Bill Summary

H.F. 2414

Second engrossment

Subject	Health and Human Services Omnibus Finance Bill
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Overview

This bill provides fiscal year 2020 and 2021 appropriations for the Department of Human Services, Department of Health, and a variety of other entities.

Article 1: Children and Family Services

This article makes various changes to the child care assistance program and child welfare provisions and increases the cash portion of the MFIP transitional standard.

Section	Description – Article 1: Children and Family Services
1	**Homeless.** Amends § 119B.011, by adding subd. 13b. Defines "homeless" under the statute governing the child care assistance program. Provides a September 21, 2020, effective date.
2	**Provider.** Amends § 119B.011, subd. 19. Modifies the definition of "provider" under the statute governing the child care assistance program. Provides a July 1, 2019, effective date.
3	**Transition year families.** Amends § 119B.011, subd. 20. Modifies the definition of "transition year families" under the statute governing the child care assistance program. Provides a March 23, 2020, effective date.
4	**Supervision of counties and providers.** Amends § 119B.02, subd. 3. Requires the commissioner to provide technical assistance and training to child care providers about proper billing and attendance record-keeping procedures for reimbursement under CCAP and ensure that the training provided to child care providers is linguistically and culturally accessible. Provides a July 1, 2020, effective date.

Section	Description – Article 1: Children and Family Services
5	**Child care market rate survey.** Amends § 119B.02, subd. 7. Changes the frequency of the child care market rate survey from once every two years to once every three years beginning in state fiscal year 2021. Provides an immediate effective date.
6	**Applications.** Amends § 119B.025, subd. 1. Specifies the process counties must follow when handling applications of families who meet the definition of homeless. Provides a September 21, 2020, effective date.
7	**Information to applicants; child care fraud.** Amends § 119B.025, by adding subd. 5. At the time of initial application and at redetermination, requires counties to provide written notice to applicants and participants listing the activities that constitute child care fraud and the consequences of committing child care fraud. Requires applicants and participants to acknowledge receipt of the child care fraud notice in writing. Provides a September 1, 2019, effective date.
8	**Portability pool.** Amends § 119B.03, subd. 9. Modifies the portability pool by requiring families who are receiving basic sliding fee child care assistance and move from one county to another to notify the family's previous county of residence of the move (under current law, families must notify the new county of residence within 60 days of moving and submit information to the new county of residence to verify eligibility for the basic sliding fee program). Removes the six-month time limit on receipt of portability pool assistance. Provides a December 2, 2019, effective date.
9	**Eligible participants.** Amends § 119B.05, subd. 1. Expands the list of eligible participants under the MFIP child care program by adding MFIP child-only cases for children six years of age or younger when either (1) the child's primary caregiver has a diagnosis of mental illness and is in need of intensive treatment, or (2) the child is in need of a consistent caregiver.
10	**General eligibility requirements.** Amends § 119B.09, subd. 1. Specifies a family remains eligible for child care assistance until the redetermination if the family has a child that reaches 13 years of age or the child has a disability and reaches 15 years of age. Provides a June 29, 2020, effective date.
11	**Maintain steady child care authorizations.** Amends § 119B.095, subd. 2. Requires the amount of child care authorized to continue at the same number of hours or more hours until redetermination when a child reaches 13 years of age or a child with a disability reaches 15 years of age. Provides a June 29, 2020, effective date.

Section	Description – Article 1: Children and Family Services
12	**Assistance for persons who are homeless.** Amends § 119B.095, by adding subd. 3. Makes homeless applicants for child care assistance eligible for 60 hours of child care assistance per service period for three months from the date the county receives the application. Allows additional hours to be authorized as needed based on the applicant's participation in employment, education, or Minnesota family investment program (MFIP) or diversionary work program (DWP) employment plan. Requires the parent to verify that the parent meets eligibility and activity requirements for child care assistance to continue receiving assistance after the initial three months. Provides a September 21, 2020, effective date.
13	**Subsidy restrictions.** Amends § 119B.13, subd. 1. Paragraph (a) modifies the CCAP maximum rates to be based on the 2018 child care provider survey. Paragraph (i) modifies the maximum registration fee paid under child care assistance to be based on the 2018 market rate survey. Provides a September 20, 2019, effective date for paragraph (a) and a September 23, 2019, effective date for paragraph (i).
14	**Fair hearing allowed for applicants and recipients.** Amends § 119B.16, subd. 1. Modifies the fair hearings process under the CCAP. Provides a February 26, 2021, effective date.
15	**Fair hearing allowed for providers.** Amends § 119B.16, subd. 1a. Modifies the fair hearings process for providers under the CCAP. Provides a February 26, 2021, effective date.
16	**Joint fair hearings.** Amends § 119B.16, subd. 1b. Modifies the joint fair hearings process for providers and families under the CCAP. Provides a February 26, 2021, effective date.
17	**Notice to providers.** Amends § 119B.16, by adding subd. 1c. Requires the county or commissioner to mail written notice to the provider against whom the action is being taken prior to taking an appealable action. Specifies timelines for mailing the notice and the information that must be included in the notice. Provides a February 26, 2021, effective date.
18	**Fair hearing stayed.** Amends § 119B.16, by adding subd. 3. Specifies circumstances under which a provider's fair hearing must be stayed. Provides a February 26, 2021, effective date.

Section	Description – Article 1: Children and Family Services
19	**Final department action.** Amends § 119B.16, by adding subd. 4. Specifies the county agency's or the commissioner's action is considered final unless the commissioner receives a timely and proper request for an appeal. Provides a February 26, 2021, effective date.
20	**Administrative review.** Creates § 119B.161. **Subd. 1. Applicability.** Specifies conditions under which a provider has the right to administrative review. **Subd. 2. Notice.** Specifies the timeline a county agency or the commissioner has for mailing a written notice to a provider when suspending payment or denying or revoking the provider's authorization. Lists the information that must be included in the notice. Requires the county agency or commissioner to send notice to each affected family if payment to a provider is suspended or the provider's authorization is denied or revoked. **Subd. 3. Duration.** Specifies the duration of a payment suspension or the denial or revocation of a provider's authorization. **Subd. 4. Good cause exception.** Lists the conditions under which the commissioner may find that good cause exists not to deny, revoke, or suspend a provider's authorization, or not to continue a denial, revocation, or suspension of a provider's authorization. Provides a February 26, 2021, effective date.
21	**Retaining early educators through attaining incentives now (REETAIN) grant program.** Creates § 119B.195. **Subd. 1. Establishment; purpose.** Establishes the REETAIN grant program to provide competitive grants to incentivize well-trained child care professionals to stay in the workforce to create more consistent care for children over time. **Subd. 2. Administration.** Requires the commissioner to allocate grant funds to a nonprofit organization with demonstrated ability to manage benefit programs for child care professionals to administer the REETAIN grant program. Allows up to ten percent of grant funds to be used for administration of the program. **Subd. 3. Application.** Requires applicants to apply for the grant program on the forms and according to the timelines established by the commissioner. **Subd. 4. Eligibility.** Lists grant applicant eligibility requirements.

Section	Description – Article 1: Children and Family Services

Subd. 5. Grant awards. Requires grants to be made annually. Allows grant funds to be used for program supplies, training, or personal expenses.

Subd. 6. Report. Requires the commissioner to report annually to the legislature by January 1, on the number of grants awarded and program outcomes.

Provides a July 1, 2019, effective date, and makes the first report under subdivision 6 due by January 1, 2021.

22 **Use.**

Amends § 245C.32, subd. 2. Requires the commissioner to provide maltreatment summary data to government agencies seeking the data for child protection purposes.

23 **American Indian child welfare projects.**

Amends § 256.01, subd. 14b. Adds clarifying language to subdivision allowing for projects to initiate tribal delivery of child welfare services.

24 **MFIP transitional standard.**

Amends § 256J.24, subd. 5. Increases the cash portion of the MFIP transitional standard by $100 per month per household beginning February 1, 2020. Requires the commissioner to publish the updated standard.

25 **Payments.**

Amends § 256M.41, subd. 3. Modifies provision that distributes payments based on county performance by eliminating the 20 percent withhold, so the counties receive 100 percent of the funds on or before July 10 of each year.

26 **County performance on child protection measures.**

Amends § 256M.41 by adding subd. 4. Requires the commissioner to set child protection measures and standards, and requires an underperforming county to demonstrate that the county has designated sufficient funds and implemented a reasonable strategy to improve child protection performance. Allows the commissioner to redirect up to 20 percent of a county's funds to the performance improvement plan, and specifies that sanctions for noncompliance with federal performance standards still apply.

27 **Foster care.**

Amends § 260C.007, subd. 18. Clarifies definition of "foster care."

Adds placement co-located with a parent or guardian in a licensed residential family-based substance use disorder treatment program, and adds a child returned for a trial home visit to the foster care definition.

Section	Description – Article 1: Children and Family Services
28	**Licensed residential family-based substance use disorder treatment program.** Amends § 260C.007 by adding subd. 22a. Defines "licensed residential family-based substance use disorder treatment program."
29	**Hearing and release requirements.** Amends § 260C.178, subd. 1. Adds cross-reference.
30	**Family-focused residential placement.** Proposes coding for § 260C.190. **Subd. 1. Placement.** Allows for a child to be placed co-located with a parent in a licensed residential family-based substance use disorder treatment program for up to 12 months. **Subd. 2. Case plans.** Requires a written case plan indicating that placement with a parent in a residential family-based substance use disorder treatment program is in the child's best interest; specifies case plan requirements and timelines. **Subd. 3. Required reviews and permanency proceedings.** Specifies required court procedures and timelines for case review and permanency, in different circumstances, for a child co-located with a parent in a residential family-based substance use disorder treatment program.
31	**Dispositions.** Amends § 260C.201, subd. 1. Adds language to include a child co-located with a parent in a residential family-based substance use disorder treatment program; clarifies permanency proceeding language.
32	**Written findings.** Amends § 260C.201, subd. 2. Adds language to include a child co-located with a parent in a residential family-based substance use disorder treatment program, to the requirement for written findings regarding the appropriateness of a placement when legal custody of the child is transferred.
33	**Case plan.** Amends § 260C.201, subd. 6. Requires a case plan for a child co-located with a parent in a residential family-based substance use disorder treatment program to specify the recommendation for co-location before the placement.

Section	Description – Article 1: Children and Family Services
34	**Placement decisions based on best interest of the child.** Amends § 260C.212, subd. 2. Requires the agency to determine and document whether co-location with a parent in a residential family-based substance use disorder treatment program is in the child's best interests.
35	**Voluntary foster care; child is collocated with parent in treatment program.** Proposes coding for § 260C.228. **Subd. 1. Generally.** Allows for a written voluntary placement agreement after a child's case plan recommends a co-located placement in a residential family-based substance use disorder treatment program. **Subd. 2. Judicial review.** Establishes requirements for judicial review and agency reporting for a voluntary placement under this section. **Subd. 3. Termination.** Specifies that the voluntary placement agreement terminates when the parent is discharged for the treatment program, or upon written and dated request from the parent.
36	**Administrative or court review of placements.** Amends § 260C.452, subd. 4. Adds requirement for official documentation that a youth was formerly in foster care, for a local social services agency transition plan at age 18 or older.
37	**Required permanency proceedings.** Amends § 260C. 503, subd. 1. Adds reference to new section relating to residential family-based substance use disorder treatment program placement.
38	**Parent not considered voluntarily unemployed, underemployed, or employed on a less than full-time basis.** Amends § 518A.32, subd. 3. Makes this subdivision applicable to all incarcerated parents by removing the exception for parents incarcerated due to nonpayment of child support. Makes the section effective the day following final enactment.
39	**Duties of local welfare agency and local law enforcement agency upon receipt of report; mandatory notification between police or sheriff and agency.** Amends § 626.556, subd. 10. Adds requirement for the local welfare agency or the agency responsible for the child welfare assessment or investigation to request that the commissioner collect child abuse and neglect records from each state where an alleged offender lived in the previous five years. Establishes requirements for transmission of requests and notifications.

Section	Description – Article 1: Children and Family Services
40	**Reports required.** Amends § 626.5561, subd. 1. Removes the requirement for health care professionals (who are mandated reporters of suspected child maltreatment) to report a woman's use of a controlled substance for a nonmedical purpose or excessive consumption of alcohol during pregnancy, if the professional is providing prenatal care or other health care services to the woman.
41	**Title.** Entitles certain sections "Heaven's Law."
42	**Interstate transfer of child welfare data.** Requires the commissioner of human services to investigate and report to the legislature on potential ways to improve the sharing of child maltreatment information between states, including considering interstate compacts. Requires the report to the legislature by February 1, 2020.
43	**Instruction to commissioner.** Requires the commissioner of human services to establish a schedule for individuals in connection with a licensed children's residential facility to receive federal funding to complete a new required background study by March 1, 2020, or by March 1, 2021, for individuals connected with facilities that are not eligible for federal funding.
44	**Child welfare training academy.** **Subd. 1. Establishment; purpose.** Requires the commissioner to modify the Child Welfare Training System, to be known as the Child Welfare Training Academy. **Subd. 2. Administration.** Requires the Child Welfare Training Academy to operate through five regional hubs, using training methods best suited to the content and in line with national best practices. Specifies requirements for the training content. **Subd. 3. Partnerships.** Requires the commissioner to partner with the University of Minnesota to administer the workforce training, and with one or more agencies to focus on workforce well-being and organizational resilience. **Subd.4. Rulemaking.** Allows the commissioner to adopt rules in accordance with this section.
45	**Child welfare caseload study.** Requires the commissioner to conduct a child welfare caseload study by July 1, 2020, and report the results to the legislature by December 1, 2020. Requires continued monitoring of child welfare caseloads.

Section	Description – Article 1: Children and Family Services
46	**First children's finance child care site assistance.** **Subd. 1. Purposes.** Specifies the grant to First Children's Finance is for loans to improve child care or early education sites, or loans to plan, design, and construct or expand licensed and legal nonlicensed sites to increase the availability of child care or early education. **Subd. 2. Financing program.** Lists the activities for which First Children's Finance may use the grant funds. Requires First Children's Finance to establish the terms and conditions for loans and loan guarantees. Allows interest earnings to be used for administrative expenses. **Subd. 3. Reporting.** Lists reporting requirements First Children's Finance must meet.
47	**Direction to commissioner; homeless youth access to birth records and Minnesota identification cards.** Requires the commissioner to report to the legislature by January 1, 2020, with recommendations on providing no-cost access to birth records and identification cards for homeless youth.
48	**Direction to commissioner; family first prevention kinship services.** Requires the commissioner to review opportunities to develop kinship navigator models for children in out-of-home placement. Provides an immediate effective date.
49	**Direction to commissioner; relative search.** Requires the commissioner to develop and provide guidance to assist local social services agencies in conducting relative searches for children in out-of-home placement. Provides an immediate effective date.
50	**Repealer.** Repeals the following statutes and rules: ▪ section 119B.16, subd. 2 (informal conference) ▪ section 245E.06, subds. 2 (written notice of department sanction), 4 (consolidated hearing with licensing sanction), and 5 (effect of department's administrative determination or sanction) ▪ part 3400.0185, subp. 5 (notice to providers of actions adverse to the provider) ▪ part 2960.3030, subp. 3

Article 2: Operations

This article makes various changes to Department of Human Services (DHS) operations, including changes to DHS licensing, background studies, and program integrity.

Section	Description – Article 2: Operations
1	**General.** Amends § 13.46, subd. 2. Allows DHS to disseminate data on CCAP participants, applicants, and providers to the commissioner of education. Provides an immediate effective date.
2	**Investigative data.** Amends § 13.46, subd. 3. Allows welfare data that is collected as part of an enforcement investigation to be disclosed to other agents within the welfare system or to other government investigators, unless the disclosure would compromise an ongoing DHS investigation.
3	**Child care assistance program.** Amends § 13.461, subd. 28. Specifies the classification of CCAP data. Provides an immediate effective date.
4	**Liability for certain acts.** Amends § 15C.02. Changes the penalty for fraud against the government under chapter 15C so that the civil penalty is tied to the federal False Claims Act, which applies a civil penalty of not less than $5,000 and not more than $10,000, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990, and which means the penalties are reviewed each year by January 15.
5	**Data.** Amends § 119B.02, subd. 6. Defines "child care assistance program payment data." Classifies as private payment data that identifies an individual assistance recipient. Specifies that payment data is public if it relates to payments made to a child care center under certain circumstances. Provides an immediate effective date.
6	**Date of eligibility for assistance.** Amends § 119B.09, subd. 7. Limits retroactive payments to three months from the date of application for CCAP (the current limit is six months). Provides a July 1, 2019, effective date.
7	**Record-keeping requirement.** Amends § 119B.125, subd. 6. Modifies record-keeping requirements CCAP providers must meet. Provides a July 1, 2019, effective date.

Section	Description – Article 2: Operations
8	**Provider payments.** Amends § 119B.13, subd. 6. Requires providers to bill only for services that meet specified documentation requirements. Expands the list of conditions under which the commissioner or a county may refuse to issue a child care authorization to a provider, revoke an existing child care authorization, stop payment issued to a provider, or refuse to pay a bill submitted by a provider. Provides a July 1, 2019, effective date.
9	**Absent days.** Amends § 119B.13, subd. 7. Defines "absent day" and "holidays limit." Requires providers to properly bill for absent days and holidays. Specifies that a provider's failure to properly bill for these days results in an overpayment. Provides a July 1, 2019, effective date.
10	**Reconsiderations.** Amends § 144.057, subd. 3. Requires the Commissioner of Health to use the same set aside criteria as the Commissioner of Human Services, for individuals employed or seeking employment in the substance use disorder treatment field.
11	**Limits on receiving public funds.** Amends § 245.095. **Subd. 1. Prohibition.** For providers who are excluded from a program administered by the DHS, requires the commissioner to: (1) prohibit the excluded provider from receiving grant funds or registering in any other program administered by the commissioner; and (2) disenroll, revoke, or suspend a license, disqualify, or debar the excluded provider, vendor, or individual in any other program administered by the commissioner. **Subd. 2. Definitions.** Modifies the definitions of "excluded" and "provider." Provides an immediate effective date.
12	**Applicant.** Amends § 245A.02, subd. 3. Modifies the definition of "applicant" under the chapter of statutes governing human services licensing. Provides a January 1, 2020, effective date.
13	**Authorized agent.** Amends § 245A.02, by adding subd. 3b. Defines "authorized agent" under the chapter of statutes governing human services licensing. Provides a January 1, 2020, effective date.
14	**License.** Amends § 245A.02, subd. 8. Makes a technical change to the definition of "license" under the chapter of statutes governing human services licensing. Provides a January 1, 2020, effective date.

Section	Description – Article 2: Operations
15	**License holder.** Amends § 245A.02, subd. 9. Modifies the definition of "license holder" under the chapter of statutes governing human services licensing. Provides a January 1, 2020, effective date.
16	**Organization.** Amends § 245A.02, subd. 10c. Defines "organization" under the chapter of statutes governing human services licensing. Provides a January 1, 2020, effective date.
17	**Private agency.** Amends § 245A.02, subd. 12. Modifies the definition of "private agency" under the chapter of statutes governing human services licensing. Provides a January 1, 2020, effective date.
18	**Residential program.** Amends § 245A.02, subd. 14. Modifies the definition of "residential program" under the chapter of statutes governing human services licensing to add a separate definition for residential programs providing home and community-based services under an MA waiver.
19	**Supervision.** Amends § 245A.02, subd. 18. Modifies requirements for supervision of school-aged children in licensed child care centers and adds exceptions for restroom use and retrieval or delivery of personal items from a storage space. Provides a September 30, 2019 effective date.
20	**License required.** Amends § 245A.03, subd. 1. Modifies the list of entities prohibited from conducting certain actions without a license under the human services licensing statutes. Provides a January 1, 2020, effective date.
21	**Unlicensed programs.** Amends § 245A.03, subd. 3. Makes conforming changes related to actions that may be taken against an unlicensed entity. Provides a January 1, 2020, effective date.
22	**Application for licensure.** Amends § 245A.04, subd. 1. Makes conforming and other changes, including modifying the list of information that must be provided by the applicant, to licensure application requirements under the chapter of statutes governing human services licensing. Provides a January 1, 2020, effective date.

Section	Description – Article 2: Operations
23	**Notification of affected municipality.** Amends § 245A.04, subd. 2. Allows the commissioner to provide electronic notification to a municipality or other political subdivision affected by a license issued under the human services licensing statutes. Provides a January 1, 2020, effective date.
24	**Inspections; waiver.** Amends § 245A.04, subd. 4. Paragraphs (a) and (b) modify the list of items a licensing inspection must include and make other technical and conforming changes. Paragraphs (c) and (d) modify requirements related to child care licensing inspections, exit interviews, and adverse licensing actions. Provides a January 1, 2020, effective date for paragraphs (a) and (b), and a September 30, 2019, effective date for paragraphs (c) and (d).
25	**Commissioner's evaluation.** Amends § 245A.04, subd. 6. Modifies the list of items the commissioner must evaluate before issuing, denying, suspending, revoking, or making a conditional license. Provides a January 1, 2020, effective date.
26	**Grant of license; license extension.** Amends § 245A.04, subd. 7. Specifies the commissioner must issue a license consistent with human services licensing application procedures or temporary change of ownership procedures. Removes language prohibiting the transfer of a license and requiring a license holder to notify the commissioner before making any changes that would alter the information included on the license (this is moved to a new subdivision). Makes technical and conforming changes. Provides a January 1, 2020, effective date.
27	**Notification required.** Amends § 245A.04, by adding subd. 7a. Requires a license holder to notify the commissioner and obtain the commissioner's approval before making any change that would alter the information included on the license. Lists other changes of which the license holder must notify the commissioner. Specifies the documentation that a license holder must provide to the commissioner when a license holder changes information on file with the secretary of state. Provides a January 1, 2020, effective date.

Section	Description – Article 2: Operations

28 **Child foster home variances for capacity.**

Amends § 245A.04 by adding subd. 9a. Allows the commissioner to grant a variance for additional foster children in a family foster home if:

1) The variance is needed to maintain family connections or because the child has a severe disability;
2) There is no risk of harm to a child in the home;
3) The home can accommodate additional children;
4) The home in compliance with applicable codes; and
5) There is an exception to capacity limits and the ratio of adults to children would still ensure safety and supervision of the children.

29 **Adoption agency; additional requirements.**

Amends § 245A.04, subd. 10. Modifies the list of entities that must meet certain requirements when applying for a license to place children for adoption. Provides a January 1, 2020, effective date.

30 **License application after change of ownership.**

Creates § 245A.043.

Subd. 1. Transfer prohibited. Specifies a license is not transferable or assignable.

Subd. 2. Change of ownership. Requires submission of a new license application if the commissioner determines that there is a change in ownership. Lists the conditions under which a change in ownership occurs.

Subd. 3. Change of ownership process. Specifies the licensing application process when a change of ownership occurs. Specifies this process does not apply to a licensed program or service located in a home where the license holder resides.

Subd. 4. Temporary change in ownership license. Allows the commissioner to issue a temporary change in ownership license while the commissioner evaluates the licensing application when a change in ownership is proposed and under certain other circumstances. Specifies requirements regarding the operation of the program or service until a decision is made to grant or deny a license.

Provides a January 1, 2020, effective date.

31 **Denial of application.**

Amends § 245A.05. Modifies the list of circumstances under which the commissioner may deny a license. Provides a January 1, 2020, effective date.

