathering data on topics related to youth sports-related concussions; reviewing youth sports rules and concussion education policies; identifying pilot projects related to concussions in youth sports; and identifying barriers to obtaining better brain health outcomes.

**Subd. 3. Voluntary participation; no new reporting requirements created.** Specifies that participation in the working group is voluntary and the study shall create no new reporting requirements.

**Subd. 4. Report.** Requires the working group to submit an interim report and a final report to the legislative committees with jurisdiction over health and education, proposing a Minnesota model for reducing brain injury in youth sports. Specifies recommendations the report must include.

**Subd. 5. Sunset.** Sunsets the working group the day after submitting the final report required in subdivision 4, or January 15, 2020, whichever is earlier.

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**84** **Repealer.** Repeals § 144.4961, the Minnesota Radon Licensing Act, effective the day following final enactment; and Laws 2014, chapter 312, article 23, section 9, subdivision 5, which established reporting requirements for the Legislative Health Care Workforce Commission.

### Article 11: Health Licensing Boards

## Overview

This article moves certain occupational licensing fees from rules to statute, establishes the Board of Occupational Therapy Practice and makes corresponding statutory changes, modifies provisions governing psychology practice and licensure, and modifies provisions governing dental assistants, dental therapists, and dental hygienists.

**1** **Physician application and license fees.** Amends § 147.01, subd. 1. Moves the license fees for physicians from rules into statute and authorizes the Board of Medical Practice to charge fees developed by the Interstate Commission to determine physician qualifications to register and participate in the interstate medical licensure compact**.**

**2** **United States or Canadian medical school graduates.** Amends § 147.02, subd. 1. Specifies that the fees paid to the Board of Medical Practice are nonrefundable.

**3** **Endorsement; reciprocity.** Amends § 147.03, subd. 1. Removes the reference to Board of Medical Practice fees established by rule.

**4** **Physician assistant application and license fees.** Amends § 147A.28. Moves the license fees for physician assistants from rules to statute and specifies that the board may prorate the initial fee and the fees are to be deposited into the state government special revenue fund.

**5** **Acupuncturist application and license fees.** Amends § 147B.08 by adding subd. 4. Moves the license fees for acupuncturist from rules to statute and specifies that the board may prorate the initial license fee and that the fees are to be deposited into the state government special revenue fund.

**6** **Respiratory therapist application and license fees.** Amends § 147C.40 by adding subd. 5. Moves the license fees for respiratory therapists from rules to statute and specifies that the board may prorate the initial license fee and that the fees are to be deposited into the state government special revenue fund.

**7** **Board.** Amends § 148.6402, subd. 4. Changes the regulatory authority for the licensure of occupational therapists and occupational therapy assistants from the commissioner of health to a newly created Board of Occupational Therapy Practice. Makes section effective January 1, 2018.

**8** **Licensure application requirements: procedures and qualifications.** Amends § 148.6405. Changes references from commissioner of health to Board of Occupational Therapy Practice. Makes section effective January 1, 2018.

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**9** **Qualifying examination score required.** Amends § 148.6408, subd 2. Changes references from commissioner of health to Board of Occupational Therapy Practice. Makes section effective January 1, 2018.

**10** **Qualifying examination score required.** Amends § 148.6410, subd 2. Changes references from commissioner of health to Board of Occupational Therapy Practice. Makes section effective January 1, 2018.

**11** **Persons certified by National Board for Certification in Occupational Therapy after June 17, 1996.** Amends § 148.6412, subd. 2. Changes cross-references and terminology from commissioner of health to Board of Occupational Therapy Practice. Makes section effective January 1, 2018.

**12** **Licensure by reciprocity.** Amends § 148.6415. Changes cross-references and terminology from commissioner of health to Board of Occupational Therapy Practice. Makes section effective January 1, 2018.

**13** **Application.** Amends § 148.6418, subd. 1. Changes references from commissioner of health to Board of Occupational Therapy Practice. Makes section effective January 1, 2018.

**14** **Procedures.** Amends § 148.6418, subd. 2. Changes references from commissioner of health to Board of Occupational Therapy Practice. Makes section effective January 1, 2018.

**15** **Supervision required.** Amends § 148.6418, subd. 4. Changes reference from commissioner of health to Board of Occupational Therapy Practice. Makes section effective January 1, 2018.

**16** **Expiration of temporary licensure.** Amends § 148.6418, subd. 5. Changes references from commissioner of health to Board of Occupational Therapy Practice. Makes section effective January 1, 2018.

**17** **Application for licensure.** Amends § 148.6420, subd. 1. Changes references from commissioner of health to Board of Occupational Therapy Practice. Makes section effective January 1, 2018.

**18** **Applicants certified by National Board for Certification in Occupational Therapy.** Amends § 148.6420, subd. 3. Changes references from commissioner of health to Board of Occupational Therapy Practice. Makes section effective January 1, 2018.

**19** **Action on applications for licensure.** Amends § 148.6420, subd. 5. Changes references from commissioner of health to Board of Occupational Therapy Practice. Makes section effective January 1, 2018.

**20** **Licensure renewal.** Amends § 148.6423. Changes references from commissioner of health to Board of Occupational Therapy Practice. Makes section effective January 1, 2018.

**21** **Licensure renewal after licensure expiration date.** Amends § 148.6425, subd. 2. Changes references from commissioner of health to Board of Occupational Therapy Practice. Makes section effective January 1, 2018.

**22** **Licensure renewal four years or more after licensure expiration date.** Amends § 148.6425, subd. 3. Changes references from commissioner of health to Board of Occupational Therapy Practice. Makes section effective January 1, 2018.

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**23** **Change of name, address, or employment.** Amends § 148.6428. Changes references from commissioner of health to Board of Occupational Therapy Practice. Makes section effective January 1, 2018.

**24** **Reporting continuing education contact hours.** Amends § 148.6443, subd. 5. Changes reference from commissioner of health to Board of Occupational Therapy Practice. Makes section effective January 1, 2018.

**25** **Auditing continuing education reports.** Amends § 148.6443, subd. 6. Changes reference from commissioner of health to Board of Occupational Therapy Practice. Makes section effective January 1, 2018.

**26** **Waiver of continuing education requirements.** Amends § 148.6443, subd. 7. Changes references from commissioner of health to Board of Occupational Therapy Practice. Makes section effective January 1, 2018.

**27** **Penalties for noncompliance.** Amends § 148.6443, subd. 8. Changes references from commissioner of health to Board of Occupational Therapy Practice. Makes section effective January 1, 2018.

**28** **Initial licensure fee.** Amends § 148.6445, subd. 1. Changes reference from commissioner of health to Board of Occupational Therapy Practice. Makes section effective January 1, 2018.

**29** **Use of fees.** Amends § 148.6445, subd. 10. Changes references from commissioner of health to Board of Occupational Therapy Practice. Makes section effective January 1, 2018.

**30** **Grounds for denial of licensure or discipline; investigation procedures; disciplinary actions.** Amends § 148.6448. Changes cross-references and terminology from commissioner of health to Board of Occupational Therapy Practice. Makes section effective January 1, 2018.

**31** **Board of occupational therapy practice.** Proposes coding for § 148.6449. Establishes Board of Occupational Therapy Practice.

**Subd. 1. Creation.** Specifies board structure and member requirements.

**Subd. 2. Qualifications for board members.** States that OT practitioners on the board must represent a variety of practice areas and settings, with at least two employed outside the seven-county metro area. Limits members to two consecutive terms.

**Subd. 3. Recommendations for appointment.** Specifies process for board member appointment.

**Subd. 4. Officers.** Specifies process for officer election.

**Subd. 5. Executive director.** Requires board to appoint an employ a non-member executive director.

**Subd. 6. Terms; compensation; removal of members.** Provides that board operations must be conducted according to chapter 214.

**Subd. 7. Duties of the Board of Occupational Therapy Practice.** Lists duties and activities of the board

Makes section effective January 1, 2018.

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**32** **Declaration of policy.** Amends § 148.881. Specifies that the Board of Psychology regulates the practice of psychology through licensure and regulation to promote access to quality, ethical psychological services. Designates sections 148.88 to 148.98 as the Minnesota Psychology Practice Act.

**33** **Definitions.** Amends § 148.89.

**Subd. 2a.** Modifies "client" definition.

**Subd. 2c.** Modifies "designated supervisor" definition.

**Subd. 2d.** Adds definition of "direct services," to mean the delivery of preventive, diagnostic assessment, or therapeutic intervention services to benefit a direct recipient client.

**Subd 2e.** Adds definition of "full-time employment," to mean a minimum of 35 hours per week.

**Subd. 3a.** Adds definition of "jurisdiction," to mean United States, United States territories, or Canadian provinces or territories.