Section	Description – Article 2: Operations
32	**Closing a license.** Creates § 245A.055. **Subd. 1. Inactive programs.** Requires the commissioner to close a license if the commissioner determines that a licensed program has not been serving any client for a consecutive period of 12 months or longer. Does not prohibit the license holder from reapplying for a license if the license holder's license was closed. **Subd. 2. Reconsideration of closure.** Specifies the process of notification and reconsideration if a license is closed. **Subd. 3. Reconsideration final.** Specifies the commissioner's disposition of a request for reconsideration is final and not subject to appeal. Provides a January 1, 2020, effective date.
33	**Sanctions; appeals; license.** Amends § 245A.07, subd. 1. Makes technical and conforming changes.
34	**Temporary immediate suspension.** Amends § 245A.07, subd. 2. Modifies the list of circumstances under which the commissioner must act immediately to temporarily suspend a license. Provides a January 1, 2020, effective date.
35	**Immediate suspension; expedited hearing.** Amends § 245A.07, subd. 2a. Sets the burden of proof in an expedited hearing as a preponderance of evidence for suspensions in cases where the license holder is criminally charged in state or federal court with an offense that involves fraud or theft against a program administered by the commissioner.
36	**License suspension, revocation, or fine.** Amends § 245A.07, subd. 3. Modifies the list of circumstances under which the commissioner may suspend or revoke a license, or impose a fine. Makes technical changes. Provides a January 1, 2020, effective date.
37	**License or certification fee for certain programs.** Amends § 245A.10, subd. 4. Increases licensing fees for home and community-based services and supports programs and includes additional revenue categories for fees. Removes obsolete language.

Section	Description – Article 2: Operations
38	**Special family day care homes.** Amends § 245A.14, subd. 4. Clarifies applicable fire code for special family day care homes. Allows two or more licensed programs to be housed in the same location, if the programs are operated as separate, distinct programs and comply with all applicable rules and laws. Allows for variances for collaborative child care models. Provides a September 30, 2019, effective date.
39	**Experienced aides; child care centers.** Amends § 245A.14, subd. 8. Removes training requirements that are consolidated in this article. Provides a September 30, 2019, effective date.
40	**Valid driver's license.** Amends § 245A.14 by adding subd. 16. Allows a person with a current, valid driver's license appropriate to the vehicle to transport children for a licensed child care center. Provides a September 30, 2019 effective date.
41	**Reusable water bottles or cups.** Amends § 245A.14 by adding subd. 17. Allows a child care center to provide drinking water to a child in a reusable water bottle or cup if the center develops and ensures implementation of a written policy that includes procedures for cleaning and sanitizing, proper labeling, and storage. Provides a September 30, 2019, effective date.
42	**Policies and procedures.** Amends § 245A.145, subd. 1. Requires the Department of Human Services, rather than licensed child care providers, to develop policies and procedures for reporting suspected child maltreatment, and to provide the policies and procedures to providers in plain language. Provides a September 30, 2019, effective date.
43	**Licensing agency phone number displayed.** Amends § 245A.145, subd. 2. Removes obsolete date; removes requirement for licensing agency telephone number to be printed in bold and large font on a child care provider license; modifies terminology. Provides an immediate effective date.
44	**Supervision of family child care license holder's own child.** Proposes coding for § 245A.149. Allows an individual to supervise a family child care license holder's own child, without meeting licensure requirements, if the individual: 1) is related to the license holder; 2) is not a caregiver, helper, or substitute for the program; and 3) cares only for the license holder's child. Provides a September 30, 2019, effective date.

Section	Description – Article 2: Operations
45	**Fire marshal inspection.** Amends § 245A.151. Adds certified license-exempt child care centers to fire marshal inspection provision. Provides a September 30, 2019, effective date.
46	**Delegation of authority to agencies.** Amends § 245A.16, subd. 1. Allows time-limited variances for substitute care in family child care. Requires reporting of fires. Provides a September 30, 2019, effective date.
47	**Licensed family child foster care.** Adds subd. 9 to § 245A.16. Requires a county agency or private agency to review specified information relating to non-disqualifying background study results before denying or revoking a family child foster care license, and to send a summary of the review to the commissioner, including a recommendation for licensing action. Provides a March 1, 2020, effective date.
48	**Child passenger restraint systems; training requirement.** Amends § 245A.18, subd. 2. Removes obsolete language; removes exception for child care providers that only transport school age children in school buses. Lowers age of children transported from nine to eight; establishes variance to training requirements for emergency relative placement under specified circumstances. Provides a September 30, 2019, effective date.
49	**Mandatory reporting.** Creates § 245A.24. Requires all county and DHS licensors to report suspected fraud to the appropriate authorities.
50	**Child care center training requirements.** Amends § 245A.40. Clarifies and consolidates child care center training and documentation requirements for orientation, in-service training, child development and learning, first aid, CPR, abusive head trauma, sudden unexpected infant death, and child passenger restraint systems. Adds definitions for “substitute,” “staff person,” and “unsupervised volunteer.” Provides a September 30, 2019, effective date.
51	**Child care center health and safety requirements.** Amends § 245A.41. Clarifies and consolidates child care training and documentation requirements for allergy prevention and response and handling and disposal of bodily fluids. Modifies emergency preparedness plan requirements. Moves requirements for child passenger restraint requirements. Allows for a provider to satisfy telephone requirements with a cellular phone. Provides a September 30, 2019 effective date.

Section	Description – Article 2: Operations
52	**Family child care training requirements.** Amends § 245A.50. Consolidates and clarifies training family child care training requirements for initial training (adding CPR and first aid training), child development and learning, behavior guidance, first aid, CPR, sudden unexpected infant death and abusive head trauma, child passenger restraint systems, and ongoing training. Defines "helper," "substitute," "caregiver," and "The Basics of Family Child Care for Substitutes." Provides a September 30, 2019, effective date.
53	**Emergency preparedness plan.** Amends § 245A.51, subd. 3. Removes obsolete date; adds requirement for accommodations for infants and toddlers in family child care emergency preparedness plans. Provides a September 30, 2019, effective date.
54	**Transporting children.** Amends § 245A.51 by adding subd. 4. Moves requirements for transporting children in family child care. Provides a September 30, 2019, effective date.
55	**Telephone requirement.** Amends § 245A.51 by adding subd. 5. Allows for a family child care provider to satisfy telephone requirements with a cellular phone and specifies that a provider is not required to post emergency numbers. Provides a September 30, 2019, effective date.
56	**Family child care physical space requirements.** Proposes coding for § 245A.52. Updates family child care physical space requirements to align with current fire code. Moves requirements from rule to statute and updates requirements to align with current code. Provides a September 30, 2019, effective date.
57	**Substitute and replacement caregivers in family child care.** Proposes coding for § 245A.53. **Subd. 1. Total hours allowed.** Permits the use of a substitute caregiver for family child care for up to 400 hours in a calendar year. Requires the license holder to document the substitute care. **Subd. 2. Emergency replacement supervision.** Paragraph (a) allows for an emergency replacement, who has not completed training or background study requirements, in a licensed family or group family day care; specifies what constitutes an emergency situation. Paragraph (b) requires the license holder to minimize the time an emergency replacement cares for children, not to exceed 24 hours per incident.

Section	Description – Article 2: Operations

Paragraph (c) prohibits the license holder from knowingly using an emergency replacement caregiver who would be disqualified from caring for children if a background study were conducted.

Paragraph (d) requires the license holder to arrange for emergency care by a substitute, if possible.

Paragraph (e) requires the license holder to notify the county licensing agency within 7 days that an emergency replacement was used, and the circumstances leading to the use of the emergency replacement. Requires the county licensing agency to then notify DHS within 3 business days after receiving the notice from the license holder.

Paragraph (f) specifies that a license holder is not required to provide names of substitutes or emergency replacements to parents or the county licensing agency.

Provides a September 30, 2019, effective date.

58 **Child care centers; risk reduction plan.**

Amends § 245A.66, subd. 2. Adds supervision of school-age children to requirements for risk reduction plan. Provides a September 30, 2019, effective date.

59 **Yearly review of risk reduction plan.**

Amends § 245A.66, subd. 3. Clarifies that review of the risk reduction plan must occur each calendar year. Removes orientation language that is consolidated elsewhere. Provides a September 30, 2019, effective date.

60 **License-exempt child care center certification holder.**

Amends § 245C.02 by adding subd. 5a. Defines "license-exempt child care center certification holder" for purposes of the background studies chapter. Provides a September 30, 2019, effective date.

61 **Child care background study subject.**

Amends § 245C.02, subd. 6a. Modifies and clarifies the individuals who are required to have a child care-related background study.

62 **Children's residential facility.**

Amends § 245C.02 by adding subd. 6b. Defines "children's residential facility" for purposes of the background studies chapter. Provides a July 1, 2019, effective date.

Section	Description – Article 2: Operations
63	**Licensed family child foster care.** Amends § 245C.02 by adding subd. 12a. Defines "licensed family child foster care" for purposes of the background studies chapter. Provides a March 1, 2020, effective date.
64	**Substance use disorder treatment field.** Amends § 245C.02 by adding subd. 20. Defines "substance use disorder treatment field" for purposes of the background studies chapter.
65	**Licensed programs.** Amends § 245C.03, subd. 1. Clarifies that child care background study subjects are defined in section 245C.02, subd. 6a.
66	**Privacy notice to background study subject.** Amends § 245C.05, subd. 2c. Clarifies language regarding FBI fingerprint retention.
67	**Fingerprint data notification.** Amends § 245C.05, subd. 2d. Clarifies language regarding FBI fingerprint retention.
68	**Electronic transmission.** Amends § 245C.05, subd. 4. Adds a summary of nondisqualifying background study results and relevant underlying investigative information to the information that DHS must transmit electronically to county and private agencies for child foster care. Provides a March 1, 2020, effective date.
69	**Fingerprints and photograph.** Amends § 245C.05, subd. 5. Adds children's residential facilities. Clarifies language regarding FBI fingerprint retention. Provides a July 1, 2019, effective date for paragraph (a).
70	**Background study requirements for minors.** Amends § 245C.05, subd. 5a. Requires individuals 17 or younger employed by a child care program, or when there is otherwise reasonable cause, to submit non-fingerprint-based data for a check of out-of-state criminal and sex offender registries.
71	**Background studies conducted by Department of Human Services.** Amends § 245C.08, subd. 1. Adds children's residential facilities to background study provisions. Requires individuals 18 or older affiliated with a child care program to submit non-fingerprint-based data for a check of out-of-state criminal and sex offender registries. Provides a July 1, 2019, effective date for paragraph (a).

Section	Description – Article 2: Operations
72	**Arrest and investigative information.** Amends § 245C.08, subd. 3. (a) Allows for the review of arrest and investigative information by the commissioners of health and human services. (b) Allows the commissioner to review a subject's FBI records more than once, when specifically required by law. (c) Specifies that national criminal history check information is private data that cannot be shared. (d) Specifies that the entity that submitted a background study is not required to obtain a copy of the disqualification letter if the commissioner disqualifies a subject based on national criminal history check information. Provides an October 1, 2019, effective date.
73	**Children's residential facilities.** Amends § 245C.10 by adding subd. 14. Specifies that the commissioner will recover a fee for children's residential facility background studies not to exceed $51. Provides a July 1, 2019, effective date.
74	**Direct contact pending completion of background study.** Amends § 245C.13, subd. 2. Requires direct continuous supervision prior to completion of a background study for an individual affiliated with a child care center. Prohibits direct contact services in child care centers prior to the receipt of notice that a subject is not disqualified or that more time is needed.
75	**Other state information.** Amends § 245C.13 by adding subd. 3. Allows the commissioner to issue a notice of background study results when the commissioner has not received certain records from other states within ten days of requesting the information.
76	**Disqualification from direct contact.** Amends § 245C.14, subd. 1. Specifies that the commissioner must disqualify an individual applying for family child foster care licensure from any position allowing direct contact with persons served, if the background study contains disqualifying information, as listed in section 245C.15, subdivision 6 (new subdivision). Provides a March 1, 2020, effective date.

Section	Description – Article 2: Operations
77	**15-year disqualification.** Amends § 245C.15, subd. 2. Adds felony criminal penalties for acts including human services programs to list of offenses leading to disqualification for direct contact for 15 years.
78	**Ten-year disqualification.** Amends § 245C.15, subd. 3. Adds gross misdemeanor criminal penalties for acts involving human services programs to list of offenses leading to disqualification from direct contact for ten years.
79	**Seven-year disqualification.** Amends § 245C.15, subd. 4. Adds misdemeanor criminal penalties for acts involving human services programs to list of offenses leading to disqualification from direct contact for seven years.
80	**Licensed family child foster care disqualifications.** Adds subdivision 6 to § 245C.15. Specifies disqualifying crimes and creates new criteria for disqualification for background studies affiliated with family child foster care license applicants. Paragraphs (a) and (b) list actions and crimes for which an applicant is disqualified, no matter how much time has passed. Paragraphs (c) and (d) list actions and crimes for which an applicant is disqualified if less than five years have passed. Provides a March 1, 2020, effective date.
81	**Risk of harm; set aside.** Amends § 245C.22, subd. 4. Specifies criteria for a set-aside of a background study disqualification for an individual seeking employment in the substance use disorder treatment field; lists crimes and conduct for which an individual would remain disqualified; requires the individual to have successfully completed substance use disorder treatment at least one year prior and to abstain from controlled substances for at least one year prior to the reconsideration request.

Section	Description – Article 2: Operations
82	**Scope of set-aside.** Amends § 245C.22, subd. 5. Provides an exception for a set-aside for a person employed in the substance use disorder treatment field, under subd**ivision** 4, when the individual previously received a set-aside for a different program or agency.
83	**Disqualification; bar to set aside a disqualification; request for variance.** Amends § 245C.24. (b) Requires the commissioner of human services to consider granting a licensing variance or set-aside for an individual if more than 20 years have passed since the discharge of a criminal sentence for a crime or conduct that would otherwise warrant a permanent disqualification from direct contact services. Specifies that the commissioner is not required to consider a variance or set-aside for a person disqualified for criminal sexual conduct. Adds paragraph (d) to subdivision 2, specifying that the commissioner must not set aside a disqualification for any of the crimes or actions listed in section 245C.15, subdivision 6, paragraph (a), for anyone 18 or older affiliated with a licensed family child foster care program. Amends subdivisions 3 and 4 to allow the commissioner to set aside disqualifications for family child foster care licensing, in certain circumstances. Adds subdivision 5, specifying that the commissioner must not set aside a disqualification for any of the crimes or actions listed in section 245C.15, subdivision 6, paragraph (c) committed within the past five years, for anyone 18 or older affiliated with a licensed family child foster care program. Adds subdivision 6, specifying that the commissioner must not set aside a disqualification for an individual affiliated with a children's residential facility who was convicted of a felony for physical assault or a drug-related offense in the past five years. Provides a March 1, 2020, effective date and a July 1, 2019, effective date for subdivision 6.
84	**License holder and license-exempt child care center certification holder variance.** Amends § 245C.30, subd. 1. Adds license-exempt child care center certification holders to those to whom the commissioner may grant a variance. Provides a September 30, 2019 effective date.
85	**Disclosure of reason for disqualification.** Amends § 245C.30, subd. 2. Adds license-exempt child care center certification holders to provision relating to disqualification disclosure. Provides September 30, 2019, effective date.

Section	Description – Article 2: Operations
86	**Consequences for failing to comply with conditions of variance.** Amends § 245C.30, subd. 3. Adds license-exempt child care center certification holders to provisions relating to failure to comply with variance conditions. Provides September 30, 2019, effective date.
87	**Financial misconduct or misconduct.** Amends § 245E.01, subd. 8. Modifies the definition of "financial misconduct" or "misconduct" under the statute governing CCAP fraud investigations to include the new crimes and criminal penalties created in section 120.
88	**Provider definitions.** Amends § 245E.02, by adding subd. 1a. Defines "provider."
89	**Substitute.** Amends § 245H.01 by adding subd. 7. Defines "substitute" for purposes of certified license-exempt child care centers. Provides a September 30, 2019, effective date.
90	**Staff Person.** Amends § 245H.01 by adding subd. 8. Defines "staff person" for purposes of certified license-exempt child care centers. Provides a September 30, 2019, effective date.
91	**Unsupervised volunteer.** Amends § 245H.01 by adding subd. 9. Defines "unsupervised volunteer" for purposes of certified license-exempt child care centers. Provides a September 30, 2019, effective date.
92	**Reconsideration of certification denial.** Amends § 245H.03 by adding subd. 4. Adds provision allowing for reconsideration of a denial of a certification application. Provides a September 30, 2019, effective date.
93	**Decertification.** Amends § 245H.07. Adds provisions allowing for reconsideration of a decertification of a certified license-exempt child care center and provides specific procedures for decertifications due to maltreatment and CCAP revocation. Provides a September 30, 2019 effective date for subdivision 1 to 3 and a February 26, 2021, effective date for subdivision 4.
94	**Individuals to be studied.** Amends § 245H.10, subd. 1. Adds reference to child care background study provisions.

Section	Description – Article 2: Operations
95	**Reporting.** Amends § 245H.11. Requires license-exempt child care center certification holder to have written policies for reporting of abuse and neglect. Provides a September 30, 2019, effective date.
96	**Fees.** Amends § 245H.12. Creates a $200 application fee and $100 renewal fee for certification of license-exempt child care centers. Provides a July 1, 2019, effective date.
97	**Building and physical premises; free of hazards.** Amends § 245H.13, subd. 5. Adds reference to state fire code and fire marshal inspection requirements for certification of license-exempt child care centers. Provides September 30, 2019, effective date.
98	**Risk reduction plan.** Amends § 245H.13 by adding subd. 7. Requires a certified license-exempt child care center to develop a risk reduction plan; specifies what the plan must include. Provides September 30, 2019, effective date.
99	**Required policies.** Amends § 245H.13 by adding subd. 8. Requires a certified center to have written health and safety policies. Provides September 30, 2019, effective date.
100	**Behavior guidance.** Amends § 245H.13 by adding subd. 9. Requires a certified center to ensure that staff and volunteers use positive behavior guidance; lists prohibited acts. Provides September 30, 2019, effective date.
101	**Supervision.** Amends § 245H. 13 by adding subd. 10. Outlines supervision requirements for certified centers. Provides September 30, 2019, effective date.
102	**First aid and cardiopulmonary resuscitation.** Amends § 245H.14, subd. 1. Requires director and all staff persons in certified centers to have initial first aid and CPR training within specified timelines and every other calendar year thereafter. Provides September 30, 2019, effective date.
103	**Abusive head trauma.** Amends § 245H.14, subd. 3. Requires director and all staff persons in certified centers to complete abusive head trauma training before assisting in the care of a child under school age. Provides September 30, 2019, effective date.

Section	Description – Article 2: Operations
104	**Child development.** Amends § 245H.14, subd. 4. Requires director and all staff persons in certified centers to complete child development training within specified timeframes. Provides September 30, 2019, effective date.
105	**Orientation.** Amends § 245H.14, subd. 5. Requires director and all staff persons in certified centers to complete orientation health and safety training within specified timeframes. Provides September 30, 2019, effective date.
106	**In service.** Amends § 245H.14, subd. 6. Requires director and all staff persons in certified centers to complete annual health and safety training within specified timeframes. Provides September 30, 2019, effective date.
107	**Written emergency plan.** Amends § 245H. 51, subd. 1. Adds requirement for accommodations for infants and toddlers in certified license-exempt child care center written emergency plans. Provides September 30, 2019, effective date.
108	**Hearing authority.** Amends § 256.046, subd. 1. Makes technical changes.
109	**Administrative disqualification of child care providers caring for children receiving child care assistance.** Amends § 256.046, by adding subd. 3. Specifies the process for DHS or a local agency to pursue an administrative disqualification of a child care provider. Allows a provider to appeal an administrative disqualification.
110	**Disqualification from program.** Amends § 256.98, subd. 8. Modifies the disqualification period for child care providers caring for children receiving child care assistance.
111	**Vendor of medical care.** Amends § 256B.02, subd. 7. Modifies the definition of “vendor of medical care” under the chapter of statutes governing MA.
112	**Grounds for sanctions against vendors.** Amends § 256B.064, subd. 1a. Expands the list of reasons for which the commissioner may impose sanctions against a vendor of medical care.

Section	Description – Article 2: Operations
113	**Sanctions available.** Amends § 256B.064, subd. 1b. Requires the commissioner to suspend a vendor's participation in MA for a minimum of five years under certain circumstances.
114	**Imposition of monetary recovery and sanctions.** Amends sec. 256B.064, subd. 2. Allows DHS or a managed care organization to keep any payments being withheld when a provider is convicted of a crime related to MA. Grants the commissioner additional fining authority for providers who repeatedly violate MA program rules.
115	**Vendor mandates on prohibited payments.** Amends § 256B.064, by adding subd. 3. Paragraph (a) requires the commissioner to maintain and publish a list of each excluded individual and entity that was convicted of a crime related to an MA health service, or suspended or terminated. Prohibits MA payments from being made by a vendor for items or services furnished by an individual or entity that is on the exclusion list. Paragraph (b) specifies vendor requirements related to frequency of checking the exclusion list. Paragraph (c) specifies the vendor's requirement to check the exclusion list and terminate payments to individuals or entities on the list. Paragraph (d) lists sanctions that may be applied if a vendor pays MA funds to an individual or entity on the exclusion list.
116	**Notice.** Amends § 256B.064, by adding subd. 4. Paragraph (a) allows DHS to serve notices by first class mail with an affidavit of service. Paragraph (b) requires DHS to give notice in writing to a recipient placed in the Minnesota restricted recipient program. Requires the notice to be sent by first class mail. Allows a recipient placed in the Minnesota restricted recipient program to contest the placement by submitting a written request for a hearing to DHS within 90 days of the notice being mailed.
117	**Immunity; good faith reporters.** Amends § 256B.064, by adding subd. 5. Grants civil and criminal immunity to persons who make a good faith report of fraud or abuse in public assistance programs and ensures the identity of the reporter remains confidential.

Section	Description – Article 2: Operations
118	**Minnesota restricted recipient program; personal care assistance services.** Creates § 256B.0646. Paragraph (a) allows the commissioner to place a recipient of PCA or community first services and supports (CFSS) in the Minnesota restricted recipient program when the recipient's use of those programs results in abusive or fraudulent billing. Paragraph (b) requires a recipient to comply with additional conditions for the use of PCA services or CFSS if the commissioner determines it is necessary to prevent future misuse of PCA services or abusive or fraudulent billing. Lists the additional conditions that may apply. Paragraph (c) allows a recipient placed in the Minnesota restricted recipient program to appeal this placement. Provides an immediate effective date.
119	**Recipient protection.** Amends § 256B.0651, subd. 17. Allows the commissioner to notify recipients who receive care from a provider that the provider's payments may be withheld or that the provider's participation in MA may be suspended or terminated. Provides an immediate effective date.
120	**Documentation of PCA services provided.** Amends § 256B.0659, subd. 12. Requires the PCA time sheet to include a recipient's MA identification number or date of birth. Provides an immediate effective date.
121	**Access to medical records.** Amends § 256B.27, subd. 3. Removes a requirement that a vendor of medical care receive 24 hour notification from the commissioner before the commissioner gains access to records. Grants the commissioner immediate access to medical records when investigating a possible overpayment of MA funds. Specifies that denying the commissioner access is cause for the vendor's immediate suspension of payment or termination.
122	**Home and community-based service billing requirements.** Amends § 256B.4912, by adding subd. 11. Paragraph (a) lists requirements in order for a home and community-based service to be eligible for reimbursement. Paragraph (b) requires the provider to maintain documentation that staff have attested to and understand a statement regarding service billings for MA or services provided under a federally approved waiver plan. Paragraph (c) allows DHS to recover payment for a service that does not satisfy the requirements of this subdivision.