**Subd. 4.** Modifies "licensee" definition.

**Subd. 4a.** Modifies "provider or provider of services" definition.

**Subd 4b**. Modifies "primary supervisor" definition.

**Subd 5.** Modifies "practice of psychology" definition to include prediction of human behavior, evaluating, assessing, or predicting behavior, and applying psychological principles in legal settings. Modifies the activities that constitute the practice of psychology.

**Subd. 6.** Adds definition of "telesupervision."

**34** **Board of Psychology.** Amends § 148.90, subd. 1. Modifies the composition of the Board of Psychology. Adds one member who is a licensed psychologist with a doctoral degree; requires both psychologists, not necessarily licensed, to have doctoral degrees representing different training programs in psychology; removes individual licensed or qualified to be a licensed psychologist.

**35** **Members.** Amends § 148.90, subd. 2. Specifies that a public board member shall not be licensed by another health-related licensing board, the commissioner of health, or licensed in another jurisdiction.

**36** **General.** Amends § 148.905, subd. 1. Removes "psychological practitioners" from those licensed. Adds requirements for the board to consider before adopting or implementing a new national licensing examination.

**37** **Effective date.** Amends § 148.907, subd. 1. Removes August 1, 1991 date, adds exemption.

**38** **Requirements for licensure as a licensed psychologist.** Amends § 148.907, subd. 2. Specifies that postdoctoral supervised employment must be completed between 12 and 60 months. Allows the board to grant a variance.

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**39** **Exemptions to license requirement.** Proposes coding for § 148.9075.

**Subd. 1. General.** Prohibits licensed health professionals or mental health practitioners from holding themselves out as licensed to practice psychology; specifies that they may perform the functions of their occupations.

**Subd. 2. Business or industrial organization.** Specifies that a business, organization, or agency may use psychological techniques for personnel or evaluation purposes. Prohibits these entities from selling, offering, or providing psychological services unless performed or supervised by a person licensed by the board.

**Subd. 3. School psychologist.** Permits the practice of school psychology within the scope of employment, with a license or certificate from the State Board of Teaching.

**Subd. 4. Clergy or religious officials.** Permits recognized religious officials to conduct counseling activities within the scope of their regular duties, if the official does not use the title of psychologist.

**Subd. 5. Teaching and research.** Permits an educator in an accredited institution to teach and conduct research in psychology if the institution provides oversight and the educator is not providing direct clinical services.

**Subd. 6. Psychologist in disaster or emergency relief.** Permits a psychologist sent to Minnesota to respond to a disaster or emergency relief effort to practice in the state for less than 30 days, and the sponsoring organization can certify the psychologist's assignment. Permits the board to grant an extension.

**Subd. 7. Psychological consultant.** Specifies that a license from the board is not required for a licensed, certified, or registered nonresident serving as an expert witness, consultant, presenter, or educator on a limited basis.

**Subd. 8. Students.** Permits the practice of psychology for practicums, internships, and postdoctoral supervised employment. Requires student trainees and interns to use specified titles.

**Subd. 9. Other professions.** Clarifies that a person licensed under sections 148.88 to 148.98 may not engage in any other regulated profession, unless licensed or registered in that profession.

**40** **Relicensure.** Proposes coding for § 148.9077. Permits a former licensee to reapply to the board for licensure under the laws and rules in effect on the date of initial licensure.

**41** **Application.** Amends § 148.9105, subd. 1. Removes psychological practitioner emeritus registration; changes fee for retired providers.

**42** **Documentation of status.** Amends § 148.9105, subd. 4. Removes psychological practitioner.

**43** **Representation to the public.** Amends § 148.9105, subd. 5. Removes psychological practitioner emeritus.

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**44** **Generally.** Amends § 148.916, subd. 1. (a) Extends the amount of time an applicant for guest licensure must intend to practice in Minnesota, from seven days to 30 days.

(b) Establishes eligibility requirements for guest licensure:

(1) psychology license/registration/certification in another jurisdiction;

(2) doctoral degree in psychology from accredited institution;

(3) good moral character;

(4) no pending complaints or disciplinary actions;

(5) passage of professional responsibility exam; and

(6) payment of fee.