Section	Description – Article 2: Operations
123	**Home and community-based service documentation requirements.** Amends § 256B.4912, by adding subd. 12. Paragraph (a) allows documentation to be collected and maintained electronically or in paper form by providers and requires documentation to be produced upon request of the commissioner. Paragraph (b) requires documentation of a service to be in English and to be legible according to the standard of a reasonable person. Paragraph (c) lists the documentation that must be included for a service that is reimbursed at an hourly or specified minute-based rate. Paragraph (d) lists the documentation that must be included for a service that is reimbursed at a daily rate.
124	**Waiver transportation documentation and billing requirements.** Amends § 256B.4912, by adding subd. 13. Establishes documentation and billing requirements for waiver transportation services.
125	**Equipment and supply documentation requirements.** Amends § 256B.4912, by adding subd. 14. Establishes documentation and billing requirements for equipment and supplies paid for under a home and community-based services waiver.
126	**Adult day service documentation and billing requirements.** Amends § 256B.4912, by adding subd. 15. Establishes documentation and billing requirements for adult day services paid for under a home and community-based services waiver. Provides an August 1, 2019, effective date.
127	**Criminal penalties for acts involving human services programs.** Creates § 609.817. **Subd. 1. Prohibited payments made relating to human services programs.** Creates a felony offense for knowingly and willfully offering payment to a person to induce that person to: (1) apply for or receive, or induce another person to apply for or receive, a human services benefit; or (2) purchase, lease, order, or arrange for the purchase, lease, or order of any good, facility, service, or item administered or funded by the DHS. **Subd. 2. Receipt of prohibited payments relating to human services programs.** Creates a felony offense for knowingly and willfully soliciting or receiving payment in return for: (1) applying for or receiving a human services benefit, service, or grant; or (2) purchasing, leasing, ordering, or arranging for the purchase, lease, or order of any good, facility, service, or item for which payment may be made by DHS or a local social services agency.

Section	Description – Article 2: Operations

Subd. 3. Payments exempt. Specifies this section does not apply to remuneration exempted from the federal Anti-Kickback laws and regulations.

Subd. 4. Penalties. Specifies criminal penalties for persons who violate subdivision 1 or 2.

Subd. 5. Aggregation. Allows the value of the money, property, or services received by the defendant within any six-month period to be aggregated in any prosecution.

Subd. 6. Venue. Specifies the venue for prosecution.

Subd. 7. False claims. Specifies a claim that includes items or services resulting from a violation of this section constitutes a false claim.

Subd. 8. Actual knowledge or specific intent not required. Specifies a person need not have actual knowledge of this section or specific intent to commit a violation of this section.

128 **Limitations.**

Amends § 628.26. Requires indictments or complaints of violations of section 126 to be filed in the proper court within six years of the commission of the offense.

129 **Repealer.**

Repeals rules relating to child care fire safety and telephone requirements that are moved to statute in this article; repeals subdivision relating to certified license-exempt child care direct contact and a subdivision related to child care assistance program overpayments for failure to comply with access to records requirements. Provides a September 30, 2019, effective date.

Article 3: Direct Care and Treatment

This article establishes an administrative review process for counties to challenge liability for cost of care in direct care and treatment facilities, modifies the required county share of the cost of care for individuals in the Minnesota Sex Offender Program (MSOP), including the cost of care for individuals provisionally discharged to the community, and repeals sections relating to state-operated services funding.

Section	Description – Article 3: Direct Care and Treatment
1	**Administrative review of county liability for cost of care.** Amends § 246.54 by adding subd. 3. Establishes a process for a county to request an administrative review of the county share of the cost of care when a delay in discharging a client from a direct care and treatment facility is caused by specific actions or inaction by the facility.
2	**Liability of county; reimbursement.** Amends § 246B.10. Specifies that the county share for the cost of care for a civilly committed sex offender is 10 percent per day, for individuals admitted to the MSOP before August 1, 2011. Specifies that the county share for the cost of care is 25 percent per day for individuals admitted to the MSOP on or after August 1, 2011, for days at the facility or services received while the individual is on provisional discharge. Modifies conditions requiring the county to pay the state the remaining amount for the MSOP cost of care. Makes this section effective July 1, 2019.
3	**Direction to commissioner; report required.** Requires the commissioner to submit a report to the legislature by January 1, 2023, providing an update on county and state efforts to reduce unnecessary days spent in state-operated direct care and treatment facilities; requires the report to include information on the fiscal impact of such stays.
4	**Direction to commissioner; discharge coordination with counties.** Requires the commissioner to consult with counties to develop incentives for housing individuals discharged and provisionally discharged from MSOP.
5	**Repealer.** (a) Repeals § 246.18, subds. 8 and 9 (related to the state-operated services account). (b) Repeals Laws 2010, First Special Session chapter 1, article 25, section 3, subdivision 10 (state-operated services appropriations).

Article 4: Continuing Care for Older Adults

This article makes various changes to the nursing facility payment rate system, called value-based reimbursement (VBR), including reforming the property payment rates, and requires the commissioner of human services to allocate grants to counties and tribal governments for staffing to protect vulnerable adults or to expand adult protective services.

Section	Description – Article 4: Continuing Care for Older Adults
1	**Resident assessment schedule.** Amends § 144.0724, subd. 4. In a subdivision requiring nursing facilities to conduct certain resident assessments to determine case mix classifications for reimbursement, provides that for rehabilitation therapy a facility must perform a significant change in status assessment if all speech, occupational, and physical therapies have ended, and specifies timing for this assessment. Also specifies that any modifications to the most recent assessments must be included in the case mix classification analysis.
2	**Short stays.** Amends § 144.0724, subd. 5. Provides that a nursing facility is not required to conduct an admission assessment of a resident if the resident is admitted to and discharged from the facility on the same day.
3	**Request for reconsideration of resident classifications.** Amends § 144.0724, subd. 8. Allows a reconsideration of a resident's case mix classification by the commissioner of health to include consideration of any items changed during the audit process, and removes language requiring a reconsideration request to include a copy of the minimum data set (MDS) used to determine the case mix classification.
4	**Definitions.** Amends § 144.071, subd. 1a. In a subdivision defining terms for the nursing home bed moratorium section, modifies the definitions of building, capital assets, and depreciation guidelines by adding cross-references to the definitions of those terms in section 256R.261 (definitions for nursing facility property rates). Also strikes definitions of project construction costs and technology.

Section	Description – Article 4: Continuing Care for Older Adults
5	**Moratorium.** Amends § 144A.071, subd. 2. In current law the commissioner of health may approve a nursing facility construction project whose costs are at or below $1,000,000; construction projects with costs above that amount must meet one of the criteria in paragraph (a) or (b) in order to be approved by the commissioner. This section raises the cost threshold for construction projects the commissioner may approve without requiring the project to satisfy additional criteria, from $1,000,000 to $1,500,000. Also requires the commissioner of human services, in addition to the commissioner of health as in current law, to be provided with an itemized cost estimate for project construction costs before final plan approval of a construction project.
6	**Exceptions authorizing increase in beds; hardship areas.** Amends § 144A.071, subd. 3. The amendments to paragraph (d) provide that if a nursing facility in a hardship area adds beds and after these beds are added 50 percent or more of the facility's beds are newly licensed, the facility's operating payment rate and external fixed payment rate shall be determined according to a new subdivision governing total payment rates for new facilities (§ 256R.21, subd. 5), and the facility's property payment rate shall be determined under a new section governing property payment rates (§ 256R.26).
7	**Exceptions for replacement beds.** Amends § 144A.071, subd. 4a. In a paragraph authorizing a nursing facility moratorium exception to replace a facility in Wilkin County damaged by a flood, changes a reference governing the interim and settle-up payment provisions for that facility from a rule being repealed in this bill to a new section in chapter 256R governing interim payment rates and settle-up (§ 256R.27).
8	**Exceptions for replacement beds after June 30, 2003.** Amends § 144A.071, subd. 4c. In a paragraph authorizing a nursing facility moratorium exception to licensed beds transferred to a new facility on the grounds of the Ah-Gwah-Ching campus, changes a reference governing the interim and settle-up payment provisions for that facility from a rule being repealed in this bill to a new section in chapter 256R governing interim payment rates and settle-up (§ 256R.27).
9	**Cost estimate of a moratorium exception project.** Amends § 144A.071, subd. 5a. In a subdivision establishing requirements for cost estimates of nursing facility moratorium exception projects, requires the commissioner of human services to prepare an estimate of the property-related payment rate to be established when the project is complete, and specifies what governs the final property rate. Strikes paragraphs governing the interest rate used to estimate the cost of a proposal.

Section	Description – Article 4: Continuing Care for Older Adults
10	**Relocation projects.** Amends § 144A.073, subd. 3c. Allows the commissioner to accept relocation proposals at any time (current law allows the commissioner to accept at any time relocation proposals that are cost-neutral with respect to state costs). Also strikes a paragraph describing how cost neutrality is measured.
11	**Contractual agreements.** Amends § 256B.434, subd. 1. Removes obsolete language and clarifies this applies to nursing facilities located in Minnesota that elect to enroll as a medical assistance provider. Provides an immediate effective date.
12	**Duration and termination of contracts.** Amends § 256B.434, subd. 3. Removes obsolete language and provides an immediate effective date.
13	**Adult protection grant allocation.** Adds § 256M.42. Provides for allocation of adult protection grants by the commissioner of human services. **Subd. 1. Formula.** Requires the commissioner of human services to annually allocate money to each county board and tribal government approved by the commissioner to assume county agency duties for adult protective services or as a lead investigative agency, according to the specified formula. Prohibits the commissioner from changing this formula or recommending a change without public review and input. **Subd. 2. Payment.** Requires the commissioner to make initial allocations on or before October 10, 2019, and on or before July 10 each year thereafter. **Subd. 3. Prohibition on supplanting existing money.** Requires money allocated under this section to be used to fund staffing to protect vulnerable adults or to expand adult protective services, and prohibits this money from being used to supplant current county or tribal expenditures for these purposes. Provides a July 1, 2019, effective date.
14	**Capital assets.** Amends § 256R.02, subd. 8. Modifies the definition of “capital assets” under the nursing facility VBR.
15	**External fixed costs.** Amends § 256R.02, subd. 19. Modifies the definition of “external fixed costs” under the nursing facility VBR. Provides a January 1, 2020, effective date.

Section	Description – Article 4: Continuing Care for Older Adults
16	**Interim payment rates.** Amends § 256R.02, by adding subd. 25a. Defines "interim payment rates" under the nursing facility VBR.
17	**Settle up payment rates.** Amends § 256R.02, by adding subd. 47a. Defines "settle up payment rates" under the nursing facility VBR.
18	**Reporting of financial statements.** Amends § 256R.08, subd. 1. Expands the list of information nursing facilities must report to the commissioner to include information regarding licensee ownership interest or control in a related party or organization. For purposes of this section, defines "profit and loss statement" and "related party." Provides a November 1, 2019, effective date.
19	**Pilot projects for energy-related programs.** Amends § 256R.10, by adding subd. 8. Requires the commissioner to develop a pilot project to reduce overall energy consumption and evaluate the financial impacts of property-assessed clean energy approved projects in nursing facilities.
20	**Calculation of a quality score.** Amends § 256R.16, subd. 1. Removes the July 1 effective date for adjustments to the methodology for computing the total quality score.
21	**Total payment rate for new facilities.** Amends § 256R.21, by adding subd. 5. Specifies the manner in which the total payment rate must be determined for a new facility created under a cost-neutral relocation moratorium exception project. Provides a January 1, 2020, effective date.
22	**Determination of total care-related payment rate limits.** Amends § 256R.23, subd. 5. Modifies the calculation for determining each facility's total care-related payment rate limit. Provides a January 1, 2020, effective date.
23	**Other operating payment rate.** Amends § 256R.24. Modifies the calculation for determining a facility's other operating payment rate by breaking up the other operating costs into three components: (1) laundry, housekeeping, and dietary; (2) administration; and (3) maintenance and plant operations. Specifies a facility's payment rate for laundry, housekeeping, and dietary equals 105 percent of the seven-county metro area median cost. Sets a facility's payment rate for administrative, maintenance, and plant operations at $49.06 per day effective January 1, 2020, and allows for one percent growth each year

Section	Description – Article 4: Continuing Care for Older Adults

through December 31, 2023. Beginning January 1, 2014, adjusts the payment rate for administrative, maintenance, and plant operations by an inflation factor.

Specifies a facility's other operating payment rate equals the sum of the three components.

24 **External fixed costs payment rate.**

Amends § 256R.25. Removes planned closure rate adjustments, consolidation rate adjustments, and single-bed room incentives from the external fixed costs payment rate (these adjustments are repealed as part of this proposal). Provides a January 1, 2020, effective date.

25 **Property payment rate.**

Amends § 256R.26.

Subd. 1. Generally. Paragraph (a) requires the commissioner to reimburse nursing facilities participating in MA for the rental use of real estate and depreciable assets.

Paragraph (b) requires the commercial valuation system selected by the commissioner to be utilized in all appraisals. Prohibits adjustments or substitutions from being permitted for any alternative analysis of properties.

Paragraph (c) requires the property appraisal firm selected by the commissioner to produce a report detailing both the depreciated replacement cost (DRC) and undepreciated replacement cost (URC) of the nursing facility. Excludes the valuation of movable equipment, land, or land improvements from the valuation. Requires the valuation to be adjusted for any shared area included in the DRC and URC not used for nursing facility purposes. Excludes the physical plant for central operations from the appraisal.

Paragraph (d) allows the initial appraisal to include the full value of all shared areas. Requires the DRC, URC, and square footage to be adjusted to reflect only the nursing facility usage of shared areas in the final nursing facility values. Specifies the basis for the adjustment.

Subd. 2. Appraised value. Bases the DRC and URC on the appraisals of a building and attached fixtures as determined by the contracted property appraisal firm using a commercial valuation system selected by the commissioner.

Subd. 3. Initial rate year. Specifies the property payment rate for the initial rate year effective January 1, 2020.

Subd. 4. Subsequent rate years. Paragraph (a) requires the commissioner, beginning in calendar year 2020, to contract with a property appraisal firm to appraise the building and attached fixtures for nursing facilities using the

Section	Description – Article 4: Continuing Care for Older Adults

commercial valuation system. Requires approximately one-third of nursing facilities to be appraised each year.

Paragraph (b) specifies the timing for a nursing facility to appeal findings of fact in an appraisal report.

Paragraphs (c) and (d) specify the manner in which property payment rates are determined for rate years 2021 to 2023.

Paragraph (e) specifies requirements for appraisals completed after 2016.

Subd. 5. Special reappraisals. Paragraph (a) allows a nursing facility that completes an addition to or replacement of a building or attached fixtures to request a property rate adjustment. Specifies the process for requesting and determining a property rate adjustment.

Paragraph (b) allows a nursing facility that completes a threshold construction project to request a project rate adjustment if the building improvement or addition costs exceed $300,000 and the project is not reflected in an appraisal used for rate setting. Specifies additional eligibility requirements for a property rate adjustment under this paragraph and the manner in which the rate adjustment is determined.

Paragraph (c) specifies appraisal requirements for nursing facilities new to the medical assistance (MA) program effective January 1, 2020.

Subd. 6. Limitation on appraisal valuations. Limits the increase in the URC to $500,000 per year since the last completed appraisal plus any completed moratorium exception project costs. Requires any limitation to the URC to be applied in the same proportion to the DRC.

Subd. 7. Total hold harmless rate. Paragraph (a) lists the items included in the total hold harmless rate.

Paragraph (b) adds certain moratorium rate adjustments to the total hold harmless rate.

Paragraph (c) includes the following in the total hold harmless rate: (1) planned closure rate adjustments; (2) consolidation rate adjustments; and (3) single-bed room incentives from previous years.

Paragraph (d) provides a January 1, 2026, expiration date for this subdivision.

Subd. 8. Phase out of hold harmless rate. For a facility that has a higher total hold harmless rate than the new property payment rate, specifies a phase out schedule of the hold harmless rate over six years. Provides a January 1, 2026, expiration date for this subdivision.

Section	Description – Article 4: Continuing Care for Older Adults
26	**Nursing facility property rate definitions.** Creates § 256R.261. **Subd. 1. Definitions.** Specifies the following terms have the meanings given them for purposes of the nursing facility property payment rates under VBR. **Subd. 2. Addition.** Defines "addition." **Subd. 3. Appraisal.** Defines "appraisal." **Subd. 4. Building.** Defines "building." **Subd. 5. Commercial valuation system.** Defines "commercial valuation system." **Subd. 6. Depreciable movable equipment.** Defines "depreciable movable equipment." **Subd. 7. Depreciated replacement cost or DRC.** Defines "depreciated replacement cost" or "DRC." **Subd. 8. Depreciation expense.** Defines "depreciation expense." **Subd. 9. Depreciation guidelines.** Defines "depreciation guidelines." **Subd. 10. Equipment allowance.** Defines "equipment allowance." **Subd. 11. Fair rental value system.** Defines "fair rental value system." **Subd. 12. Fixed equipment.** Defines "fixed equipment." **Subd. 13. Land improvement.** Defines "land improvement." **Subd. 14. Rental rate.** Defines "rental rate." **Subd. 15. Shared area.** Defines "shared area." **Subd. 16. Threshold project.** Defines "threshold project." **Subd. 17. Undepreciated replacement cost or URC.** Defines "undepreciated replacement cost" or "URC." **Subd. 18. Undepreciated replacement cost (URC) per bed limit.** Defines "undepreciated replacement cost (URC) per bed limit."

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27 **Property rate calculation under fair rental value system.**

Creates § 256R.265.

Subd. 1. Square feet per bed limit. Specifies the calculation for the square feet per bed limit.

Subd. 2. Total URC limit. Specifies the calculation for the total URC limit.

Subd. 3. Calculation of total property rate. Specifies the calculation for the total property rate.

28 **Interim and settle up payment rates.**

Creates § 256R.27.

Subd. 1. Generally. Paragraph (a) requires a newly constructed nursing facility or a nursing facility with a capacity increase of 50 percent or more to receive interim payment rates and settle up payment rates.

Paragraph (b) requires a nursing facility to submit a written application to the commissioner to receive interim payment rates.

Paragraph (c) specifies the effective date of the interim payment rates and prohibits interim payment rates from being in effect for more than 17 months.

Paragraph (d) specifies the time period during which the nursing facility must receive the interim payment rates.

Paragraph (e) specifies the manner in which the settle up payment rates must be determined during the 15-month period following the settle up reporting period.

Paragraph (f) specifies the time period during which the settle up payment rates are in effect.

Paragraph (g) specifies the manner in which the total operating payment rate and the external fixed costs payment rate must be determined following the time period under paragraph (e).

Subd. 2. Determination of interim payment rates. Paragraph (a) requires a nursing facility to submit an interim cost report for the reporting year in which the nursing facility plans to begin operation. Specifies the information that must be included in the interim cost report. Specifies the calculation to determine the anticipated interim standardized days and resident days for the reporting period.

Paragraph (b) specifies the calculation for the interim total operating payment rate.

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Subd. 3. Determination of settle up payment rates. Paragraphs (a) and (b) specify the time period for which a facility must file settle up cost reports.

Paragraph (c) specifies the calculation for the settle up total operating payment rate.

29 **Interim and settle up payment rates for new owners and operators.**

Creates § 256R.28.

Subd. 1. Generally. Paragraph (a) specifies a facility that undergoes a change of ownership or operator resulting in a change of licensee must receive interim payment rates and settle up payment rates.

Paragraph (b) specifies the effective date of the interim rates and prohibits interim rates from being in effect for more than 26 months.

Paragraph (c) requires the nursing facility to continue to receive the interim payment rates until the settle up payment rates are determined.

Paragraph (d) makes the settle up payment rates effective retroactively to the effective date of the new license and remain effective until the end of the interim rate period.

Paragraph (e) specifies the manner in which the settle up payment rates must be determined during the 15-month period following the settle up reporting period.

Paragraph (f) specifies the manner in which the total operating payment rate and the external fixed costs payment rate must be determined following the time period under paragraph (e).

Subd. 2. Determination of interim payment rates. Specifies the manner in which the interim total payment rates must be calculated.

Subd. 3. Determination of settle up payment rates. Paragraphs (a) and (b) specify the time period for which a facility must file settle up cost reports.

Paragraph (c) specifies the calculation for the settle up total payment rate.

30 **Rate adjustment for private rooms for medical necessity.**

Amends § 256R.44. Reduces the amount paid for a private room for medical necessity and removes a cross-reference that is proposed to be repealed. Provides a January 1, 2020, effective date.

31 **Rate adjustment for critical access nursing facilities.**

Amends § 256R.47. Extends the suspension of this provision to December 31, 2023.

Section	Description – Article 4: Continuing Care for Older Adults
32	**Determination of rate adjustment.** Amends § 256R.50, subd. 6. Limits bed relocation rate adjustments to three full years following the effective date of the rate adjustment. Sunsets this subdivision when the final rate adjustment determined under this subdivision expires.
33	**Direction to commissioner; moratorium exception funding.** In fiscal year 2020, allows the commissioner of human services to approve moratorium exception projects for which the full annualized share of MA costs does not exceed $1,500,000 plus any carryover of previous appropriations for this purpose. Provides an immediate effective date.
34	**Revisor instruction.** Instructs the revisor of statutes to renumber the nursing facility contracting provisions that are currently coded in section 256B.434, subdivisions 1 and 3, as amended by this act, as a section in chapter 256R and revise any statutory cross-references consistent with the recoding.
35	**Repealer.** Paragraph (a) repeals Minn. Stat. §§ 144A.071, subd. 4d (consolidation of nursing facilities); 256R.40 (nursing facility voluntary closure); and 256R.41 (single-bed room incentive) effective July 1, 2019. Paragraph (b) repeals Minn. Stat. §§ 256B.431, subds. 3a (property-related costs after July 1, 1985), 3f (property costs after July 1, 1988), 3g (property costs after July 1, 1990, for certain facilities), 3i (property costs for the rate year beginning July 1, 1990), 10 (property rate adjustments and construction projects), 13 (hold harmless property-related rates), 15 (capital repair and replacement cost reporting and rate determination), 16 (major additions and replacements; equity incentive), 17 (special provisions for moratorium exceptions), 17a (allowable interest expense), 17c (replacement-costs-new per bed limit), 17d (determination of rental per diem for total replacement projects), 17e (replacement-costs-new per bed limit effective October 1, 2007), 18 (updating appraisals, additions, and replacements), 21 (indexing thresholds), 22 (changes to nursing facility reimbursement), 30 (bed layaway and delicensure), and 45 (rate adjustments for some moratorium exception projects); 256B.434, subds. 4 (alternate rates for nursing facilities), 4f (construction project rate adjustments effective October 1, 2006), 4i (construction project rate adjustments for certain nursing facilities), and 4j (construction project rate increase for certain nursing facilities); and 256R.36 (hold harmless), and Minn. Rules, parts 9549.0057 (determination of interim and settle up operating cost payment rates); and 9549.0060, subps. 4, 5, 6, 7, 10, 11, and 14 (determination of the property-related payment rate) effective January 1, 2020. Paragraph (c) repeals Minn. Stat. § 256B.434, subds. 6 (contract payment rates; appeals) and 10 (exemptions), effective the day following final enactment.

Article 5: Disability Services

This article modernizes the Telecommunications Access Minnesota Program, requires early intensive developmental and behavioral intervention providers to receive background studies, modifies home and community-based services standards, modifies day services, modernizes the purchase of health care coverage for people living with HIV and aligns the program with the federal Affordable Care Act, establishes an enhanced rate for PCA services and CFSS, modifies the Disability Waiver Rate System, modifies electronic visit verification, and makes various other changes.

Section	Description – Article 5: Disability Services
1	**Deaf.** Amends § 237.50, subd. 4a. Modifies terminology in the definition of "deaf" under the telecommunications chapter of statutes. Provides a July 1, 2019, effective date and requires implementation by October 1, 2019.
2	**Discounted telecommunications or Internet services.** Amends § 237.50, by adding subd. 4c. Defines "discounted telecommunications services or Internet services." Provides a July 1, 2019, effective date and requires implementation by October 1, 2019.
3	**Hard-of-hearing.** Amends § 237.50, subd. 6a. Modifies the definition of "hard-of-hearing." Provides a July 1, 2019, effective date and requires implementation by October 1, 2019.
4	**Interconnectivity product.** Amends § 237.50, by adding subd. 6b. Defines "interconnectivity product." Provides a July 1, 2019, effective date and requires implementation by October 1, 2019.
5	**Telecommunications device.** Amends § 237.50, subd. 10a. Modifies terminology in the definition of "telecommunications device." Provides a July 1, 2019, effective date and requires implementation by October 1, 2019.
6	**Telecommunications relay services.** Amends § 237.50, subd. 11. Modifies terminology in the definition of "telecommunications relay services." Provides a July 1, 2019, effective date and requires implementation by October 1, 2019.
7	**Creation.** Amends § 237.51, subd. 1. Expands the devices distributed through the Telecommunications Access Minnesota Program to include interconnectivity products. Provides a July 1, 2019, effective date and requires implementation by October 1, 2019.