**45** **Applicants for licensure.** Amends § 148.916, subd. 1a, guest licensure technical changes.

**46** **Supervision.** Amends § 148.924.

**Subd. 1. Supervision.** Modifies definition of "supervision;" specifies that supervision may include telesupervision.

**Subd. 2. Postdegree supervised psychological employment.** Specifies "psychological."

**Subd. 3. Individuals qualified to provider supervision.** Removes master's-level licensure supervision provisions, allowing for only doctoral applicants for licensure.

**Subd. 4.** Repeals subdivision 4.

**Subd. 6. Supervisee duties.** Technical changes to duties for applicants preparing for licensure during postdegree supervised psychological employment.

**Subd. 7.** Repeals subdivision 7.

**47** **Requirements for representations to public.** Amends § 148.96, subd. 3. Adds "psychology fellow" to permitted designations. Removes reference to the practice of school psychology.

**48** **General requirements.** § 148B.53, subd. 1. Removes exception for licensed psychologists to be licensed as professional counselors.

**49** **Waiver of examination.** Amends § 150A.06, subd. 3. Adds dental therapists and dental assistants to the list of professionals for whom examination requirements may be waived, under certain circumstances and at the discretion of the board.

**50** **Licensure by credentials.** Amends § 150A.06, subd. 8. Requires dental assistants to have graduated from an accredited dental assisting program and be certified by the Dental Assisting National Board.

**51** **Restorative procedures.** Amends § 150A.10, subd. 4. Allows dental assistants and dental hygienists trained and board certified in certain restorative dental functions to place restorative material on primary and permanent teeth, after a dentist or dental therapist has prepared the tooth structure.

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**52** **Health-related licensing board.** Amends § 214.01, subd. 2. Adds the Board of Occupational Therapy Practice to the definition of "health related licensing board" in chapter 214. Makes section effective January 1, 2018.

**53** **Board of Occupational Therapy Practice.** Requires the governor to appoint the members of the Board of Occupational Therapy Practice by October 1, 2017, and requires the board to convene its first meeting by November 1, 2017. Makes section effective July 1, 2017.

**54** **Revisor's instruction.** Instructs the revisor to replace references relating to the creation of the Board of Occupational Therapy Practice. Makes section effective January 1, 2018.

**55** **Revisor's instruction.** Instructs the revisor to change the headnote of section 147.0375 (medical faculty licensure), to read "LICENSURE OF EMINENT PHYSICIANS." Makes section effective the day following final enactment.

**56** **Repealer.** Repealers associated with fees that are being moved from rules to statute; repeal of sunset in § 147.0375, subd. 7; repeal of provisions related to psychology practice act changes, and Board of Occupational Therapy; specific effective dates.

## Article 12: Opiate Abuse Prevention

This articles contains provisions related to preventing opiate abuse. The article requires warning labels on opiate prescriptions, places quantity limits on opiate prescriptions for acute dental pain and acute pain related to refractive surgery, modifies MA payment procedures for certain injectable drugs, requires a report on opioid crisis grants, and provides grant funding for a chronic pain rehabilitation therapy demonstration project.

**1** **Controlled substances.** Amends § 151.212, subd. 2. Requires a pharmacy or practitioner, when dispensing an opiate, to display on the label or container a specific warning about the risk of overdose and addiction.

**2** **Limit on quantity of opiates prescribed for acute dental and ophthalmic pain.** Amends § 152.11, by adding subd. 4. (a) Limits prescriptions for opiate or narcotic pain relievers listed in Schedules II to IV to a four-day supply, when used for treatment of acute dental pain, or acute pain associated with refractive surgery. Requires the quantity prescribed to be consistent with the dosage listed in the professional labeling for the drug.

(b) Defines "acute pain."

(c) Allows a practitioner to prescribe more than a four-day supply, based on the practitioner's professional judgement.

**3** **Payment rates.** Amends § 256B.0625, subd. 13e. Requires MA payment for nonscheduled injectable drugs used to treat substance abuse and administered in an outpatient setting to be paid directly to the dispensing pharmacy. (Under current law, payment for drugs administered in an outpatient setting can be made only to the administering facility or practitioner.) Requires the dispensing pharmacy to submit the claim, if the pharmacy dispenses the drug pursuant to a prescription issued by the practitioner and delivers the drug to the practitioner for administration. Requires payments to be made according to this section. Prohibits a pharmacy from dispensing a practitioner-administered injectable drug directly to an enrollee. Allows the

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commissioner to conduct postpayment review to evaluate patient access, and requires findings to be reported to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by January 1, 2019.