Section	Description – Article 5: Disability Services
8	**Commissioner of human services duties.** Amends § 237.51, subd. 5a. Modifies the commissioner's duties under the Telecommunications Access Minnesota Program by making conforming changes and requiring the commissioner to assist a person with completing an application for discounted telecommunications services. Provides a July 1, 2019, effective date and requires implementation by October 1, 2019.
9	**Expenditures.** Amends § 237.52, subd. 5. Makes conforming changes. Provides a July 1, 2019, effective date and requires implementation by October 1, 2019.
10	**Telecommunications devices and interconnectivity products.** Amends § 237.53. Makes conforming changes related to expanding the types of devices distributed by the program and requires the commissioner of human services to assess the person's telecommunications needs and provide information about assistive communications devices and products and where a person might obtain or purchase such devices. Lists assistive communications devices and products. Requires the commissioner of human services to assist a person who is applying for telecommunications devices and products in applying for discounted telecommunications services. Provides a July 1, 2019, effective date and requires implementation by October 1, 2019.
11	**Early intensive developmental and behavioral intervention providers.** Amends § 245C.03, by adding subd. 13. Requires the commissioner to conduct background studies when initiated by an early intensive developmental and behavioral intervention provider.
12	**Early intensive developmental and behavioral intervention providers.** Amends § 245C.10, by adding subd. 14. Requires the commissioner to recover the cost of background studies for early intensive developmental and behavioral intervention providers through a fee of no more than $32 per study charged to the enrolled agency. Appropriates fees collected to the commissioner for the purposes of conducting background studies.
13	**Applicability.** Amends § 245D.03, subd. 1. Modifies the lists of basic support services and intensive support services under the statutory chapter governing Home and Community-Based Services Standards to include additional services. Provides a January 1, 2021, effective date, or upon federal approval, whichever is later. Requires the commissioner of human services to notify the revisor when federal approval is obtained.

Section	Description – Article 5: Disability Services
14	**Requirements for intensive support services.** Amends § 245D.071, subd. 1. Modifies the list of intensive support services exempt from certain requirements. Provides an immediate effective date.
15	**Integrated community supports; setting capacity report.** Creates § 245D.12. Paragraph (a) requires integrated community support license holders to submit a setting capacity report to the commissioner to ensure the service delivery location meets home and community-based services setting requirements. Paragraph (b) lists the information the report must include. Paragraph (c) allows only one license holder to deliver integrated community supports at a multifamily housing building. Makes this section effective upon the date of federal approval. Requires the commissioner of human services to notify the revisor when federal approval is obtained.
16	**Contribution amount.** Amends § 252.27, subd. 2a. Reduces the parental contribution required under the MA TEFRA option.
17	**Reimbursement.** Amends § 252.275, subd. 3. Reduces the county share for semi-independent living services from 30 percent to 15 percent. Provides a July 1, 2019, effective date.
18	**Determinations.** Amends § 252.28, subd. 1. Modifies the commissioner's duty to determine the need for certain day services for persons with disabilities.
19	**Day services for adults with disabilities.** Amends § 252.41, subd. 3. Modifies the definition of "day services for adults with disabilities." Provides a January 1, 2021, effective date, or upon federal approval, whichever is later. Requires the commissioner of human services to notify the revisor when federal approval is obtained.
20	**Independence.** Amends § 252.41, subd. 4. Modifies the definition of "independence" under the statute governing day services. Provides a January 1, 2021, effective date, or upon federal approval, whichever is later. Requires the commissioner of human services to notify the revisor when federal approval is obtained.

Section	Description – Article 5: Disability Services
21	**Integration.** Amends § 252.41, subd. 5. Modifies the definition of "integration." Provides a January 1, 2021, effective date.
22	**Productivity.** Amends § 252.41, subd. 6. Modifies the definition of "productivity." Provides a January 1, 2021, effective date.
23	**Regional center.** Amends § 252.41, subd. 7. Modifies the definition of "regional center." Provides a January 1, 2021, effective date.
24	**Vendor.** Amends § 252.41, subd. 9. Modifies the definition of "vendor." Provides a January 1, 2021, effective date.
25	**Service principles.** Amends § 252.42. Updates terminology, expands services to all persons with disabilities (currently services are limited to persons with developmental disabilities). Provides a January 1, 2021, effective date.
26	**Commissioner's duties.** Amends § 252.43. Updates terminology, makes technical changes. Provides a January 1, 2021, effective date.
27	**Lead agency board responsibilities.** Amends § 252.44. Updates terminology, specifies the authority under which case management services are provided, removes obsolete language. Provides a January 1, 2021, effective date.
28	**Vendor's duties.** Amends § 252.45. Updates terminology and cross-references. Provides a January 1, 2021, effective date.
29	**Purchase of health care coverage for people living with HIV.** Amends § 256.9365. **Subd. 1. Program established.** Expands the program to include cost sharing for prescriptions, including co-payments, deductibles, and coinsurance. Prohibits the commissioner from paying for the portion of a premium that is paid by the individual's employer.

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	Subd. 2. Eligibility requirements. Modifies eligibility requirements for the program. **Subd. 3. Cost-effective coverage.** Removes obsolete language.
30	**Housing access grants.** Amends § 256B.0658. Modifies the population eligible for MA housing access grant funding by removing language referencing individuals eligible for MA home and community-based services and making individuals who are aged, blind, or who have a disability eligible.
31	**PCA; requirements.** Amends § 256B.0659, subd. 11. Establishes the qualifications that must be met in order for PCA services to qualify for the enhanced rate. Provides for a July 1, 2019, effective date.
32	**Enhanced rate.** Amends § 256B.0659, by adding subd. 17a. Sets the PCA enhanced rate at 107.5 percent of the rate paid for PCA services. Specifies the enhanced rate includes any rate adjustment implemented by the commissioner on July 1, 2019, to comply with the terms of the direct support services providers collective bargaining agreement. Provides a July 1, 2019, effective date.
33	**Requirements for provider enrollment of PCA provider agencies.** Amends § 256B.0659, subd. 21. Requires provider agencies to document that the agency will use all of the revenue generated by an MA rate increase due to a collective bargaining agreement for employee PCA wages and benefits.
34	**PCA provider agency; general duties.** Amends § 256B.0659. subd. 24. Requires PCA provider agencies to document that the additional revenue received as a result of the enhanced rate is passed on to the PCAs who provided the services. Provides a July 1, 2019, effective date.
35	**PCA provider agency; required documentation.** Amends § 256B.0659, subd. 28. Requires PCA provider agencies to verify PCA training requirement completion for enhanced rate reimbursement. Provides for a July 1, 2019, effective date.
36	**Direct care workforce report.** Creates § 256B.0715. Requires the commissioner to annually assess the direct care workforce and publish findings in a report each August beginning August 1, 2020.

Section	Description – Article 5: Disability Services
	Specifies the information that must be considered in preparing the report. Makes this section effective the day following final enactment.
37	**Elderly waiver cost limits.** Amends § 256B.0915, subd. 3a. Adds paragraph (f), which requires the commissioner to approve exceptions to the monthly case mix budget cap to pay for an enhanced rate for PCA services. Limits the amount of the exception and requires the exception to be reapproved on an annual basis at the time of a participant's annual reassessment. Provides a July 1, 2019, effective date, or upon federal approval, whichever is later. Requires the commissioner of human services to notify the revisor when federal approval is obtained.
38	**Background studies.** Amends § 256B.0949, by adding subd. 16a. Specifies background study requirements are met by an early intensive developmental and behavioral intervention services agency through the commissioner's NETStudy system.
39	**Rate stabilization adjustment.** Amends § 256B.4913, subd. 4a. Removes obsolete language and the seventh year of banding, which was not approved by the federal Centers for Medicare and Medicaid Services (CMS). Makes this section effective the day following final enactment.
40	**Stakeholder consultation and county training.** Amends § 256B.4913, subd. 5. Makes technical changes. Makes this section effective January 1, 2020.
41	**Definitions.** Amends § 256B.4914, subd. 2. Defines "comparable occupations" and "direct care staff." Modifies the definition of "unit of service."
42	**Data collection for rate determination.** Amends § 256B.4914, subd. 4. Removes obsolete language related to banding, which will end on December 31, 2019. Makes this section effective January 1, 2020.
43	**Base wage index and standard component values.** Amends § 256B.4914, subd. 5. Paragraphs (b) to (g) add a competitive workforce factor of 4.7 percent. Paragraphs (h) and (k) remove obsolete language related to the 2017 automatic inflationary adjustment and change the frequency of future adjustments from once every five years to once every two years.

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Paragraph (i) requires the commissioner to adjust the competitive workforce factor by two percent on July 1, 2022, and July 1, 2024.

Paragraph (j) requires the commissioner to report to the legislature with an analysis of the competitive workforce factor on January 1, 2026. Specifies the information that must be included in the report.

Adds paragraph (l), which removes the 2014 and 2015 out-of-framework adjustments from rates calculated under DWRS. (On February 15, 2018, CMS notified DHS that these adjustments were duplicative of the inflationary adjustments built into DWRS and CMS would not allow the duplication; therefore, Minnesota was not eligible for federal matching funds for the duplicative adjustments. DHS paid both the state and federal share of the value of the out-of-framework adjustments for the remainder of fiscal year 2018, but removed these adjustments from the DWRS rates beginning on July 1, 2018.)

Adds paragraph (m), which specifies that any rate adjustments made outside of the DWRS rate framework that apply to rates calculated under DWRS are removed from rate calculations upon implementation of automatic inflation adjustments under paragraphs (h) and (k).

Makes this section effective January 1, 2020, except: (1) paragraphs (h) and (k) are effective July 1, 2022, or upon federal approval, whichever is later; and (2) paragraph (l) is effective retroactively from July 1, 2018. Requires the commissioner of human services to notify the revisor of statutes when federal approval is obtained.

44 **Direct care staff; compensation.**

Amends § 256B.4914, by adding subd. 5a. Paragraphs (a) to (c) require providers paid with rates determined under DWRS to use a certain percentage of the revenue generated by rates determined under the DWRS for direct care staff compensation.

Paragraph (d) lists applicable compensation.

Makes this section effective January 1, 2020.

45 **Payments for residential support services.**

Amends § 256B.4914, subd. 6. Modifies the rate calculation for residential support services to include the competitive workforce factor and removes obsolete language related to banding and the implementation period. Makes this section effective January 1, 2020, or upon federal approval, whichever is later. Requires the commissioner of human services to notify the revisor when federal approval has been obtained.

Section	Description – Article 5: Disability Services
46	**Payments for day programs.** Amends § 256B.4914, subd. 7. Modifies terminology and the rate calculation for day programs to include the competitive workforce factor. Makes this section effective January 1, 2020, or upon federal approval, whichever is later. Requires the commissioner of human services to notify the revisor when federal approval has been obtained.
47	**Payments for unit-based services with programming.** Amends § 256B.4914, subd. 8. Modifies the list of unit-based services with programming and the rate calculation for unit-based services with programming to include the competitive workforce factor. Makes this section effective January 1, 2020, or upon federal approval, whichever is later. Requires the commissioner of human services to notify the revisor when federal approval has been obtained.
48	**Payments for unit-based services without programming.** Amends § 256B.4914, subd. 9. Modifies the rate calculation for unit-based services without programming to include the competitive workforce factor. Makes this section effective January 1, 2020, or upon federal approval, whichever is later. Requires the commissioner of human services to notify the revisor when federal approval has been obtained.
49	**Updating payment values and additional information.** Amends § 256B.4914, subd. 10. Removes obsolete language related to outdated reporting and implementation requirements and banding. Adds direct care workforce labor market measures to the list of items DHS must review and evaluate under the DWRS. Modifies the frequency of adjustments to the regional variance factors. Requires the commissioner, in consultation with others, to study value-based models and outcome-based payment strategies for fee-for-service home and community-based services and report to the legislature by October 1, 2020, with recommended strategies to promote new models of care and reimbursement structures, assist clients in evaluating options, support person-centered planning, and create a broader range of client options. Makes this section effective the day following final enactment, except for paragraph (f), which is effective January 1, 2020.
50	**Reporting and analysis of cost data.** Amends § 256B.4914, subd. 10a. Adds paragraph (f), which requires providers with rates determined under DWRS to submit labor market data to the commissioner annually beginning November 1, 2019. Adds paragraph (g), which requires the commissioner to publish annual reports on provider and state-level labor market data, beginning February 1, 2020. Adds paragraph (h), which requires the commissioner to: (1) temporarily suspend payments to a provider if data requested under paragraph (f) is not received 90 days after

Section	Description – Article 5: Disability Services
	the required submission date; and (2) make withheld payments once data is received by the commissioner. Makes this section effective the day following final enactment.
51	**Exceptions.** Amends § 256B.4914, subd. 14. Removes obsolete language related to commissioner's reporting requirements and banding. Makes this section effective January 1, 2020.
52	**County or tribal allocations.** Amends § 256B.4914, subd. 15. Removes obsolete language.
53	**Eligibility.** Amends § 256B.85, subd. 3. Specifies a pregnant woman eligible under MA is eligible for community first services and supports (CFSS) without federal financial participation if the woman meets certain criteria. Provides an immediate effective date.
54	**Enhanced rate.** Amends § 256B.85, by adding subd. 7a. Establishes a CFSS enhanced rate of 107.5 percent of the rate paid for CFSS. Specifies the enhanced rate includes any rate adjustment implemented by the commissioner on July 1, 2019, to comply with the terms of the direct support services providers collective bargaining agreement. Provides a July 1, 2019, effective date.
55	**Agency-provider and FMS provider qualifications and duties.** Amends § 256B.85, subd. 10. Requires CFSS agency-providers to maintain documentation of training requirements needed to qualify for an enhanced rate. Provides a July 1, 2019, effective date.
56	**Agency-provider model.** Amends § 256B.85, subd. 11. Requires agency-providers to use all of the revenue generated by an MA rate increase due to a collective bargaining agreement for support worker wages and benefits.
57	**Requirements for enrollment of CFSS agency-providers.** Amends § 256B.85, subd. 12. Requires agency-providers to document that 100 percent of the revenue generated by an MA rate increase due to a collective bargaining agreement is used for support worker wages and benefits.

Section	Description – Article 5: Disability Services
58	**Support workers requirements.** Amends § 256B.85, subd. 16. Specifies CFSS support worker requirements to qualify for the enhanced rate. Provides a July 1, 2019, effective date.
59	**Consumer-directed community supports (CDCS) budget methodology.** Amends Laws 2017, 1st Spec. Sess. ch. 6, art. 1, § 45. **Subd. 1. Exception for persons leaving institutions and crisis residential settings.** No changes. **Subd. 2. Shared services.** Defines "shared services," requires individuals sharing services to use the same financial management services provider, requires individuals sharing services to develop a plan for shared services and a shared services agreement and specifies the information that must be included in the plan and agreement, allows any individual to withdraw from participating in a shared services agreement at any time, and specifies the duties of the lead agency and commissioner. Makes this section effective October 1, 2019, or upon federal approval, whichever is later, except for the commissioner's duties, which are effective immediately. Requires the commissioner of human services to notify the revisor when federal approval is obtained.
60	**Electronic visit verification.** Amends Laws 2017, 1st Spec. Sess. ch. 6, art. 3, § 49. **Subd. 1. Documentation; establishment.** Modifies terminology. **Subd. 2. Definitions.** Modifies terminology and expands the definition of "service." **Subd. 3. Requirements.** Modifies terminology and removes obsolete language. Requires the commissioner to make a state-selected electronic visit verification system available to service providers. **Subd. 3a. Provider requirements.** Specifies provider requirements related to selecting an electronic visit verification system and complying with requirements and the implementation date established by the commissioner. Prohibits reimbursement rates from being reduced as a result of federal action to reduce the federal MA percentage. **Subd. 4. Legislative report.** Removes obsolete language.

Section	Description – Article 5: Disability Services
61	**Individual providers of direct support services.** Ratifies the labor agreement between the state of Minnesota and the Service Employees International Union Healthcare Minnesota, submitted to the Legislative Coordinating Commission on March 11, 2019, and provides a July 1, 2019, effective date.
62	**Rate increase for direct support services providers workforce negotiations.** Requires the commissioner of human services to increase reimbursement rates, individual budgets, grants, or allocations by 2.37 percent for services provided on or after July 1, 2019, to implement the minimum hourly wage, holiday, enhanced rate, and paid time off provisions of the labor agreement between the state of Minnesota and SEIU Healthcare Minnesota.
63	**Direction to commissioner; skilled nurse visit rates.** Requires the commissioner of human services to ensure that skilled nurse visits reimbursed under MA are coded using codes compliant with HIPAA. Defines "skilled nurse visit."
64	**Direction to commissioner; interagency agreements.** Requires the Department of Commerce, Public Utilities Commission, and Department of Human Services to amend all interagency agreements necessary to implement the changes to the Telecommunications Access Minnesota Program by October 1, 2019.
65	**Direction to commissioner; federal authority for reconfigured waiver services.** Requires the commissioner of human services to seek necessary federal authority to implement new and reconfigured waiver services and to notify the revisor when federal approval is obtained and when new services are fully implemented.
66	**Disability waiver reconfiguration.** **Subd. 1. Intent.** Specifies it is the intent of the legislature to reform the MA waiver programs for people with disabilities to simplify administration of the programs, incentivize person-centered supports, enhance each person's personal authority over the person's service choice, align benefits across waivers, encourage equity across programs and populations, and promote long-term sustainability of needed services. Requires the disability waiver reconfiguration to maintain service stability and continuity. **Subd. 2. Report.** By January 15, 2021, requires the commissioner to submit a report to the legislature on any necessary waivers, state plan amendments, requests for new funding or realignment of existing funds, any changes to statutes or rule, and any other federal authority necessary to implement the disability waiver reconfiguration. Also requires the report to include information about the commissioner's work to collect feedback from stakeholders.

Section	Description – Article 5: Disability Services
	Subd. 3. Proposal. By January 15, 2021, requires the commissioner to develop a proposal to reconfigure the MA disability waivers and specifies the information that must be included in the proposal. Requires the commissioner to publish a draft report with sufficient time for interested persons to offer additional feedback.
67	**Direct care workforce rate methodology study.** Requires the commissioner of human services, in consultation with stakeholders, to evaluate the feasibility of developing a rate methodology for the PCA program and CFSS similar to the DWRS and to report to the legislature with recommendations, including proposed legislation, by February 1, 2020.
68	**Direction to commissioner of human services; TEFRA option improvement measures.** Paragraph (a) requires the commissioner of human services, using existing appropriations, to develop content to be included on the MNsure website explaining the TEFRA option under MA for applicants who indicate during the application process that a child in the family has a disability. Paragraph (b) requires the commissioner to: (1) develop a cover letter explaining the TEFRA option under MA, as well as the application and renewal process, to be disseminated along with the application form to applicants who may qualify for MA under the TEFRA option; (2) provide the content and form to the executive director of MNsure for inclusion on the MNsure website; and (3) develop and implement education and training for lead agency staff. Paragraph (c) requires the commissioner to convene a stakeholder group to consider improvements to the TEFRA option enrollment and renewal process. Paragraph (d) lists the membership of the stakeholder group. Paragraph (e) requires the stakeholder group to submit a report of the group's recommended improvements and any associated costs to the commissioner by December 31, 2020. Requires the commissioner to provide a copy of the report to the legislative committees with jurisdiction over MA.
69	**Direction to commissioner; direct care staff compensation report.** By January 15, 2022, requires the commissioner, in consultation with stakeholders, to report to the legislature with recommendations to implement: (1) penalties for providers who do not meet the direct care staff compensation requirements; (2) good cause exemptions for providers who do not meet the direct care staff compensation requirements; and (3) rebasing of the direct care staff compensation requirements.

Section	Description – Article 5: Disability Services
70	**Revisor instruction.** Instructs the revisor, in consultation with others, to prepare legislation for the 2020 legislative session to codify laws governing CDCS.
71	**Revisor instruction.** Instructs the revisor of statutes to renumber Minnesota Statutes, section 256B.4913, subd. 5 (county training), as a subdivision in Minnesota Statutes, section 256B.4914, and to make necessary cross-reference changes in Minnesota Statutes consistent with the renumbering. (This is a technical instruction to move the remaining language of section 256B.4913 into section 256B.4914 once the banding period is completed on December 31, 2019).
72	**Repealer.** Paragraph (a) repeals Minnesota Statutes, § 256B.0705 (PCA; mandated service verification) the day following final enactment. Paragraph (b) repeals Minn. Stat. §§ 252.431 (supported employment services; departmental duties; coordination); 252.451 (business agreements; support and supervision of persons with disabilities) effective September 1, 2019. Paragraph (c) repeals Minn. Stat. §§ 252.41, subd. 8 (supported employment); and 256B.4913, subdivisions 4a (rate stabilization adjustment), 6 (implementation), and 7 (new services), effective January 1, 2020 (these subdivisions all become obsolete once the banding period is completed on December 31, 2019).

Article 6: Chemical and Mental Health

This article modifies provisions related to payment for substance use disorder treatment services, waiver eligibility, and housing support eligibility, and modifies and establishes new requirements related to mental health grants, psychiatric residential treatment facility services, certified community behavioral health clinics, behavioral health homes and medical respite homes, and the transition to community initiative.

Section	Description – Article 6: Chemical and Mental Health
1	**Mental health screening.** Amends § 13.851. Specifies treatment of law enforcement mental health screening data.
2	**Services and programs.** Amends § 245.4661, subd. 9. Adds culturally specific mental health and substance use disorder provider consultation to the list of adult mental health grant programs.
3	**Establishment and authority.** Amends § 245.4889, subd. 1. Adds reference to new section detailing school-linked mental health grants; specifies that children's mental health grantees must obtain all available third-party funding and reimbursement sources. Makes this section effective the day following final enactment.
4	**School-linked mental health grants.** Proposes coding for § 245.4901. **Subd. 1. Establishment.** Directs the commissioner of human services to establish a school-linked mental health grant program. **Subd. 2. Eligible applicants.** Specifies that grant applicants must be: 1) certified as a mental health center or clinic; 2) a community mental health center; 3) an Indian health service facility or facility owned and operated by a tribe; 4) a provider of children's therapeutic services and supports; or 5) enrolled in MA as a mental health or substance use disorder provider agency, with certain staff requirements. **Subd. 3. Allowable grant activities and related expenses.** (a) Lists allowable grant activities and services, and related expenses. (b) Requires grantees to obtain all available third-party reimbursement sources, as a condition of receiving grant funds, excluding public schools. Requires grantees to serve students regardless of health coverage or ability to pay.

Section	Description – Article 6: Chemical and Mental Health
	Subd. 4. Data collection and outcome measurement. Requires grantees to provide data to the commissioner to evaluate the program's effectiveness.
	Makes this section effective the day following final enactment.
5	**Certified community behavioral health clinics.**
	Amends § 245.735, subd. 3.
	(a) Removes reference to the prospective payment system.
	Adds licensed alcohol and drug counselors to clinic staff for CCBHC services.
	Adds substance use to CCBHC services.
	Removes requirement for a CCBHC to be certified to provide integrated treatment for co-occurring mental illness and substance use disorders.
	Adds requirement for CCBHCs to comply with peer services standards under relevant statutes, if the CCBHC provides peer services.
	Modifies terminology throughout.
	(d) Allows the commissioner to grant a variance for a CCBHC that is certified but not approved for prospective payment, if the variance would not increase the state share of costs.
	Removes paragraphs (f), (g), and (h) relating to prospective payments, federal approval and financial participation, and limitations on CCBHC certifications.
	Makes this section effective the day following final enactment.
6	**Admission criteria.**
	Amends § 245F.05, subd. 2. Modifies language governing admission criteria for withdrawal management programs.
7	**Rules for substance use disorder care.**
	Amends § 245A.03, subd. 3. Specifies that initial set of SUD services is approved for a recipient of public assistance if a brief screening result is positive for alcohol or substance misuse. Makes this section contingent on federal approval or July 1, 2019.
8	**Chemical dependency treatment allocation.**
	Amends § 254B.02, subd. 1. Removes language allowing transfer of funds from the chemical dependency fund for administrative purposes. Makes this section effective July 1, 2019.

Section	Description – Article 6: Chemical and Mental Health
9	**Chemical dependency fund payment.** Amends § 254B.03, subd. 2. Adds cross-reference to vendor requirements for payment from the chemical dependency fund for room and board costs. Makes this section effective July 1, 2019.
10	**Division of costs.** Amends § 254B.03, subd. 4. Updates terminology; adds chemical dependency room and board services exception to county share cost percentage. Removes obsolete language. Makes this section effective July 1, 2019.
11	**Eligibility.** Amends § 254B.04, subd. 1. Modifies eligibility for chemical dependency treatment fund services. Specifies that MA enrollees are eligible for substance use disorder treatment room and board services. Makes this section effective July 1, 2019.
12	**Room and board provider requirements.** Amends § 254B.05, subd. 1a. Specifies that IRTS or residential crisis services providers are eligible vendors of room and board, and provides exemption. Makes this section effective September 1, 2019.
13	**State collections.** Amends § 254B.06, subd. 1. Removes language requiring the commissioner to deposit a percentage of state funds to be used for chemical dependency consolidated treatment fund operating costs. Makes this section effective July 1, 2019.
14	**Allocation of collections.** Amends § 254B.06, subd. 2. Removes requirement for the commissioner to allocate all federal financial participation collections to a special revenue account. Removes obsolete language. Makes this section effective July 1, 2019.
15	**Transition to community initiative.** Amends § 256.478. **Subd. 1. Eligibility.** Specifies criteria for eligibility for the transition to community initiative, to assist individuals with transitioning from a state-operated treatment center or hospital. **Subd. 2. Transition grants.** Requires the commissioner to make transition to community grants available to individuals who meet eligibility criteria. Makes this section effective July 1, 2019.

Section	Description – Article 6: Chemical and Mental Health
16	**Certified community behavioral health clinic services.** Adds subdivision 5m to § 256B.0625. (a) Specifies that medical assistance covers CCBHC services that meet the requirements of section 245.735, subdivision 3. (b) Directs the commissioner to establish standards and methodologies for a prospective payment system for medical assistance payments to CCBHCs. (c) Allows the commissioner to limit the number of CCBHCs for the prospective payment system to ensure that claims do not exceed the money appropriated. Requires the commissioner to prioritize CCBHCs that meet criteria listed in this paragraph, in the order listed. (d) Specifies that the prospective payment system must continue to be based on federal instructions for the CCBHC demonstration. Provides exceptions to the federal instructions for the prospective payment system. Makes this section effective July 1, 2019, or upon federal approval, whichever is later.
17	**Integrated care model; mental health case management services by Center for Victims of Torture.** Amends § 256B.0625 by adding subd. 20c. Paragraph (a) requires the commissioner to collaborate with the Center for Victims of Torture to develop a pilot project to support the continued testing of an integrated care model for mental health targeted case management at one designated site. Paragraph (b) requires the commissioner to contract directly with the center to provide services, at $695 per member, per month, with state funding. Paragraph (c) specifies that individuals being served by the center who are eligible for MA and eligible to receive mental health targeted case management will be served using the integrated care model and evaluated using the center's social functioning tool. Paragraph (d) requires the commissioner to collaborate with the center to evaluate whether the social functioning tool can be adapted for more general use. Requires a report to the legislature by July 1, 2020, and annually thereafter, on the results of the evaluation.
18	**Other medical or remedial care.** Amends § 256B.0625, subd. 24. Removes provision excluding licensed substance use disorder treatment programs from subdivision specifying that MA covers other medical or remedial care. Removes provision requiring these services to be paid from the chemical dependency treatment fund. Makes this section effective July 1, 2019.

Section	Description – Article 6: Chemical and Mental Health
19	**Substance use disorder services.** Amends § 256B.0625 by adding subd. 24a. Specifies that MA covers substance use disorder treatment services, except for room and board. Makes this section effective July 1, 2019.
20	**Psychiatric residential treatment facility services for persons younger than 21 years of age.** Amends § 256B.0625, subd. 45a. Increases allowed beds for PRTF services from 150 to 300 and removes limitation on number of sites; requires the commissioner to prioritize PRTF programs that demonstrate capacity to serve children and youth with specified behaviors. Allows current providers of children's residential treatment to submit a letter of intent to develop a PRTF program, in a format developed by the commissioner. Specifies required contents of the letter of intent and requires the commissioner to respond within 60 days regarding approval of the program plan. Specifies process for initiating services. Makes this section effective July 1, 2019.
21	**Payment for Part B Medicare crossover claims.** Amends § 256B.0625, subd. 57. Excludes CCBHCs subject to the new prospective payment system from the limitation on medical assistance payment for an enrollee's cost-sharing associated with Medicare Part B. Makes this section effective July 1, 2019, contingent upon federal approval.
22	**Eligible individual.** Amends § 256B.0757, subd. 2. Modifies provisions governing health home services. Permits commissioner to develop health home models that comply with federal law. Allows for coverage of health home services for persons eligible for medical assistance who have a mental illness or emotional disturbance. Makes this section effective the day following final enactment.
23	**Discharge criteria.** Amends § 256B.0757 by adding subd. 2a. Paragraph (a) specifies that an individual may be discharged from a behavioral health home if: ▪ the provider cannot locate, contact, and engage the individual for over three months, after persistent efforts; or ▪ the individual is unwilling to participate in behavioral health home services.

Section	Description – Article 6: Chemical and Mental Health

Paragraph (b) requires the provider to offer a face-to-face meeting with the individual, the individual's identified supports, and the provider to discuss available options, prior to discharge.

Makes this section effective the day following final enactment.

24 **Designated provider.**

Amends § 256B.0757, subd. 4.

Removes paragraph directing the commissioner to develop and implement certification standards for behavioral health homes.

Makes this section effective the day following final enactment.

25 **Behavioral health home services provider requirements.**

Amends § 256B.0757 by adding subd. 4a.

Requires a behavioral health home services provider to:

1) be an enrolled Minnesota Health Care Programs provider;
2) provide MA-covered primary care or behavioral health service;
3) use electronic health records;
4) use an electronic patient registry;
5) demonstrate capacity to administer approved screenings for substance use disorder or alcohol and tobacco use;
6) demonstrate capacity to make appropriate referrals;
7) have policies and procedures to track and evaluate referrals;
8) conduct a brief needs assessment when services begin;
9) conduct a health wellness assessment with 60 days of intake;
10) conduct a health action plan within 90 days of intake, and at least once every six months;
11) agree to cooperate with state monitoring and evaluation of services; and
12) use an approved form to obtain written consent for behavioral health home services.

Makes this section effective the day following final enactment.

26 **Behavioral health home provider training and practice transformation requirements.**

Amends § 256B.0757 by adding subd. 4b.

Paragraph (a) requires providers to ensure that staff delivering behavioral health home services complete adequate training; specifies what training must include.

Section	Description – Article 6: Chemical and Mental Health

Paragraph (b) requires providers to ensure that staff are capable of delivering culturally responsive services.

Paragraph (c) requires providers to participate in the department's practice transformation activities to support continued skill and competency development.

Makes this section effective the day following final enactment.

27 **Behavioral health home staff qualifications.**

Amends § 256B.0757 by adding subd. 4c. Paragraph (a) requires providers to maintain staff with required and appropriate professional qualifications.

Paragraph (b) requires an integration specialist to be a licensed registered nurse if behavioral health home services are offered in a mental health setting.

Paragraph (c) requires an integration specialist to be a mental health professional if behavioral health home services are offered in a primary care setting.

Paragraph (d) requires the systems navigator to be a mental health practitioner or community health worker, as defined in statute, if behavioral health home services are provided in a mental health or primary care setting.

Paragraph (e) specifies requirements for the qualified health home specialist position.

Makes this section effective the day following final enactment.

28 **Behavioral health home service delivery standards.**

Amends § 256B.0757 by adding subd. 4d.

Paragraph (a) lists service delivery standards a behavioral health home provider must meet.

Paragraph (b) requires the provider to create a plan with the individual and the individual’s supports, to support the individual after discharge from a hospital, residential treatment program, or other setting. Specifies protocols that must be included in the plan.

Paragraph (c) specifies requirements for notification and communication if the individual is enrolled in a managed care plan.

Paragraph (d) requires a provider to provide 60 days’ notice to individuals, the department, and managed care plans, before terminating behavioral health home services; requires a provider to refer individuals receiving services to a new provider.

Section	Description – Article 6: Chemical and Mental Health
29	**Behavioral health home provider variances.** Amends § 256B.0757 by adding subd. 4e. Paragraph (a) allows the commissioner to grant variances to specific behavioral health home requirements. Paragraph (b) allows the commissioner to grant a variance if (1) failure to grant the variance would result in hardship or injustice to the applicant; (2) the variance would be consistent with the public interest; and (3) the variance would not reduce the level of service. Paragraph (c) allows the commissioner to grant a variance for innovative services. Paragraph (d) specifies that the commissioner's decision to grant or deny a variance is not appealable. Makes this section effective the day following final enactment.
30	**Evaluation and continued development.** Amends § 256B.0757, subd. 8. Clarifies language to include behavioral health homes. Makes this section effective the day following final enactment.
31	**Substance use disorder demonstration project.** Proposes coding for § 256B.0759. **Subd. 1. Establishment.** Requires the commissioner to develop and implement a medical assistance demonstration project to test reforms of Minnesota's substance use disorder treatment system. **Subd. 2. Provider participation.** Allows substance use disorder treatment providers to participate in the demonstration project. **Subd. 3. Provider standards.** Requires the commissioner to establish requirements for participating providers, consistent with federal requirements. Specifies that a participating residential provider must be licensed, and lists additional provider requirements. **Subd. 4. Provider payment rates.** Requires payment rates to be increased for services provided to MA enrollees; specifies increase percentages for listed services. **Subd. 5. Federal approval.** Requires the commissioner to seek federal approval for the demonstration project and receive federal financial participation.

Section	Description – Article 6: Chemical and Mental Health
32	**Cost limits for elderly waiver applicants who reside in a nursing facility or other eligible facility.** Amends § 256B.0915, subd. 3b. Removes obsolete language and makes conforming changes in paragraph (a). Paragraph (b) makes persons who meet the eligibility criteria for elderly waiver and a home and community-based transition grant eligible for a special monthly budget limit under the elderly waiver program. Requires the special monthly budget limit to be adjusted annually and specifies the manner in which the special monthly budget limit must be reduced for persons using consumer-directed community supports. Paragraph (c) allows the commissioner to provide an additional payment for documented costs between a threshold determined by the commissioner and the special monthly budget limit to a managed care plan for elderly waiver services for persons who are: (1) eligible for the special monthly budget limit; and (2) enrolled in a managed care plan that provides elderly waiver services. Paragraph (d) allows service rate limits for adult foster care and customized living services to exceed the service rate limits under certain circumstances, providing that the total cost for all services does not exceed the monthly conversion or the special monthly budget limit. Requires service rates to be established using tools provided by the commissioner. Makes this section effective upon federal approval. Requires the commissioner of human services to notify the revisor when federal approval is obtained.
33	**Waiver allocations for transition populations.** Amends § 256B.092, subd. 13. Modifies transition developmental disability waiver language to incorporate the eligibility criteria established in section 256.478. Makes this section effective July 1, 2019.
34	**Per diem rate.** Amends § 256B.0941, subd. 3. Requires the commissioner to establish a per provider per diem rate, rather than a statewide rate, for PRTF services.
35	**Waiver allocations for transition populations.** Amends § 256B.49, subd. 24. Modifies transition brain injury waiver language to incorporate the eligi**bility criteria established in section** 256.478. Makes this section effective July 1, 2019.
36	**Individual eligibility requirements.** Amends § 256I.04, subd. 1. Specifies that an individual is eligible for housing support payments for up to three months if the individual lacks a fixed, adequate nighttime residence upon discharge from a residential behavioral health program. Makes this section effective September 1, 2019.

Section	Description – Article 6: Chemical and Mental Health
37	**Required services.** Amends § 256I.04, subd. 2f. Requires providers serving participants discharged from a residential behavioral health program to assist participants with applying for continuing housing support payments. Makes this section effective September 1, 2019.
38	**Amount of housing support payment.** Amends § 256I.06, subd. 8. Modifies cross-reference. Makes this section effective September 1, 2019.
39	**Intake procedure; approved mental health screening.** Amends § 641.15, subd, 3a. Allows law enforcement to share the names of persons who have screened positive for mental illnesses with the local social services agency, and allows for referral services. Requires destruction of private data if the offender refuses services.
40	**Effective date.** Amends Laws 2017, First Special Session chapter 6, section 71, the effective date. Extends provision governing state-only MA funding for mental health covered services provided in children's residential facilities that have been determined by the federal Centers for Medicare and Medicaid Services to be institutions for mental diseases, indefinitely. Makes this section effective April 30, 2019.
41	**Effective date.** Amends Laws 2017, First Special Session chapter 6, section 72, the effective date. Extends provision governing state-only MA payment rates for mental health services provided in children's residential facilities that have been determined by the federal Centers for Medicare and Medicaid Services to be institutions for mental diseases, indefinitely. Makes this section effective April 30, 2019.
42	**Community competency restoration task force.** **Subd. 1. Establishment; purpose**. Establishes the community competency restoration task force, to evaluate community competency restoration programs and develop recommendations to address the needs of individuals deemed incompetent to stand trial. **Subd. 2. Membership.** Specifies composition of the task force and member qualifications. Requires members to be appointed by July 15, 2019. **Subd. 3. Duties.** Specifies duties of the task force, including: 1) identifying current services and resources available for individuals who have been found incompetent to stand trial;

Section	Description – Article 6: Chemical and Mental Health

2) analyzing current trends of county competency referrals and the impact of diversion projects or stepping-up initiatives;
3) analyzing selected case reviews and other data to identify risk levels, service usage, housing status, and health insurance status prior to being jailed;
4) researching how other states address this issue; and 5) developing recommendations to address the growing number of individuals deemed incompetent to stand trial.

Subd. 4. Officers; meetings. Requires the commissioner of human services to convene the first meeting by August 1, 2019; specifies officer election and meeting procedures.

Subd. 5. Staff. Requires the commissioner of human services to provide staff assistance; allows the task force to use the Council of State Governments Justice Center.

Subd. 6. Report required. Requires the task force to submit a report on its progress and findings to the legislature by February 1, 2020; requires the task force to submit a report to the legislature including recommendations to address the growing number of individuals deemed incompetent to stand trial, by February 1, 2021.

Subd. 7. Expiration. Specifies that the task force expires when the second required report is submitted, or on February 1, 2021, whichever is later.

Makes this section effective the day following final enactment.

43 **Direction to commissioner; improving school-linked mental health grant program.**

Requires the commissioner to collaborate with the commissioner of education and other entities to assess the school-linked mental health grant program and make recommendations for improvement. Specifies what the assessment must include. Requires a report to the legislature. Makes this section effective the day following final enactment.

44 **Direction to commissioner; CCBHC rate methodology.**

Paragraph (a) requires the commissioner to develop recommendations for a rate methodology that reflects each CCBHC's cost of providing the CCBHC services, consistent with applicable federal requirements. Requires the commissioner to consider federal guidance for the CCBHC demonstration program and costs associated with listed services.

Paragraph (b) requires the commissioner to consult with CCBHC providers to develop the rate methodology by February 15, 2020. Requires a report to the legislature on the recommendations for the CCBHC rate methodology and any necessary statutory updates.

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Paragraph (c) specifies that an entity that receives a prospective payment system rate that overlaps with the CCBHC rate is not eligible for a CCBHC rate. Requires the commissioner to consult with CCBHCs and other providers to study a rate methodology that eliminates payment duplication. Requires a report to the legislature by February 15, 2021 on this rate methodology study.

45 **Direction to commissioner; continuum of care-based rate methodology.**

Subd. 1. Rate methodology. (a) Directs the commissioner of human services to develop a comprehensive rate methodology for the CCDTF that reimburses substance use disorder treatment providers for the full continuum of care. Specifies that the new rate methodology must be uniform and statewide, and must accurately reflect provider expenses.

(b) Specifies what the continuum of care-based rate methodology must include.

(c) Allows the commissioner to contract with a health care policy consultant or other entity to provide stakeholder facilitation and provider outreach in order to develop the continuum of care-based rate methodology provide technical assistance.

(d) Requires the commissioner to develop comprehensive billing guidance for the continuum of care-based rate methodology.

(e) Lists stakeholders the commissioner is required to consult when developing the continuum of care-based rate methodology.

Subd. 2. Reports. Requires the commissioner to report to the legislature on any licensure changes necessary to align provider qualifications with the continuum of care-based rate methodology by November 1, 2020, and requires the commissioner to propose legislation for the 2021 legislative session to implement the new methodology.

46 **Repealer.**

Repeals § 254B.03, subd. 4a, relating to division of costs for chemical dependency services on or after October 1, 2008.

Article 7: Mental Health Uniform Service Standards

This article simplifies and streamlines standards for publicly funded mental health services, creating a new chapter, 245I, the Mental Health Uniform Service Standards Act. Chapter 245I establishes common requirements for provider qualifications, administrative procedures, treatment planning, and conducting diagnostic assessments. The article also repeals outdated rules and statutes, codifies relevant rules in statute, and makes conforming cross-reference changes throughout statutes.

Sections 74 to 78 make changes to Mobile Crisis Response services, clarifying situations for mobile crisis team response, prioritizing certain calls and requests, and modifying requirements so a crisis team can gather information from a third party at the scene to establish a need for services.

Additionally, in section 134**,** this article directs the Commissioner of Human Services, in collaboration with stakeholders, to develop a plan for a unified, comprehensive licensing structure for all publicly funded mental health services, prioritizing program integrity, the welfare of persons served, improved integration of mental health and substance use disorder treatment services, and the reduction of administrative burden on providers.

Article 8: Health Care

This article contains provisions related to the medical assistance and MinnesotaCare programs. This article also repeals the sunset of the MinnesotaCare provider tax.

Section	Description – Article 8: Health Care
1	**Classifications.** Amends § 13.69, subd. 1. Requires the Department of Public Safety to provide the last four digits of the Social Security number to the Department of Human Services for recovery of Minnesota health care program benefits paid. Provides a July 1, 2019, effective date.
2	**Transfers.** Amends § 16A.724, subd. 2. Makes a conforming change related to another section in the bill (adding § 256B.0625, subd. 67) which codifies a rider allowing a transfer from the health care access fund to the general fund.
3	**Licensed health care provider.** Amends § 62A.671, subd. 6. Adds community health workers to the list of providers that can provide telemedicine services under private sector health plans and under MA.

Section	Description – Article 8: Health Care
4	**Definitions.** Amends § 62Q.184, subd. 1. The amendment to paragraph (b) includes a preferred drug list developed by MA in the definition of "clinical practice guideline." The amendment to paragraph (d) includes in the definition of health plan company managed care organizations, county-based purchasing plans, and integrated health partnerships participating in MA and Minnesota. These entities under current law are specifically excluded from the definition of health plan company (and therefore not required to comply with step therapy override requirements).
5	**Step therapy override process; transparency.** Amends § 62Q.184, subd. 3. Allows enrollees or providers to appeal the denial of a step therapy override by a health plan company (including MA and MinnesotaCare) using the administrative review process established for human services programs.
6	**Protection from conversion therapy.** Proposes coding for section 214.078. **Subd. 1.** Defines "conversion therapy." **Subd. 2.** (a) Prohibits any mental health practitioner or mental health professional from engaging in conversion therapy with a client under age 18 or with a vulnerable adult, as defined in statute. (b) Specifies that engaging in conversion therapy with clients under 18 or with vulnerable adults may lead to disciplinary action taken by the provider's relevant professional licensing board. Makes this section effective the day following final enactment.
7	**Controlling individual.** Amends § 245A.02, subd. 5a. Updates a cross-reference.
8	**Program management and oversight.** Amends § 245D.081, subd. 3. Updates a cross-reference and makes a technical edit.
9	**Incentive program.** Amends § 256.962, subd. 5. Increases from $25 to $70 the application assistance bonus paid to navigators for enrolling individuals in MA. Provides a July 1, 2019, effective date.

Section	Description – Article 8: Health Care
10	**Hospital payment rates.** Amends § 256.969, subd. 2b. Gives the commissioner ongoing authority to make additional payment adjustments to rebased hospital payment rates (under current law, this authority applies through the next two rebasing periods).
11	**Payments.** Amends § 256.969, subd. 3a. Provides that payments for hospital discharges shall not exceed on a per claim, rather than aggregate as under current law, basis a hospital's charges.
12	**Disproportionate numbers of low-income patients served.** Amends § 256.969, subd. 9. The amendment to paragraph (d) modifies the DSH payment methodology. A new paragraph (f) requires the commissioner to establish an additional payment adjustment for hospitals that provide high levels of administering high-cost drugs to enrollees in fee-for-service MA. Requires the commissioner to consider fee-for-service MA utilization rates and payments for drugs purchased through the 340B program and administered to fee-for-service enrollees. If the adjustment exceeds a hospital's specific disproportionate share hospital limit, requires the commissioner to make a payment to the hospital that equals the nonfederal share of the excess amount. Limits the total nonfederal share of adjustments to $1.5 million. States that the section is effective July 1, 2019, except paragraph (f) is effective for discharges on or after April 1, 2019.
13	**Out-of-state hospitals in local trade areas.** Amends § 256.969, subd. 17. Modifies the admission threshold that governs when an out-of-state hospital has rates established using the procedures and methods that apply to Minnesota hospitals.
14	**Metabolic disorder testing of medical assistance recipients.** Amends § 256.969, subd. 19. Provides that a payment increase related to the cost of metabolic disorder testing of newborns remains in effect until fully recognized in the base year cost.
15	**Competitive bidding.** Amends § 256B.04, subd. 14. Allows the commissioner to volume purchase through competitive bidding and negotiation allergen-reducing products as described in section 256B.0625, subdivision 66, paragraph (c).
16	**Provider enrollment.** Amends § 256B.04, subd. 21. (a) Requires the commissioner to enroll providers and conduct screening activities as required by federal regulations and specifies related requirements.

Section	Description – Article 8: Health Care

(b) Requires the commissioner to revalidate each provider at least once every five years, and personal care assistance agencies once every three years.

(c) Specifies criteria for conducting revalidations.

(d) Allows the commissioner to suspend a provider's ability to bill, if a provider fails to comply with any individual provider requirement or condition of participation. Provides that suspension is not subject to an administrative appeal.

(e) Requires all correspondence and notifications to be delivered electronically, or by first-class mail if a provider does not have a MN-ITS account and mailbox. States that this does not apply to communications related to background studies.

Provides a July 1, 2019, effective date.

17 **Application fee.**

Amends § 256B.04, subd. 22. Strikes language that is reinstated in section 256B.04, subdivision 21. Provides a July 1, 2019, effective date.

18 **Subsidized foster children.**

Amends § 256B.055, subd. 2. Provides MA eligibility for children who are not eligible for Title IV-E assistance (federal payments for foster care) but are determined eligible for foster care or kinship assistance under chapter 256N. Provides a January 1, 2020, effective date.