**4** **Report on opioid crisis grant; use of grant funds.** (a) Requires the commissioner of human services, within two weeks of the annual project report being submitted to the federal funder, to report to legislative committees on: (1) funds received as part of federal State Targeted Response to the Opioid Crisis Grants; and (2) uses of the funds received.

(b) Requires the commissioner to use remaining grant funds, and any additional funds received from other sources, to provide grants to counties for opioid abuse prevention, increase public awareness of opioid abuse, and prevent opioid use through the use of data analytics.

**5** **Chronic pain rehabilitation therapy demonstration project.**

**Subd. 1. Establishment.** Directs the commissioner to award a two-year grant to a rehabilitation institute meeting specified criteria for a bundled payment arrangement for chronic pain rehabilitation therapy for MA enrollees. Specifies components of the demonstration project.

**Subd. 2. Performance measures.** Requires the commissioner to develop performance measures to evaluate the demonstration project. Lists measures that may be included.

**Subd. 3. Eligibility.** To be eligible, requires individuals to: (1) be 21 or older; (2) be eligible for MA; and (3) meet criteria appropriate for chronic pain rehabilitation. Specifies factors the commissioner may consider in determining these criteria.

**Subd. 4. Payment for services.** Specifies criteria for bundled payments.

**Subd. 5. Report.** Requires the institute to annually report to the commissioner on cost savings and performance indicators. Requires the commissioner, one year after completion of the demonstration project, to report to legislative committees on the demonstration project. Provides that the report may include recommendations to increase access to chronic pain rehabilitation therapy.

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### Article 13: Miscellaneous

## Overview

This article requires establishment of a special enrollment period to allow individuals whose employers offer QSEHRAs to purchase individual health plans; defines terms in the Human Services Licensing Act; requires legislative notice and approval for certain federal waivers and approvals; and requires the commissioner of commerce to plan for Minnesota to convert from MNsure to the federally facilitated marketplace.

**1** **Annual open enrollment periods; special enrollment periods.** Amends § 62K.15. Requires a health carrier that offers individual health plans to provide a special enrollment period in the individual market for employees of small employers that offer a qualified small employer health reimbursement arrangement.

**2** **Controlling individual.** Amends § 245A.02, subd. 5a. Clarifies the definition of "controlling individual" in the Human Services Licensing Act to mean the owner of a licensed program, each officer of the organization, each authorized agent, each compliance officer, and each managerial official with decision-making authority for operation of the program. Clarifies that an employee stock ownership plan trust or a participant or board member of an employee stock ownership plan is not a controlling individual, unless the participant or board member is otherwise a controlling individual as specified in this subdivision.

**3** **Owner.** Adds subd. 10b to § 245A.02. Defines "owner" in the Human Services Licensing Act to mean an individual or organization that has a direct or indirect ownership interest of 5 percent or more in a licensed program. Also defines related terms.

**4** **Legislative notice and approval required for certain federal waivers or approvals.** Adds § 256.999. Before submitting an application for a section 1332 waiver, for a section 1115 waiver, or for a state Medicaid plan amendment, requires the commissioner or board seeking the waiver or amendment to provide notice and a copy of the application to the legislative committees with jurisdiction over health and human services policy and finance and commerce.

If a 1332 waiver, 1115 waiver, or state Medicaid plan amendment is approved during the legislative session, requires approval of the waiver or amendment by a law enacted after the waiver or approval is granted, in order for the waiver or amendment to be implemented.

If a 1332 waiver, 1115 waiver, or state Medicaid plan amendment is approved when the legislature is not in session, requires a positive recommendation from the Legislative Advisory Commission (LAC) in order for the waiver or amendment to be implemented. If the LAC makes no recommendation, a negative recommendation, or a recommendation for further review, prohibits implementation of the waiver or amendment.

**5** **Establishment of federally facilitated marketplace.** Requires establishment of a federally facilitated marketplace and requires an implementation plan.

**Subd. 1. Establishment.** Paragraph (a) directs the commissioner of commerce to establish a federally facilitated marketplace for Minnesota to replace MNsure, for

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coverage beginning January 1, 2019. Directs the commissioner to incorporate elements of the Minnesota eligibility system, where appropriate and cost-effective; consult with stakeholders; and seek federal funds for planning and development costs.