19 **Asset limitations for certain individuals.**

Amends § 256B.056, subd. 3. Provides that MA will disregard a designated employment incentives asset account when determining MA eligibility for a person who is age 65 or older. Allows such an account to be designated only by a person enrolled in MA as an employed person with a disability (MA-EPD) for a 24-consecutive month period. Strikes existing language which allows a higher asset disregard ($20,000 for an individual after exclusions) for persons formerly eligible under MA-EPD who turn 65 and seek MA eligibility as a person who is elderly, blind, or has a disability (an asset limit of $3,000 for a household of one/$6,000 for a household of two normally applies to this group). Specifies criteria for a designated employment incentives asset account. Provides a July 1, 2019, effective date.

20 **Excess income standard.**

Amends § 256B.056, subd, 5c. Increases the MA spenddown standard for persons who have disabilities, are blind, or are age 65 or older to 83 percent of FPG, effective July 1, 2021.

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21	**Telemedicine services.** Amends § 256B.0625, subd. 3b. Provides an exception from the limit on MA coverage of telemedicine (three services per enrollee per calendar week) if the: 1) telemedicine services provided by the licensed health provider are for the treatment and control of tuberculosis; and 2) services are provided in a manner consistent with the recommendations and best practices specified by the Centers for Disease Control and Prevention and the Commissioner of Health.
22	**Conversion therapy.** Amends § 256B.0625 by adding subdivision 5m, specifying that conversion therapy is not covered by medical assistance.
23	**Dental services.** Amends § 256B.0625, subd. 9. Expands MA coverage of dental services for nonpregnant adults, to include coverage of nonsurgical treatment for periodontal disease, including scaling and root planing once every two years for each quadrant, and routine periodontal maintenance procedures.
24	**Drugs.** Amends § 256B.0625, subd. 13. Strikes language relating to the quantity of over-the-counter medications that may be dispensed. States that the section is effective April 1, 2019, or upon federal approval, whichever is later.
25	**Drug formulary.** Amends § 256B.0625, subd. 13d. Allows MA to cover drugs or active pharmaceutical ingredients used for weight loss. Under current law, the MA formulary only covers drugs for weight loss if they are medically necessary lipase inhibitors used by recipients with Type II diabetes.
26	**Payment rates.** Amends § 256B.0625, subd. 13e. Amends § 256B.0625, subd. 13e. Makes a variety of changes to MA payment methods for outpatient prescription drugs. The changes made in paragraph (a) include: ▪ setting payment based on the ingredient cost of the drugs plus a professional dispensing fee ▪ defining usual and customary price ▪ setting the dispensing fee for drugs meeting the federal definition of "covered outpatient drugs" at $10.48 and specifying dispensing fees for other types of drugs

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- requiring dispensing fees to be pro-rated based upon the quantity of a drug dispensed
- setting the ingredient cost for providers participating in the federal 340B program at the 340B ceiling price or the National Average Drug Acquisition Cost (NADAC), whichever is lower
- requiring 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 (current law sets the maximum amount as that paid by third party payors with maximum allowable cost programs)

The amendment to paragraph (c) eliminates add-ons to the dispensing fee for certain drugs dispensed to long-term care facility residents using a unit dose blister card system.

The amendment to paragraph (d) sets the ingredient cost of a multisource drug at the NADAC of the generic product, or the maximum allowable cost established by the commissioner.

The amendment to paragraph (e) increases, from 20 to 28.6 percent, the discount from the payment rate for drugs obtained through the 340B program.

The amendment to paragraph (f) adds references to the maximum allowable cost and makes changes in terminology, in a provision of law dealing with specialty pharmacy products.

A new paragraph (h) requires the commissioner to contract with a vendor to conduct cost of dispensing surveys for Minnesota pharmacies. Specifies criteria for the survey. Requires the initial survey to be completed by January 1, 2021, and repeated every three years.

A new paragraph (i) requires the commissioner to increase the ingredient cost by two percent for prescription and nonprescription drugs subject to the MinnesotaCare wholesale distributor tax.

States that the section is effective April 1, 2019, or upon federal approval, whichever is later. States that paragraph (i) expires if federal approval is denied.

27 **Prior authorization.**

Amends § 256B.0625, subd. 13f. Eliminates the prohibition on use of prior authorization for certain antihemophilic factor drugs. Provides an immediate effective date.

Paragraph (f) requires MA prior authorization procedures to comply with step therapy override requirements under section 62Q.184.

Provides an immediate effective date, except that paragraph (f) is effective July 1, 2019.

Section	Description – Article 8: Health Care
28	**Transportation costs.** Amends § 256B.0625, subd. 17. Requires all nonemergency medical transportation drivers to be individually enrolled with the commissioner and reported on the claim as the individual providing the service. Removes language requiring consultation with the Minnesota Department of Transportation. Provides a July 1, 2019, effective date.
29	**Transportation services oversight.** Amends § 256B.0625, by adding subd. 17d. Requires the commissioner to contract with a vendor or dedicate staff to oversee providers of nonemergency medical transportation (NEMT) services. Provides a July 1, 2019, effective date.
30	**Transportation provider termination.** Amends § 256B.0625, by adding subd. 17e. Prohibits a terminated NEMT provider from enrolling as a NEMT provider for five years following termination. If the provider seeks reenrollment after the five-year period, requires the provider to be placed on a one-year probation, during which the commissioner shall complete unannounced site visits and request documentation to review compliance with program requirements. Provides an immediate effective date.
31	**Other clinic services.** Amends § 256B.0625, subd. 30. A new paragraph (g) provides that for services provided on or after January 1, 2021, claims for clinic services provided by federally qualified health centers (FQHCs) and rural health clinics shall be paid by the commissioner, according to an annual election by the center or clinic, under the current prospective payment system in paragraph (f) or the alternative payment methodology in paragraph (l). A new paragraph (l) establishes the alternative payment methodology. Provides that all claims for payment of clinic services provided by FQHCs and rural health clinics shall be paid according to specified requirements. This section also replaces references to federally qualified health centers with “FQHC” throughout.
32	**Medical supplies and equipment.** Amends § 256B.0625, subd. 31. States that allergen-reducing products provided according to subdivision 66, paragraph (c), shall be considered durable medical equipment. States that the section is effective January 1, 2020, or upon federal approval, whichever is later.
33	**Payment for Part B Medicare crossover claims.** Amends § 256B.0625, subd. 57. Exempts Indian Health Services from a provision that limits MA payment of an enrollee’s Medicare Part B cost-sharing to the MA allowed

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amount, when the MA rate exceeds the amount paid by Medicare. Provides an immediate effective date.

34 **Enhanced asthma care services.**

Amends § 256B.0625, by adding subd. 66. (a) States that MA covers enhanced asthma care services and related products provided in children's homes for children with poorly controlled asthma. To be eligible, requires a child:

(1) to be under age 21;

(2) to have poorly controlled asthma, defined as having received asthma care from a hospital emergency department at least once in the past year or having been hospitalized for the treatment of asthma at least one in the past year; and

(3) to have received a referral for services and products under this subdivision from a treating health care provider.

(b) States that covered services include home visits provided by a registered environmental health specialist or lead risk assessor credentialed by the Department of Health or a healthy homes specialist credentialed by the Building Performance Institute.

(c) Requires covered products to be identified and recommended for the child by a registered environmental health specialist, healthy homes specialist, lead risk assessor, certified asthma educator, public health nurse, or other health professional providing asthma care, and proven to reduce asthma triggers. Lists specific products covered. Allows the commissioner to determine other products that may be covered, as new best practices for asthma are identified.

(d) Defines a home assessment as a home visit to identify asthma triggers and to provide education on trigger-reducing products. Limits a child to two home assessments, except that an additional home assessment may be provided if the child moves to a new home, a new asthma trigger enters the home, or if the child's health care provider identifies a new allergy for the child. Requires the commissioner to determine the frequency with which a child may receive a product listed in paragraph (c), based on the reasonable expected lifetime of the product.

States that the section is effective January 1, 2020, or upon federal approval, whichever is later.

35 **Provider tax rate increase.**

Amends § 256B.0625, by adding subd. 67. Moves from rider into statute a provision that increases MA and MinnesotaCare payments to managed care plans and MA and MinnesotaCare fee-for-service payments, to reflect MA and MinnesotaCare being subject to the MinnesotaCare provider taxes and the HMO premium tax.

Section	Description – Article 8: Health Care
36	**Grounds for sanctions against vendors.** Amends § 256B.064, subd. 1a. Allows the commissioner to impose sanctions against a pharmacy for failure to respond to a cost of dispensing survey. Provides an effective date of April 1, 2019.
37	**Requirements for provider enrollment of personal care assistance provider agencies.** Amends § 256B.0659, subd. 21. The amendment to paragraph (a) clarifies that personal care provider agencies must provide to the commissioner at the time of enrollment, reenrollment, and revalidation, bond coverage and other information for each business location. Also makes related changes. The amendment to paragraph (c) requires specified employees of personal care provider agencies to complete required training before submitting an application for agency enrollment. A new paragraph (d) requires all surety bonds, fidelity bonds, workers compensation insurance, and liability insurance to be maintained continuously, and specifies related requirements. Provides an immediate effective date.
38	**Payment rate transparency.** Amends § 256B.69, by adding subd. 38. Requires the commissioner to compare fee-for-service MA, Medicare, and MA managed care and county-based purchasing plan aggregate payment rates for the most frequently used services, and publish and update this information on the DHS website. Provides an October 1, 2020, effective date.
39	**Reimbursement for doula services.** Adds § 256B.758. For services provided on or after July 1, 2019, sets MA payment rates for doula services provided by a certified doula at $47 per prenatal or postpartum visit and $488 for attending and providing doula services at birth.
40	**Reimbursement for basic care services.** Amends § 256B.766. Requires payment rates for durable medical equipment, prosthetics, orthotics, or supplies subject to the Medicare limit to be paid at the Medicare rate. States that the section is effective July 1, 2019, subject to federal approval.
41	**Grant program established.** Amends § 256B.79, subd. 2. Modifies the integrated care for high-risk pregnant women pilot program to be continuing grant program.

Section	Description – Article 8: Health Care
42	**Grant awards.** Amends § 256B.79, subd. 3. Removes obsolete date. Specifies that priority in awarding grants must be given to qualified integrated perinatal care collaboratives that have received grants under the pilot program before January 2019.
43	**Eligibility for grants.** Amends § 256B.79, subd. 4. Updates language to reflect change to continuing grant program.
44	**Gaps in communication, support, and care.** Amends § 256B.79, subd. 5. Updates language to reflect change to continuing grant program.
45	**Report.** Amends § 256B.79, subd. 6. Requires the commissioner to report to the legislature by January 31, 2021, and every two years thereafter, about the outcomes of the grant program. Updates language to reflect change to continuing grant program.
46	**Payment of certain providers.** Amends § 256L.11, subd. 2. Provides that alternative payment methodologies shall not apply to MinnesotaCare services provided by FQHCs, rural health clinics, Indian Health Service facilities, and certified behavioral health clinics.
47	**Contingent reduction in tax.** Amends § 295.52, subd. 8. Makes a conforming change related to the continuation of the MinnesotaCare provider tax. Provides an effective date of the day following final enactment.
48	**Advertisement and sales; misrepresentation of conversion therapy.** Amends § 325F.69 by adding a subdivision. Prohibits any person or entity from using any fraudulent or deceptive practices when advertising for or offering conversion therapy. Defines “conversion therapy.”

Section	Description – Article 8: Health Care
49	**Basic health care grants.** Amends Laws 2003, 1st Spec. Sess. ch. 14, art. 13C, § 2, subd. 6, as further amended. Strikes rider language that increased MA and MinnesotaCare managed care payment rates for costs related to elimination of the exemption from the insurance premium and MinnesotaCare provider taxes, and increased fee-for-service rates for payments related to the MinnesotaCare provider tax. (These provisions are reinstated in this bill as codified language.)
50	**Study of clinic costs.** Requires the Commissioner of Human Services to conduct a five-year comparative analysis of the actual change in FQHC and rural health clinic costs versus the CMS FQHC Market Basket inflator, and report findings to the legislature by July 1, 2025.
51	**Repealer.** (a) Repeals sections 256B.0625, subdivision 63 (payment to clinics for mental health or dental services provided on the same day; this concept is included in the alternative payment methodology described in section 256B.0625, subdivision 30, paragraph (l)); 256B.0659, subdivision 22 (annual review of PCA provisions); and 256L.11, subdivision 2a (provision allowing higher payment rates for FQHC services provided to MinnesotaCare families and children). (b) Repeals section 256B.79, subdivision 7 (specifies a June 30, 2019, expiration date for section 256B.79), effective the day following final enactment. (c) Repeals Laws 2011, First Special Session chapter 9, article 6, section 97, subdivision 6, effective the day following final enactment. This provision repeals the MinnesotaCare provider tax, effective for gross revenues received after December 31, 2019.

Article 9: OneCare

This article implements the OneCare Buy-In proposal, and establishes a state premium tax credit and a premium subsidy program. The article also provides MinnesotaCare eligibility for persons affected by the "family glitch," requires the Department of Health to contract for an evaluation of a unified health care financing system, and requires other studies.

Section	Description – Article 9: OneCare
1	**Definitions.** Amends § 62J.497, subd. 1. Excludes state and federal programs under chapters 256B (MA), 256L (MinnesotaCare), and 256T (OneCare Buy-in) from the definition of "group purchaser" used in the electronic prescription drug program.

Section	Description – Article 9: OneCare

2 **Advanced payment of state-based health insurance premium credit.**

Adds § 62V.12. This section requires the MNsure board to determine whether an individual is eligible to receive an advance payment of the health insurance premium tax credit, to notify an eligible individual's health carrier to reduce the individual's premium amount accordingly, and to make advance payments to the health carrier.

Subd. 1. Determination of eligibility for advanced payment of state-based health insurance premium tax credit. Requires the MNsure board to determine an individual's eligibility for an advance payment of the health insurance premium tax credit created in section 4. If eligible, the board must inform the individual's health carrier to deduct a pro rata share of the credit from each month's premium charged to the individual.

To be eligible, an individual must purchase a health plan through MNsure, not be enrolled in medical assistance or MinnesotaCare, and be eligible for the tax credit in section 4. Individuals must also file a state tax return to verify the applicable credit amount; if an individual does not file a tax return for a prior tax year in which advance payments were made, they may not receive further advance payments.

Subd. 2. Payments to health carriers. Requires the board to make the payments referenced in subdivision 1.

Subd. 3. Health carrier responsibilities. Requires a health carrier to reduce the premium amount by an amount equal to the pro rata share of the tax credit, itemize this amount on a covered individual's billing statement, and reconcile these amounts with MNsure.

Subd. 4. Appeals. Allows an individual to appeal eligibility determinations under rules currently established by MNsure.

Subd. 5. Data practices. Applies current data classifications to health insurance premium tax credit applications made under this section.

Subd. 6. Data sharing. Allows MNsure to share data as allowed under current law.

Subd. 7. Appropriations. Appropriates money from the health care access fund to the MNsure board to make the advance payments.

Effective date: Advance payments applied to premiums in plan years 2021 and beyond.

Section	Description – Article 9: OneCare
3	**Definitions.** Adds § 62V.13. Defines the following terms: board, eligible individual, gross premium, health carrier, MNsure, net premium, premium subsidy, and qualified health plan. "Eligible individual" is defined as a Minnesota resident who is not eligible to receive an advance premium tax credit or a premium tax credit for a given month of coverage, is not enrolled in MA or MinnesotaCare, and has purchased a qualified plan through MNsure. "Premium subsidy" is defined as a rebate payment to discount the cost of insurance that is equal to 20 percent of the monthly gross premium paid for qualified health plan coverage that covers the individual, the individual's spouse, and dependents, and is excluded from any calculation when determining eligibility for a DHS program.
4	**Payment to health carriers on behalf of eligible individuals.** Adds § 62V.131. **Subd. 1. Program established.** Requires the board to establish and administer the premium subsidy program to help eligible individuals pay for qualified health plan coverage through MNsure, in plan year 2020 and each subsequent plan year for which an appropriation is approved. **Subd. 2. Administration.** Requires MNsure to determine if an applicant is an eligible individual. For eligible individuals, requires MNsure to calculate the individual's premium subsidy, notify the relevant health carrier of the subsidy amount, and direct the health carrier to deduct the premium subsidy amount from the individual's gross premium, as a discount to the individual's qualified health plan premium. **Subd. 3. Payments to health carriers.** (a) Requires the board to make payments to health carriers equal to the amount of premium subsidy discounts provided, for those months for which eligible individuals paid the net premium amount to the health carrier. Requires payments to health carriers to be based on the premium subsidy provided to an eligible individual, regardless of the cost of coverage purchased. (b) Requires health carriers seeking reimbursement to submit an invoice and supporting information to the board. (c) States that the board shall consider health carriers as vendors (for purposes of agency prompt payment requirements), with each invoice representing the completed delivery of a service. **Subd. 4. Data practices.** States the data classifications for MNsure data apply to data on individuals applying for or receiving a premium subsidy (this has the effect of classifying the data as private data on individuals).

Section	Description – Article 9: OneCare
	Subd. 5. Data sharing. Allows the board to share or disseminate the data in subdivision 4 as provided under MNsure law on data sharing.
5	**Appeals.** Adds § 62V.132. Provides that individuals may appeal initial determinations and redeterminations of eligibility for, and the level of, premium subsidies. Requires the appeals to follow the procedures specified in Minnesota Rules.
6	**Applicability of gross premium.** Adds § 62V.133. States that the premium base for calculating applicable taxes on insurance premiums under chapter 297I (two percent of premiums for indemnity insurers and one percent for HMOs, community integrated service networks, and nonprofit health service plan corporations) shall be the gross premium.
7	**Administration of dental services.** Adds § 256B.0371. (a) Directs the commissioner of human services, effective January 1, 2022, to contract with a dental administrator, to administer dental services to all recipients of MA and MinnesotaCare. (b) Requires the administrator to provide administrative services, including but not limited to: 1) provider recruitment, contracting, and assistance; 2) recipient outreach and assistance; 3) utilization management and medical necessity review for dental services; 4) dental claims processing; 5) coordination with other services; 6) management of fraud and abuse; 7) monitoring access to dental services; 8) performance measurement; 9) quality improvement and evaluation requirements; and 10) management of third-party liability. (c) Sets payments to contracted dental providers at the rates established under § 256B.76 (the MA reimbursement rate). Provides a January 1, 2022, effective date.
8	**Reimbursement under other state health care programs.** Amends § 256B.0644. Requires a vendor of medical care under MA that dispenses outpatient prescription drugs to participate as a provider or contractor in MinnesotaCare, as a condition of participating as an MA provider. Provides a January 1, 2022, effective date.

Section	Description – Article 9: OneCare
9	**Prescription drugs.** Amends § 256B.69, subd. 6d. Requires the commissioner to exclude coverage for prescription drugs from managed care contracts. Strikes a reference to managed care plans administering a prescription drug benefit under MA. Provides a January 1, 2022, effective date.
10	**Statewide procurement.** Amends § 256B.69, subd. 35. For CY 2021, allows the commissioner to extend a managed care or county-based purchasing plan's contract for a sixth year, for the provision of services in the seven-county metropolitan area to MA and MinnesotaCare enrollees who are families and children. Requires MA and MinnesotaCare procurement for this group of individuals in the seven-county metropolitan area for CY 2022.
11	**Dental reimbursement.** Amends § 256B.76, subd. 2. Sunsets, effective January 1, 2022, a 9.65 percent rate increase for dental services provided outside of the seven-county metropolitan area and a 23.8 percent increase for dental services provided to children. Effective January 1, 2022, increases MA dental payment rates by 54 percent. States that this increase does not apply to state-operated dental clinics, federally qualified health centers, rural health centers, or Indian health centers. (This provision has the effect of setting MinnesotaCare dental payment rates at this level, since MinnesotaCare pays providers at the MA rate unless otherwise specified.)
12	**Critical access dental providers.** Amends § 256B.76, subd. 4. Sunsets, effective January 1, 2022, the 37.5 percent MA rate increase paid to critical access dental providers.
13	**Outpatient prescription drugs.** Amends § 256L.03, by adding subd. 7. States that outpatient prescription drugs for all MinnesotaCare enrollees are covered according to § 256L.30. Provides a January 1, 2022, effective date.
14	**Must not have access to employer-subsidized minimum essential coverage.** Amends § 256L.07, subd. 2. Allows an individual who has access to subsidized health coverage through a spouse's or parent's employer, that meets the requirements of minimum essential coverage under federal regulations, to be eligible for MinnesotaCare, if the amount the employee pays for employee and dependent coverage exceeds the required premium contribution.

Section	Description – Article 9: OneCare
15	**Federal waiver.** Amends § 256L.07, by adding subd. 2b. Requires the commissioner of human services, in consultation with the Board of Directors of MNsure, to apply for a federal waiver to allow a person eligible for MinnesotaCare under § 256L.07, subd. 2, paragraph (b) (exemption from no access to subsidized coverage requirement due to the "family glitch"), to enroll in MinnesotaCare and to qualify for advanced premium tax credits and cost-sharing reductions, and qualify to purchase coverage under the OneCare Buy-In. Provides an immediate effective date.
16	**Critical access dental providers.** Amends § 256L.11, subd. 7. Sunsets, effective January 1, 2022, the 20 percent MinnesotaCare rate increase paid to critical access dental providers.
17	**Outpatient prescription drugs.** Adds § 256L.30. **Subd. 1. Establishment of program.** Requires the commissioner to administer and oversee the outpatient prescription drug program for MinnesotaCare. Prohibits the commissioner from including the outpatient pharmacy benefit in a contract with a public or private entity. **Subd. 2. Covered outpatient prescription drugs.** (a) Requires the commissioner, in consultation with the drug formulary committee, to establish an outpatient prescription drug formulary for MinnesotaCare that satisfies the federal essential health benefit requirements. Allows the commissioner to modify the formulary after consulting with the formulary committee and providing for public notice and comment. Exempts the establishment of the formulary from rulemaking. Directs the commissioner to make the formulary available to the public on the agency website. (b) Requires the formulary to contain at least one drug in every U.S. Pharmacopeia category and class or the same number of drugs in each category and class as the essential health benefit benchmark plan, whichever is greater. (c) Allows the commissioner to negotiate drug rebates or discounts directly with a drug manufacturer to place a drug on the formulary. Also allows negotiation of rebates or discounts through a contract with a vendor. Requires the commissioner, beginning January 15, 2022, and each January 15 thereafter, to report to the legislature on the rebates and discounts negotiated, their aggregate dollar value, and how the savings were applied. (d) Allows the commissioner to use prior authorization, and allows the formulary committee to recommend drugs for prior authorization. Allows the commissioner to request that the committee review a drug for prior authorization.

Section	Description – Article 9: OneCare

(e) Specifies procedures to be followed by the commissioner before requiring prior authorization for a drug.

(f) Allows the commissioner to automatically require prior authorization for up to 180 days for any drug approved by the Food and Drug Administration after July 1, 2019. Specifies related criteria.

(g) Allows the commissioner to require prior authorization before nonformulary drugs are eligible for payment.

(h) Requires prior authorization requests to be processed according to federal regulations on essential health benefits and prescription drugs.

Subd. 3. Pharmacy provider participation. (a) Requires pharmacies participating in MA to participate as a provider in the MinnesotaCare outpatient prescription drug program.

(b) Prohibits a pharmacy from refusing services to an enrollee, unless specified conditions apply.

Subd. 4. Covered outpatient prescription drug reimbursement rate. (a) Specifies the basis for determining the amount of payment for prescription drugs.

(b) Specifies the basis for determining the amount of payment for a pharmacy that acquires drugs through the 340B Drug Pricing Program.

(c) Defines the usual and customary price for purposes of the subdivision.

Provides a January 1, 2022, effective date.

Subd. 5. Prescription drug benefit consumer protections. Requires the prescription drug benefit to include the protections in Code of Federal Regulations, title 45, section 156.122, including a standard formulary exception request, expedited exception request, external exception request, and application of coverage appeal laws.

18 **Definitions.**

Adds § 256T.01. Defines the following terms: commissioner, department, essential health benefits, individual market, and MNsure website. Provides an immediate effective date.

19 **OneCare Buy-in.**

Adds § 256T.02.

Subd. 1. Establishment. (a) Requires the commissioner of human services to establish a program to offer products developed for the OneCare Buy-In through the MNsure website.

Section	Description – Article 9: OneCare

(b) Directs the commissioner, in collaboration with the commissioner of commerce and MNsure board, to:

1) establish a cost allocation methodology to reimburse MNsure operations in lieu of the premium withhold;
2) implement mechanisms for financial sustainability and mitigate adverse financial impacts; and
3) coordinate eligibility, coverage, and provider networks to ensure, to the extent possible, continuity of care between MA, MinnesotaCare, and the OneCare Buy-in.

(c) States that the buy-in shall be considered a public health care program for purposes of chapter 62V, and the MinnesotaCare program for purposes of state health care program participation requirements.

(d) States that DHS is deemed to be certified as an HMO, and in compliance with state laws that apply to HMOs. Gives the commissioner the authority to accept and expend federal funds.

(e) Requires OneCare Buy-In health plans, unless otherwise specified, to meet all requirements of chapters 62A (accident and health insurance), 62D (health maintenance organizations), 62K (market rules), 62M (utilization review), 62Q (health plan companies), and 62V (MNsure), determined to be applicable by the regulating authority. Provides that OneCare Buy-In premiums are subject to the 1 percent tax on gross premiums.

Subd. 2. Premium administration and payment. (a) Requires the commissioner to annually establish a per-enrollee monthly premium rate, and to publish the rate by August 1 of each year.

(b) Requires premium administration under the buy-in to be consistent with federal requirements under the Affordable Care Act. Requires premium rates to be established in accordance with section 62A.65, subd. 3 (premium rate restrictions).

Subd. 3. Rates to providers. Requires provider payment rates to be targeted to the current MinnesotaCare rates, plus the aggregate difference between those rates and Medicare rates. Provides that the aggregate must not consider services that receive a Medicare encounter payment.

Subd. 4. Reserve and other financial requirements. (a) Establishes a OneCare Buy-In reserve account and requires enrollee premiums to be deposited into the account. Specifies related requirements.

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(b) Beginning January 1, 2023, requires enrollee premiums to be set at a level to fund all ongoing claims, management, and information technology costs, and the operational and administrative functions of the OneCare Buy-In program.

(c) Prohibits the commissioner from expending state dollars beyond what is specifically appropriated, or transferring funds from other accounts, in order to fund the reserve account or claims costs, or to support ongoing administration and operation of the program and its information technology systems.

Subd. 5. Covered benefits. Requires each health plan established under this chapter to include the essential health benefits under the ACA, dental benefits as provided under MA for adults, and coverage of eyeglasses as provided in Minnesota rules. Allows a health plan to include other services covered under MinnesotaCare.

Subd. 6. Third-party administrator. (a) Allows the commissioner to enter into a contract with a third-party administrator to perform the operational management of the buy-in. Specifies duties of the administrator.

(b) Requires the solicitation of vendors to serve as administrator to meet the requirements of section 16C.06 (procurement requirements).

Subd. 7. Eligibility. (a) In order to be eligible for the buy-in, requires persons to be:

1) a resident of Minnesota; and
2) not eligible for a government-sponsored program as defined under the ACA. Provides that persons entitled to Medicare Part A or enrolled in Medicare Part B are considered eligible for a government-sponsored program. Prohibits persons entitled to premium-free Medicare Part A from refusing to apply for or enroll in Medicare in order to establish eligibility for the buy-in.

(b) Allows persons eligible for a qualified health plan (with or without premium tax credits or cost-sharing reductions) to be eligible to purchase and enroll in the buy-in.

Subd. 8. Enrollment. (a) Allows a person to apply for the buy-in during the annual open and special enrollment periods for MNsure.

(b) Requires annual reenrollment for the buy-in.

Subd. 9. Premium tax credits, cost-sharing reductions, and subsidies. Provides that a person eligible under this chapter, with income not exceeding 400 percent of FPG, may qualify for advance premium tax credits and cost-sharing reductions to purchase a health plan under this chapter.

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Subd. 10. Covered benefits and payment rate modifications. Allows the commissioner, after public notice and comment, to modify covered benefits and payment rates.

Subd. 11. Provider tax. Provides that section 295.582, subdivision 1 (provider pass-through of MinnesotaCare provider tax obligations) applies to health plans offered under the buy-in.

Subd. 12. Hospital financial reimbursement fund. Requires the commissioner to establish and administer a hospital financial reimbursement fund to provide grants or supplemental payments to hospitals to mitigate the financial effects of uncompensated care caused by high deductible health plans.

Subd. 13. Request for federal authority. Requires the commissioner to seek all necessary federal waivers to establish the OneCare buy-in.

Provides that subdivisions 1 to 12 are effective January 1, 2023, and that subdivision 13 is effective the day following final enactment.

20 **OneCare Buy-in products.**

Adds § 256T.03.

Subd. 1. Platinum product. Requires the commissioner to establish a buy-in coverage option at the platinum level, to be made available in all rating areas in the state.

Subd. 2. Silver and gold products. (a) If a rating area lacks an affordable or comprehensive health care coverage option according to standards developed by the commissioner of health, directs the commissioner of human services to offer the following year silver and gold products in the rating area for a five-year period. Allows the commissioner of health to use encounter and pricing data to monitor triggers in the individual market. Also allows that commissioner, effective January 1, 2020, to require additional data elements to be submitted to conduct the necessary analysis.

(b) Requires the commissioner of human services to establish the following coverage options: one silver level plan at 70 percent of the actuarial value of the buy-in option and one gold level plan at 80 percent of the actuarial value.

Subd. 3. Qualified health plan rules. (a) Provides that the coverage options developed under this section are subject to the process under section 62K.06 (metal level mandatory offering). Also deems the coverage options as meeting the requirements of chapters 62A, 62K, and 62V that apply to qualified health plans.

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(b) Provides that benefits under this section are secondary. Requires the commissioner to use cost-avoidance techniques to coordinate with other health coverage and identify persons with other coverage.

(c) States that DHS is not an insurance company for purposes of this chapter.

Subd. 4. Actuarial value. Requires actuarial value to be calculated in accordance with federal regulations (45 CFR 156.135).

Provides a January 1, 2023, effective date.

21 **Outpatient prescription drugs.**

Adds § 256T.04.

Subd. 1. Establishment of program. Requires the commissioner to administer and oversee the outpatient prescription drug program for the OneCare Buy-in program. Prohibits the commissioner from including the outpatient pharmacy benefit in a contract with a public or private entity.

Subd. 2. Covered outpatient prescription drugs. States that outpatient prescription drugs are covered as provided in chapter 256L (MinnesotaCare).

Subd. 3. Pharmacy provider participation. States that pharmacy participation is governed by section 256L.30, subdivision 3.

Subd. 4. Reimbursement rate. Requires the commissioner to establish outpatient prescription drug reimbursement rates according to chapter 256L (MinnesotaCare).

Subd. 5. Prescription drug benefit consumer protections. States that prescription drug benefit consumer protections shall be in accordance with section 256L.30, subdivision 5.

Provides a January 1, 2023, effective date.

22 **Board of Directors of MNsure.**

Amends § 270B.12, by adding subd. 15. Authorizes the commissioner of revenue to disclose tax return information to MNsure to determine eligibility for the premium tax credit.

Effective date: Tax year 2021.

Section	Description – Article 9: OneCare

23 **Health insurance premiums.**

Amends § 290.0131, by adding subd. 15. Requires an addition to taxable income for any deduction taken by a taxpayer for health insurance premiums used to calculate the health insurance premium credit. This ensures that an individual cannot receive the benefit of both the deduction and the credit.

Effective date: Tax year 2021.

24 **Health insurance premium credit.**

Amends § 290.0693.This section creates a health insurance premium credit for certain individuals who are not eligible to receive the federal advance payment tax credit because their income exceeds 400 percent of the federal poverty line, but who nonetheless purchase a qualified health plan through MNsure. The amount of the credit is based on the amount of the federal credit determined under the IRC. Individuals may elect to receive the credit in the form of advance payments that reduce their premium amount.

Subd. 1. Credit allowed. Allows Minnesota residents who do not qualify for the federal premium assistance credit due to income limits to receive a refundable health insurance premium tax credit. The credit is calculated in the manner that the federal credit is calculated, with some modifications:

- a “coverage month” includes a month in which the individual could have obtained minimum essential coverage but did not receive coverage;
- the applicable percentage used to calculate the credit is the highest percentage allowed under the Internal Revenue Code; and
- the amount of monthly premiums used to calculate the credit must be reduced by the amount of any premium subsidy made by MNsure for the individual.

The federal credit is determined based on the premium assistance amount allowed. This amount equals the lesser of:

- a taxpayer’s monthly premium for a qualified health plan (including premiums for spouses and dependents); or
- the excess of the second lowest cost silver plan (SLCSP) available to the taxpayer over the taxpayer’s applicable percentage multiplied by their household income.

The applicable percentage introduces some income sensitivity to the federal credit; as a taxpayer’s income increases, the amount of the premium assistance amount decreases. As income decreases, the assistance amount increases, due to the reduced applicable percentage.

Subd. 2. Advance payment of credit. Allows an individual to claim the credit on their tax return or receive it as an advance credit. For advance payment

Section	Description – Article 9: OneCare

elections, the tax credit is reduced by the advance payments; if the advance payments exceed the credit, the amount of tax due by the taxpayer is increased by that amount.

This subdivision also requires the MNsure board and the commissioner of revenue to reconcile the amount of advance payments made in relation to the amount of the tax credit allowed by this section, and requires the commissioner to provide information to the board regarding individuals who did not file the return required in section 62V.12.

Subd. 3. Reporting requirements. Requires an individual to notify MNsure and the commissioner of revenue regarding changes in an individual's eligibility.

Subd. 4. Appropriation. (a) Appropriates money to the commissioner of revenue from the health care access fund to pay the refunds required in subdivision 2.

(b) Appropriates money each fiscal year from the health care access fund to the commissioner of revenue to administer this section.

Effective date: Tax year 2021.

25 **Nexus in Minnesota.**

Amends § 295.51, subd. 1a. Modifies the nexus rules providing for state jurisdiction to impose the provider tax. The modifications provide two sets of requirements: one for physical presence nexus and one for economic presence nexus.

Current law provides that a wholesale drug distributor has nexus if they have sufficient contacts with or a presence in Minnesota to satisfy the requirements of federal constitutional law.

The proposed changes apply to:

1) wholesale drug distributors;
2) persons who receive legend drugs from a person other than a drug distributor, for resale or use in Minnesota; and
3) persons who sell or repair hearing aids and prescription eyewear.

For all three taxpayers described above, the new requirements define nexus in a variety of scenarios where an entity has a physical presence in the state, by, for instance, employing in-state affiliates to conduct business activities, including those affiliates who use a home office, or by employing a representative in the state to act on its behalf, even if the representative is not permanently located in Minnesota.

In addition, this section provides that taxpayers with economic presence in the state have nexus if they meet certain thresholds for conducting business activities.

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For wholesale drug distributors and legend drug sellers that are not distributors, a taxpayer has nexus if they sell legend drugs in the state from outside the state and meet a threshold for sale, delivery, or distribution (100); gross revenues ($100,000); or price paid ($100,000).

For persons who sell or repair hearing aids or prescription eyeglasses, a taxpayer has nexus if they sell, distribute, or deliver goods into this state and meets one of the same thresholds required for drug distributors.

Taxpayers that have economic presence nexus would be required to file a provider tax return, unless they notify the commissioner of revenue that they no longer meet the threshold nexus requirements.

Effective date: Day following final enactment.

26 **Interest on overpayments.**

Amends § 295.57, subd. 3. Modifies the manner in which the commissioner of revenue must pay interest on overpayments of the provider tax, by requiring that these payments are made as currently required for corporate and individual income taxes.

Effective date: Overpayments made in 2021.

27 **Tax expense transfer.**

Amends § 295.582, subd. 1. Requires purchasers of health care services under the OneCare Buy-In (chapter 256T) to pay amounts transferred by providers due to the MinnesotaCare provider tax.

28 **Health maintenance organizations, nonprofit health service plan corporations, OneCare Buy-In plans, and community integrated service networks.**

Provides that OneCare Buy-In plan premiums are subject to the 1 percent tax on gross premiums. Requires these revenues to be deposited in the hospital financial reimbursement fund established under section 256T.02, subdivision 12. States that the section is effective for premiums received on or after January 1, 2023.

29 **Direction to commissioner; state-based risk adjustment analysis.**

Requires the commissioner of commerce, in consultation with the commissioner of health, to study the design and implementation of a state-based risk adjustment program. Requires the commissioner to report findings and recommendations to the legislature by February 15, 2021.

Section	Description – Article 9: OneCare
30	**Study of cost of providing dental services.** Requires the commissioner of human services to conduct a survey of the cost to dental providers of delivering dental services to MA and MinnesotaCare enrollees under both fee-for-service and managed care. Specifies criteria for the vendor and the survey. Requires enrolled dental vendors to respond to the survey and allows the commissioner to sanction vendors who do not respond. Requires the initial survey to be completed no later than January 1, 2021, and requires the survey to be repeated every three years. Directs the commissioner to provide a summary of the results of each survey and recommendations for any changes in dental rates to the legislature.
31	**Outpatient pharmacy benefit for enrollees of health plan companies.** Requires the commissioner of human services to develop a plan for an outpatient pharmacy benefit for enrollees of health plan companies. Specifies requirements for the plan. Requires the commissioner to present the plan to the legislature by December 15, 2019.
32	**Benefit and cost analysis of a unified health care financing system.** Requires the commissioner of health to contract with the University of Minnesota School of Public Health to conduct an analysis of the current health care financing environment and evaluate whether a unified health care financing system would provide better access to care, reduce or slow the rate of increase in health care spending, and provide other benefits, relative to the current health care financing environment. Specifies the framework of a unified health care financing system and criteria for the analysis. Requires the commissioner to report to the legislature by January 15, 2021.
33	**Rate changes and dental access.** Requires the commissioner of human services, in consultation with stakeholders and the Health Services Policy Committee, to analyze the impact of the dental payment rate changes in this article on access to dental services for MA and MinnesotaCare program participants. Specifies requirements for the analysis. Requires a preliminary report to the legislature by December 1, 2019, and a final report and any recommendations by December 1, 2020.
34	**Repealer.** Repeals § 256L.11, subd. 6a (MinnesotaCare 54 percent payment rate increase for dental providers). Provides a January 1, 2022, effective date.

Article 10: Prescription Drugs

This article contains various provisions related to prescription drugs. The article, in part, requires the licensure of pharmacy benefit managers, prohibits drug manufacturers and wholesalers from charging unconscionable drug prices, includes various drug price and formulary transparency provisions, establishes a prescription drug repository program, establishes an insulin assistance program, and provides for emergency refills and the synchronization of refills.

Section	Description – Article 10: Prescription Drugs
1	**Investigate offenses against provisions of certain designated sections; assist in enforcement.** Amends § 8.31, subd. 1. Directs the attorney general to investigate violations of the prohibition against charging unconscionable prices for prescription drugs.
2	**Restrictions.** Amends § 62J.23, subd. 2. Includes prescription drugs administered through infusion and related services and supplies in the definition of "prescription drug," for purposes of the exemption of prescription drug discounts, price reductions, a limited-time free supply, or samples, from the state application of the Medicare antikickback law.
3	**Drug coverage in emergency situations.** Adds § 62Q.528. Requires a health plan that provides drug coverage to cover drugs under section 151.211, subdivision 3 (emergency prescription refills) under the terms that would apply had the drug been dispensed according to a prescription.
4	**Prescriptions for specialty drugs.** Adds § 62Q.83. Requires a health plan company or its contracted PBM that requires or provides financial incentives for enrollees to use a mail order pharmacy to fill a prescription for a specialty drug to ensure that the mail order pharmacy dispenses the prescription in a timely manner, so that the enrollee receives the filled prescription within five business days of transmittal to the mail order pharmacy. Allows exemptions if certain conditions are met. Provides a January 1, 2020, effective date.
5	**Prescription drug benefit transparency and management.** Adds § 62Q.84. **Subd. 1. Definitions.** Defines the following terms: drug, enrollee contract year, formulary, health plan company, and prescription. **Subd. 2. Prescription drug benefit disclosure.** (a) Requires a health plan company that provides drug coverage and uses a formulary to make its formulary and related benefit information available by electronic means, and upon request in writing, at least 30 days prior to annual renewal dates.

Section	Description – Article 10: Prescription Drugs

(b) Requires formularies to be organized and disclosed consistent with the most recent version of the United States Pharmacopeia's Model Guidelines.

(c) Requires the specific enrollee benefit terms, including cost-sharing and out-of-pocket costs, to be identified for each item or category of items on the formulary.

Subd. 3. Formulary changes. (a) Allows a health plan company, at any time during a contract term, to expand the formulary, reduce copayments or coinsurance, or move a drug to a lower cost benefit category.

(b) Allows a health plan company to remove a brand name drug from the formulary or place the drug in a higher cost benefit category only if a generic or multisource drug rated as therapeutically equivalent, or a biologic drug rated as interchangeable, that is at a lower cost to the enrollee, is added, with at least 60 days' notice.

(c) Allows a health plan company to change utilization review requirements or move drugs to a higher cost benefit category that increases enrollee costs during a contract term, only with 60 days' notice, and provides that the changes do not apply to enrollees taking the drugs for the duration of the contract term.

(d) Allows a health plan company to remove drugs from its formulary that have been deemed unsafe by the Food and Drug Administration (FDA), been withdrawn by the FDA or manufacturer, or when an independent source of research, guidelines, or standards has issued drug-specific warnings or recommended changes in drug usage.

6 **Citation.**

Adds § 62W.01. States that chapter 62W may be cited as the "Minnesota Pharmacy Benefit Manager Licensure and Regulation Act."

7 **Definitions.**

Adds § 62W.02. Defines the following terms: aggregate retained rebate, claims processing service, commissioner, enrollee, health carrier, health plan, mail order pharmacy, maximum allowable cost price, multiple source drugs, network pharmacy, other prescription drug or device services, pharmacist, pharmacy, pharmacy benefit manager, plan sponsor, specialty drug, retail pharmacy, and rebates.

Section	Description – Article 10: Prescription Drugs
8	**License to do business.** Adds § 62W.03. **Subd. 1. General.** Beginning January 1, 2020, prohibits a person from operating as a pharmacy benefit manager, unless the person has a license issued by the commissioner of commerce. States that licenses are nontransferable. **Subd. 2. Application.** Requires PBMs seeking a license to apply to the commissioner of commerce. Specifies requirements for the application form. Requires each application to be accompanied by a nonrefundable fee of $8,500 and evidence of financial responsibility in the amount of $1,000,000. Also requires submittal of the network adequacy report specified in section 62W.05. Specifies timelines and procedures for application review and issuance of a license. **Subd. 3. Renewal.** Provides that a license is valid for three years. Specifies renewal procedures and requires a renewal fee of $8,500. Requires the commissioner to deny a renewal or institute a plan to cure or correct under certain circumstances. **Subd. 4. Oversight.** Authorizes the commissioner to suspend, revoke, or place on probation a PBM license, under specified circumstances. Also allows the commissioner to place restrictions or limitations on a license. **Subd. 5. Penalty.** Provides for a $5,000 per day fine if a PBM acts without a license. **Subd. 6. Rulemaking.** Allows the commissioner to adopt rules to implement this section. **Subd. 7. Enforcement.** Clarifies that the commissioner will enforce this chapter pursuant to chapter 45.
9	**Pharmacy benefit manager general business practices.** Adds § 62W.04. (a) States that a PBM has a fiduciary duty to a health carrier and must discharge that duty in accordance with state and federal law. (b) Requires a PBM to perform its duties with care, skill, prudence, diligence, and professionalism, and exercise good faith and fair dealing in performance of its contractual duties. States that a provision in contract between a PBM and a health carrier or network pharmacy that attempts to waive or limit this obligation is void. (c) Requires a PBM to notify a health carrier in writing of any activity, policy, or practice of the PBM that presents a conflict of interest.

Section	Description – Article 10: Prescription Drugs
10	**Pharmacy benefit manager network adequacy.** Adds § 62W.05. (a) Requires a PBM to provide an adequate and accessible pharmacy network within a service area. Requires a network to include a sufficient number of pharmacies to ensure that pharmacy services are available without unreasonable delay. Requires the commissioner to ensure the maximum travel distance or time to the nearest pharmacy meets the requirements under section 62K.10. States that a mail order pharmacy must not be included when determining the adequacy of a network. (b) Requires a PBM to submit to the commissioner a pharmacy network adequacy report, with license applications and renewals. (c) Allows a PBM to apply for a waiver of the network adequacy requirements in paragraph (a) and specifies waiver criteria. (d) Requires a PBM to establish a pharmacy network service area consistent with the requirements in existing law (section 62K.13) for every network subject to review under this section.
11	**Pharmacy benefit manager transparency.** Adds § 62W.06. **Subd. 1. Transparency to plan sponsors.** Requires a PBM to disclose, upon the request of a plan sponsor, specified information related to the sponsor's prescription drug benefit, including but not limited to, information on: the aggregate amount of rebates received by the PBM for each drug category, other fees received from a drug manufacturer or distributor, de-identified claims level information, the aggregate amount of payments made by the PBM to pharmacies owned and controlled by the PBM and not owned or controlled by the PBM, and fees imposed on or collected from network pharmacies. **Subd. 2. Transparency report to the commissioner.** Beginning June 1, 2020, and annually thereafter, requires each PBM to submit to the commissioner a transparency report for the prior calendar year. Requires the report to include aggregate wholesale acquisition costs, the aggregate amount of rebates received, and the aggregate of all fees received, aggregate retained rebates and other fees, aggregate retained rebate and fees percentage, de-identified and other specified information. Requires the report to be published on the agency website. Specifies the method to be used to calculate the aggregate retained rebate fee percentage. **Subd. 3. Penalty.** Allows the commissioner to impose civil penalties of not more than $1,000 per day per violation of this section.

Section	Description – Article 10: Prescription Drugs
12	**Pharmacy ownership interest; specialty pharmacy services; nondiscrimination.** Adds § 62W.07. (a) Requires PBMs with an ownership interest in a pharmacy (directly or through an affiliate or subsidiary) to disclose to the plan sponsor any difference between the amount paid to a pharmacy and the amount charged to the plan sponsor. (b) Prohibits a PBM (or an affiliate or subsidiary) from owning or having an ownership interest in a patient assistance program or mail order specialty pharmacy, unless it agrees to fair competition, no self-dealing, and no interference with prospective economic advantage, and establishes a firewall between administrative functions and the mail order pharmacy. (c) Prohibits a PBM or health carrier penalizing, requiring, or providing financial incentives to an enrollee as an incentive to use a retail, mail order, specialty, or other network pharmacy in which the PBM has an ownership interest, or that has an ownership interest in the PBM. (d) Prohibits a PBM or health carrier from imposing limits, including quantity or refill frequency limits, on a patient's access to medication, based solely on whether the health carrier or PBM has an ownership interest in a pharmacy, or the pharmacy has an ownership interest in the PBM. (e) Prohibits a PBM from requiring pharmacy accreditation standards or recertification requirements to participate in a network that are inconsistent with, more stringent than, or in addition to federal and state requirements for licensure as a pharmacy. (f) Prohibits a PBM from discriminating against a pharmacy participating in the 340B drug program.
13	**Maximum allowable cost pricing.** Adds § 62W.08. Regulates contracts between a PBM and a pharmacy related to maximum allowable cost pricing. (This language is similar to section 151.71, which is repealed in this article.)
14	**Pharmacy audits.** Adds § 62W.09. Specifies the procedures that PBMs must follow when conducting a pharmacy audit. (This language is similar to sections 151.61 to 151.70, which are repealed in the article.)
15	**Synchronization.** Adds § 62W.10. Requires a contract between a PBM and a pharmacy to allow for the synchronization of prescription drug refills for a patient at least one per year, if specified criteria are met.