Paragraph (b) provides that health plans that are offered through the federally facilitated marketplace, when implemented, and that use provider networks must at least satisfy state distance or travel times for geographic accessibility and state network adequacy requirements.

**Subd. 2. Implementation plan; draft legislation.** Directs the commissioner of commerce to consult with others and develop and present to the 2018 Legislature an implementation plan and draft legislation for conversion to a federally facilitated marketplace. Lists items that the implementation plan must address.

**Subd. 3. Vendor contract.** Requires the commissioner to contract with a vendor for technical assistance in developing the plan to convert to a federally facilitated marketplace.

**6** **Repealer.** Repeals statutes in the MNsure chapter, effective January 1, 2019.

### Article 14: Nursing Facility Technical Corrections

## Overview

This article removes and corrects obsolete nursing facility cross-references throughout Minnesota Statutes.

The 2016 Legislature enacted a bill to recodify the nursing facility payment statutes (see Laws 2016, ch. 99). Given the complexity of the nursing facility payment and rates language, the recodification was accomplished by moving most of the nursing facility language out of Minnesota Statutes, chapter 256B, and into a new chapter 256R. In addition, the nursing facility payment and rates language was reorganized for clarity and ease of use, obsolete language was removed, consistent terminology was used, and language was redrafted for clarity and consistency. This article corrects obsolete cross-references that were created by the recodification and removes obsolete language.

**1** **Resident reimbursement classifications.** Amends § 144.0722, subd. 1. Corrects an obsolete cross-reference.

**2** **Resident reimbursement case mix classifications.** Amends § 144.0724, subd. 1. Corrects an obsolete cross-reference.

**3** **Definitions.** Amends § 144.0724, subd. 2. Corrects an obsolete cross-reference.

**4** **Audit authority.** Amends § 144.0724, subd. 9. Corrects an obsolete cross-reference.

**5** **Exceptions authorizing increase in beds; hardship areas.** Amends § 144A.071, subd. 3. Corrects obsolete cross-references and corrects terminology.

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**6** **Exceptions for replacement beds.** Amends § 144A.071, subd. 4a. Corrects obsolete cross-references.

**7** **Exceptions for replacement beds after June 30, 2003.** Amends § 144A.071, subd. 4c. Corrects obsolete cross-references.

**8** **Consolidation of nursing facilities.** Amends § 144A.071, subd. 4d. Corrects obsolete cross-references.

**9** **Cost neutral relocation projects.** Amends § 144A.073, subd. 3c. Corrects an obsolete cross-reference.

**10** **Correction orders.** Amends § 144A.10, subd. 4. Removes obsolete language.

**11** **Appointment of receiver, rental.** Amends § 144A.15, subd. 2. Corrects an obsolete cross-reference.

**12** **Rate recommendation.** Amends § 144A.154. Corrects an obsolete cross-reference.

**13** **Facility closure rate adjustment.** Amends § 144A.161, subd. 10. Corrects an obsolete cross-reference.

**14** **Reuse of facilities.** Amends § 144A.1888. Corrects an obsolete cross-reference.

**15** **Nursing homes and certified boarding care homes.** Amends § 144A.611, subd. 1. Corrects an obsolete cross-reference.

**16** **Maximum charges.** Amends § 144A.74. Corrects an obsolete cross-reference.

**17** **Nursing home license surcharge.** Amends § 256.9657, subd. 1. Removes obsolete language.

**18** **Customized living service rate.** Amends § 256B.0915, subd. 3e. Corrects obsolete cross-references.

**19** **Field audits required.** Amends § 256B.35, subd. 4. Corrects an obsolete cross-reference.

**20** **Bed layaway and delicensure.** Amends § 256B.431, subd. 30. Corrects obsolete cross-references and adds references to the new nursing facility rates chapter of statutes, chapter 256R.

**21** **Scope.** Amends § 256B.50, subd. 1. Corrects obsolete cross-references.

**22** **Effective date.** Makes sections 1 to 21 effective the day following final enactment.

### Article 15: Human Services Forecast Adjustments

## Overview

Adjusts appropriations for fiscal year 2017 for forecasted programs administered by the Department of Human Services.

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### Article 16: Appropriations

# Overview

Appropriates money or adjusts appropriations for fiscal years 2018 and 2019 for the Department of Human Services, Department of Health, health-related licensing boards, Council on Disability, Ombudsman for Mental Health and Developmental Disabilities, Ombudsperson for Families, and Department of Commerce.