Section	Description – Article 10: Prescription Drugs
16	**Gag clause prohibition.** Adds § 62W.11. (a) States that a contract between a PBM or health carrier and a pharmacy or pharmacist may not prohibit, restrict, or penalize the pharmacy or pharmacist from disclosing to the enrollee any health care information deemed by the pharmacy or pharmacist as being appropriate, related to: the nature of treatment; risks or alternatives; the availability of alternative therapies, consultations, or tests; utilization review decisions; the process used to authorize or deny services or benefits; or financial incentives and structures. (b) Requires a pharmacy or pharmacist to provide to an enrollee information on the enrollee's total cost for a prescription drug, where part or all of the cost is paid or reimbursed by the employer-sponsored plan, health carrier, or PBM, in accordance with section 151.214, subdivision 1 (this provision requires pharmacists to provide information on the patient's copayment and either the pharmacy's usual and customary price or the amount the pharmacy will be paid). (c) States that a PBM or health carrier must not prohibit a pharmacist or pharmacy from discussing the information on the total cost of a drug, including the patient's copayment, the pharmacy's usual and customary price, and the net amount the pharmacy will receive from all sources for dispensing the drug. (d) States that a PBM or health carrier must not prohibit a pharmacist or pharmacy from discussing the availability of any therapeutically equivalent alternative prescription drugs or alternative methods of purchase, including paying the pharmacy's usual and customary price when that is less expensive for the enrollee than payment through the enrollee's health plan.
17	**Point of sale.** Adds § 62W.12. Prohibits a PBM or health carrier from requiring an enrollee to make a payment at the point of sale for a covered prescription drug in an amount greater than the lesser of: (1) the applicable copayment; (2) the allowable claim amount; (3) the amount the enrollee would pay purchasing the drug without using a health plan or other source of benefits or discounts; or (4) the amount the pharmacy will be reimbursed from the PBM or health carrier.
18	**Retroactive adjustments.** Adds § 62W.13. Prohibits a PBM from retroactively adjusting a pharmacy claim for a prescription drug, unless the adjustment is a result of a: (1) pharmacy audit under section 62W.09; or (2) technical billing error.

Section	Description – Article 10: Prescription Drugs
19	**Information provision; pharmaceutical assistance programs.** Amends § 147.37. Requires the Board of Medical Practice, at least annually, to encourage its licensees who prescribe drugs to make available to patients information on sources of lower cost prescription drugs, and to provide these licensees with the address for the webpage established by the Board of Pharmacy under section 151.06, subdivision 3. (This provision replaces an existing requirement to provide information on prescription drug manufacturer assistance programs.)
20	**Information provision; pharmaceutical assistance programs.** Adds § 148.192. Requires the Board of Nursing, at least annually, to encourage its licensees who prescribe drugs to make available to patients information on sources of lower cost prescription drugs, and to provide these licensees with the address for the webpage established by the Board of Pharmacy under section 151.06, subdivision 3.
21	**Practitioner.** Amends § 151.01, subd. 23. Includes in the definition of practitioner, for purposes of emergency prescription refills, physician assistants, and dental therapists.
22	**Information provision; sources of lower cost prescription drugs.** Amends § 151.06, by adding subd. 3. (a) Requires the Board of Pharmacy to publish a page on its website that provide regularly updated information on: (1) drug manufacturer patient assistance programs; (2) the prescription drug assistance program established by the Board on Aging; (3) the emergency insulin assistance program under section 256.937; (4) websites on eligibility and enrollment in government-funded programs that help pay for health care costs; (5) the 340B drug program; and (6) any other resources the board deems is useful for individuals attempting to purchase drugs at lower costs. (b) Requires the board to prepare educational documents and materials on the information provided under paragraph (a). Specifies related requirements. (c) Requires the board, at least annually, to encourage licensed pharmacists and pharmacies to make available to patients information on sources of lower cost prescription drugs, and provide these licensees with the address for the web page established under paragraph (a).

Section	Description – Article 10: Prescription Drugs
23	**Forms of disciplinary action.** Amends § 151.071, subd. 1. Allows the Board of Pharmacy to impose a civil penalty not exceeding $25,000 for each separate violation of section 151.462 (prohibition against charging unconscionable prices).
24	**Grounds for disciplinary action.** Amends § 151.071, subd. 2. Classifies a violation of section 151.462 (prohibition against charging unconscionable prices) by a manufacturer or wholesale drug distributor as prohibited conduct and grounds for disciplinary action by the Board of Pharmacy.
25	**Drug formulary.** Amends § 151.21, subd. 7. Limits an exemption from drug substitution and other requirements when a drug is dispensed to persons covered by a managed care plan with a mandatory or closed drug formulary to subdivision 3 (required generic substitution except when prescriber indicates "dispense as written"), rather than all of section 151.21.
26	**Coverage by substitution.** Amends § 151.21, by adding subd. 7a. When a pharmacist receives a prescription in which the prescriber has not expressly indicated is to be dispensed as communicated, and the prescribed drug is not covered under the purchaser's health or prescription drug plan, allows the pharmacist to dispense a therapeutically equivalent and interchangeable prescribed drug or biological product that is covered under the purchaser's plan, if the pharmacist has a written protocol with the prescriber. Specifies related notice requirements.
27	**Refill requirements.** Amends § 151.211, subd. 2. Makes a conforming change to section 152.211, subdivision 3 (emergency prescription refills).
28	**Emergency prescription refills.** Amends § 151.211, by adding subd. 3. (a) Provides that a pharmacist, using sound professional judgment and in accordance with accepted standards of practice, may dispense a legend drug without a current prescription, if all of the following conditions are met: (1) the patient has been compliant with taking the medication and has consistently had the drug filled or refilled as demonstrated by pharmacy records; (2) the pharmacy has a record of the prescription drug order for the patient, but the prescription does not provide for a refill or the time for providing refills has elapsed;

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(3) the pharmacist is unable to contact the practitioner who issued the prescription, or another practitioner responsible for the patient's care, to obtain refill authorization;

(4) the drug is essential to sustain the life of the patient or to continue therapy for a chronic condition;

(6) failure to dispense the drug would harm patient health; and

(6) the drug is not a controlled substance, except for a controlled substance prescribed to treat a seizure disorder, for which a 72-hour supply may be dispensed.

(b) Limits the amount dispensed to a 30-day supply, or the quantity originally prescribed, whichever is less, except for seizure medications. If the standard unit of dispensing exceeds a 30-day supply, the amount of drug dispensed or sold must not exceed the standard unit of dispensing.

(c) Prohibits a pharmacist from dispensing or selling the same drug to the same patient more than once in a 12-month period.

(d) Requires a pharmacist to notify the practitioner who issued the prescription within 72 hours of the drug being sold or dispensed. Requires authorization before any additional refills may be dispensed.

(e) Requires the record of the drug sold or dispensed under this section to be maintained in the same manner as other prescriptions.

29 **Requirements.**

Amends § 151.252, subd. 1. Requires a manufacturer of insulin to pay to the Board of Pharmacy the applicable insulin registration fee specified in section 151.254, by June 1 of each year, beginning June 1, 2020. Allows the board to assess a late fee, and requires the board to deposit fees into the insulin assistance account.

30 **Insulin registration fee.**

Adds § 151.77.

Subd. 1. Definition. Defines "manufacturer" and "wholesaler."

Subd. 2. Reporting requirements. (a) By March 1 of each year, beginning March 1, 2020, requires manufacturers and wholesale drug distributors to report to the board every sale, delivery, or other distribution within or into the state of insulin that occurred during the previous calendar year in a manner specified by the board. Allows the board to assess an administrative penalty of $100 per day for noncompliance.

(b) By March 1 of each year, beginning March 1, 2020, requires owners of pharmacies with at least one location in the state to report to the board the

Section	Description – Article 10: Prescription Drugs

intracompany delivery or distribution into the state of insulin, if this is not reported by a licensed wholesale drug distributor. Requires reporting to be done as specified by the board, for deliveries and distributions for the previous calendar year.

Subd. 3. Determination of the manufacturer's registration fee. (a) Requires the board to annually assess manufacturers a fee that in the aggregate equals the total cost of the insulin assistance program, including administrative costs, and to determine each manufacturer's annual registration on a pro-rated basis based on the manufacturer's percentage of the total number of units reported. Requires the commissioner of human services to notify the board of the estimated costs of the program for the first fiscal year.

(b) Requires the board to notify each manufacturer, by April 1 of each year beginning April 1, 2020, of the annual fee amount that must be paid.

(c) Allows a manufacturer to dispute the registration fee within 30 days after notification, and specifies the procedures to be used. Requires a manufacturer disputing the fee to still remit the fee.

31 **Prohibition against charging unconscionable prices for prescription drugs.**

Adds § 151.462.

Subd. 1. Purpose. Provides a purpose statement.

Subd. 2. Definitions. Defines the following terms: essential prescription drug, unconscionable price, health plan company, and wholesale acquisition cost.

"Essential prescription drug" is defined as a drug that is prescribed in Minnesota: (1) that is either: (i) covered by MA or a Minnesota Medicare Part D plan; or (ii) has been designated by the commissioner of human services as an essential medicine; and

(2) for which the wholesale acquisition cost in various formats exceeds $80. The term also includes drug-device combination products.

"Unconscionable price" means a price that: (1) is not justified by the costs of inventing, producing, selling, and distributing the drug and expanding access to the drug; and (2) applies to an essential prescription drug sold to: (i) consumers in Minnesota; (ii) the commissioner of human services for use in a Minnesota public healthcare program; or (iii) a health plan company providing care to Minnesota consumers, and the consumer, commissioner, or health plan company has no meaningful choice about whether to purchase the drug, because there is no comparable drug sold in Minnesota whose price is justified.

Subd. 3. Prohibition. Prohibits a manufacturer or wholesale drug distributor from charging or causing to be charged an unconscionable price for an essential prescription drug. States that it is not a violation for a wholesale drug distributor

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to increase the price of the drug if this is directly attributable to additional costs imposed by the manufacturer.

Subd. 4. Commissioner of human services; list of essential prescription drugs. Allows the commissioner of human services, in consultation with the DHS formulary committee, to designate essential medicines. Requires the commissioner to maintain a list of all essential prescription drugs on the agency website. Exempts the commissioner from rulemaking under chapter 14 when designating essential medicines and compiling the list of essential prescription drugs.

Subd. 5. Notification of attorney general. Requires the Board of Pharmacy, the commissioner of human services, and health plan companies to notify the attorney general of any increase, during a one-year period, of 15 percent of more in the price of an essential prescription drug sold in Minnesota.

Subd. 6. Attorney general's office to confer with drug manufacturer or distributor. Requires the attorney general, in order to bring an action for charging an unconscionable price, to provide the manufacturer or distributor with an opportunity to meet with the attorney general to justify the price of the essential prescription drug.

Subd. 7. Private right of action. States that any action brought pursuant to section 8.31, subdivision 3a (private remedies and civil action) by a person injured by a violation of this section is for the benefit of the public.

Subd. 8. Severability. States that provisions and parts of provisions of the section, or its effective date, are severable.

Effective date. Provides that the section is effective the day following final enactment and applies retroactively to any prices charged by a manufacturer or distributor for essential prescription drugs sold or distributed in Minnesota on or after July 1, 2014.

32 **Prescription drug repository program.**

Adds § 151.555.

Subd. 1. Definitions. Defines the following terms: central repository; distribute; donor; drug; health care facility; local repository; medical supplies; original, sealed, unopened, tamper-evident packaging; and practitioner.

"Central repository" means a wholesale distributor that meets certain requirements and enters into a contract with the Board of Pharmacy.

"Donor" means a health care facility, skilled nursing facility, assisted living facility meeting certain requirements, pharmacy, drug wholesaler, drug manufacturer, or an individual at least 18 years of age.

"Health care facility" means a physician's office or health care clinic, hospital, pharmacy, or nonprofit community clinic.

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"Local repository" means a health care facility that elects to accept donated drugs and meets certain requirements.

Subd. 2. Establishment. Requires the Board of Pharmacy to establish, by January 1, 2020, a drug repository program through which donors may donate a drug or medical supply, to be used by eligible individuals. Requires the board to contract with a central repository to implement and administer the program.

Subd. 3. Central repository requirements. Requires the board to select a wholesale drug distributor to act as central repository using a request for proposal process. Specifies related requirements.

Subd. 4. Local repository requirements. In order to serve as a local repository, requires a health care facility to agree to comply with all federal and state requirements related to the drug repository program, drug storage, and dispensing, and maintain any required state license or registration. Specifies application requirements. Provides that participation as a drug repository is voluntary and specifies the process to be used to withdraw from participation.

Subd. 5. Individual eligibility and application requirements. (a) In order to participate in the program, requires an individual to submit an application form to the local repository that attests that the individual: (1) is a state resident; (2) is uninsured and not enrolled in MA or MinnesotaCare, has no prescription drug coverage, or is underinsured; (3) acknowledges that the drugs or medical supplies received may have been donated; and (4) consents to a waiver of child resistant packaging requirements. Requires the local repository to issue eligible individuals with an identification card that is valid for one year, can be used at any local repository, and may be reissued upon expiration. Requires the local repository to send a copy of the application form to the central repository. Requires the board to make available on its website an application form and the format for the identification card.

Subd. 6. Standards and procedure. (a) Allows a donor to donate to the central repository or a local repository prescription drugs and medical supplies that meet specified requirements.

(b) Specifies requirements for prescriptions drugs to be eligible for donation.

(c) Specifies requirements for medical supplies to be eligible for donation.

(d) Requires the board to develop a drug repository donor form, which must accompany each donation. Specifies requirements for the form and requires the form to be available on the board's website.

(e) Allows donated drugs and supplies to be shipped or delivered to the central repository or a local repository. Requires the drugs and supplies to be inspected

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by the pharmacist or other practitioner designated by the repository to accept donations. Prohibits the use of a drop box to deliver or accept donations.

(f) Requires the central repository and local repository to inventory all drugs and supplies that are donated, and specifies related requirements.

Subd. 7. Standards and procedures for inspecting and storing donated prescription drugs and supplies. (a) Specifies requirements for the pharmacist or authorized practitioner to follow when inspecting all donated drugs and supplies.

(b) Specifies storage requirements for donated drugs and supplies.

(c) Requires the central repository and local repositories to dispose of all drugs and supplies not suitable for donation in compliance with applicable federal and state requirements related to hazardous waste.

(d) Requires shipments or deliveries of controlled substances or drugs that can only be dispensed to a patient registered with the drug's manufacturer to be documented by the central or local repository, and returned immediately to the donor or donor's representative that provided the drugs.

(e) Requires each repository to develop drug and medical supply recall policies and procedures, and specifies related requirements.

(f) Specifies record keeping requirements related to donated drugs and supplies that are destroyed.

Subd. 8. Dispensing requirements. (a) Allows donated drugs and supplies to be dispensed if they are prescribed by a practitioner for the eligible individual. Specifies related requirements.

(b) Requires the visual inspection of a drug or supply for adulteration, misbranding, tampering, and expiration, and prohibits dispensing or administering of drugs meeting these criteria.

(c) Requires individuals to sign a drug repository recipient form and specifies form requirements.

Subd. 9. Handling fees. (a) Allows a repository to charge an individual receiving a drug or supply a handling fee of no more than 250 percent of the MA dispensing fee.

(b) Prohibits a repository from receiving MA or MinnesotaCare reimbursement for a drug or supply provided through the program.

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	Subd. 10. Distribution of donated drugs and supplies. (a) Allows the central repository and local repositories to distribute donated drugs and supplies to other repositories. (b) Requires a local repository that elects not to participate to transfer all donated drugs and supplies to the central repository, and provide copies of the donor forms at the time of the transfer. **Subd. 11. Forms and record-keeping requirements.** (a) Specifies forms that must be available on the board's website. (b) Requires all records to be maintained by a repository for at least five years, and maintained pursuant to all applicable practice acts. (c) Requires data collected by the program from local repositories to be submitted quarterly or upon request of the central repository. (d) Requires the central repository to submit reports to the board as required by contract or upon request. **Subd. 12. Liability.** (a) Provides that manufacturers are not subject to criminal or civil liability for causes of action related to: (1) alteration of a drug or supply by a party not under the control of the manufacturer; or (2) failure of a party not under the control of the manufacturer to communicate product or consumer information or the expiration date of a donated drug or supply. (b) Provides civil immunity for a health care facility, pharmacist, practitioner, or donor related to participation in the program and also prohibits a health-related licensing board from taking disciplinary action. States that immunity does not apply if the act or omission involves reckless, wanton, or intentional misconduct, or malpractice unrelated to the quality of the drug or supply. **Subd. 13. Drug returned for credit.** States that this section does not allow a donation when federal or state law requires the drug to be returned to the dispensing pharmacy, for purposes of crediting the payer for the amount of drug returned.
33	**Prescription drug price transparency act.** Adds § 151.80. States that sections 151.80 to 151.83 shall be known as the Prescription Drug Price Transparency Act.
34	**Definitions.** Adds § 151.81. Defines the following terms: commissioner, new prescription drug, patient assistance program, prescription drug, price, and profit.

Section	Description – Article 10: Prescription Drugs
35	**Reporting prescription drug prices.**

Adds § 151.83.

Subd. 1. Applicability. Requires manufacturers to report the information described in subdivisions 2, 3, and 4 to the commissioner of health, beginning October 1, 2019.

Subd. 2. Prescription drug price increases reporting. For prescription drugs priced more than $40 for a course of therapy, whose price increases by 10 percent or more in a 12-month period or 16 percent or more in a 24-month period, requires a manufacturer to report to the commissioner at least 60 days in advance of the increase, the following information on drug pricing and drug costs:

(1) the wholesale acquisition cost (WAC) of the drug for each of the previous five calendar years;

(2) the price increase as a percentage of the drug's price for each of the last five calendar years;

(3) the price at initial launch;

(4) the factors that contributed to the price increase;

(5) the introductory price when approved for marketing;

(6) directs costs incurred by the manufacturer related to manufacture, marketing, research and development, distribution, other administrative costs, and profit;

(7) percentage of the price spent on developing, manufacturing, and distributing the drug;

(8) a description of any change or improvement in the drug that necessitates the price increase;

(9) the amount of financial assistance provided through any patient assistance program;

(10) any agreement contingent upon any delay in marketing a generic version;

(11) the patent expiration date;

(12) research and development costs paid using public funds;

(13) any other information the manufacturer deems relevant; and

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(14) supporting documentation.

Subd. 3. New prescription drug price reporting. For new brand name prescription drugs priced over $500 for a 30-day supply or generics priced over $200 for a 30-day supply, requires a manufacturer to report to the commissioner within 60 days of introduction, the following information on drug pricing and drug costs:

(1) the wholesale acquisition cost of the drug;

(2) the price at initial launch;

(3) the factors that contributed to the price;

(4) direct costs incurred by the manufacturer related to manufacture, marketing, research and development, distribution, other administrative costs, and profit;

(5) percentage of the price spent on developing, manufacturing, and distributing the drug;

(6) the amount of financial assistance provided through any patient assistance program;

(7) any agreement contingent upon any delay in marketing a generic version;

(8) the patent expiration date;

(9) research and development costs paid using public funds;

(10) any other information deemed relevant by the manufacturer; and

(11) supporting documentation.

Subd. 4. Newly acquired prescription drug reporting. For newly acquired brand name prescription drugs priced over $100 for a 30-day supply or generics priced over $50 for a 30-day supply, requires the manufacturer to report to the commissioner at least 60 days in advance of acquisition, the following information on drug pricing and drug costs:

(1) the wholesale acquisition cost of the drug at acquisition and in the prior calendar year;

(2) name of the company from which the drug was acquired and related information;

(3) year the drug was introduced and the WAC of the drug at the time of introduction;

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(4) the WAC for the previous five years;

(5) direct costs incurred by the manufacturer related to manufacture, marketing, research and development, distribution, other administrative costs, and profit;

(6) percentage of the price projected to be spent on developing, manufacturing, and distributing the drug;

(7) the amount of financial assistance provided through any patient assistance program;

(8) any agreement contingent upon any delay in marketing a generic version;

(9) the patent expiration date;

(10) research and development costs paid using public funds; and

(11) if available, the price as determined reasonable through effectiveness measures.

Subd. 5. Comparison data. Allows the commissioner to use any publicly available price information to verify prices reported by manufacturers.

Subd. 6. Additional information requested. Allows the commissioner to make a written request to a manufacturer for supporting documentation or additional information.

Subd. 7. Public posting of prescription drug price information. (a) Requires the commissioner to post on the department website, 30 days before a price change is effective, a list of drugs reported by a manufacturer and the information reported under subdivisions 2 to 6.

(b) Prohibits the commissioner from posting information that is not public data or information not related to the price of a drug that the commissioner determines is not in the public interest to disclose.

(c) Requires the commissioner to announce the posting and allow for public comment.

(d) Requires the commissioner to post a report on information withheld.

Subd. 8. Consultation. Allows the commissioner to consult with a nonprofit dedicated to collecting and reporting health data, and the commissioner of commerce, on the form and format of information posted and other implementation issues.

Subd. 9. Legislative report. By January 15, 2021, and annually each January 15 thereafter, requires the commissioner to report to the legislature on

Section	Description – Article 10: Prescription Drugs

implementation, including the effectiveness of addressing specified goals. Specifies other criteria for the report.

36 **Enforcement and penalties.** Adds § 151.84.

Subd. 1. Civil monetary penalties. Provides that a manufacturer may be subject to a civil penalty for failing to submit timely reports, failing to provide information, failing to respond in a timely manner to requests for additional information, and providing inaccurate or incomplete information.

Subd. 2. Enforcement. Directs the commissioner to adopt a schedule of penalties, based on severity. Directs the commissioner to impose civil penalties as provided in law governing agency administrative penalties. Allows the commissioner to remit or mitigate civil penalties. Requires civil penalties to be paid to the commissioner of management and budget and deposited in the health care access fund.

37 **Insulin assistance program.**

Adds § 256.937.

Subd. 1. Establishment. (a) Requires the commissioner of human services to implement an insulin assistance program by July 1, 2020. Requires the commissioner to:

(1) pay participating pharmacies for insulin dispensed to an eligible individual; and

(2) ensure pharmacy participation in all areas of the state and maintain an up to date list of participating pharmacies on the department's website.

Subd. 2. Eligible individual. (a) Requires individuals to submit a signed application to the commissioner. To be eligible, an individual must:

(1) be a resident of Minnesota;

(2) not be eligible for Medicare, MA, or MinnesotaCare;

(3) have a family income that does not exceed 400 percent of FPG; and

(4) be uninsured, have no prescription drug coverage, or be covered by an individual or group health plan with an out-of-pocket limit of $5,000 or greater.

States that eligibility for the program is subject to the limits of available funding.

(b) Requires the commissioner to develop an application form and make this form available. States that applicants must include their income and insurance

Section	Description – Article 10: Prescription Drugs

status with the application. Provides that the commissioner may require the applicant to submit additional information if necessary to verify eligibility.

(c) Requires the commissioner to determine eligibility for the program, upon receipt of the application and any additional information, and issue persons determined eligible with an identification card. Provides that the card is valid for 90 days and may be used at any participating pharmacy. States that an individual is not eligible for renewal until 12 months from the card's expiration date, at which time a new application must be submitted.

Subd. 3. Pharmacy participation. (a) States that pharmacy participation is voluntary. In order to participate, requires pharmacies to register with the commissioner and agree to reimbursement and contract terms. Allows a pharmacy to withdraw from participation by providing written notice.

(b) Requires pharmacies to dispense insulin to eligible individuals who present a valid prescription and an identification card.

(c) Requires eligible individuals to pay to the pharmacy a copayment equal to the MinnesotaCare prescription drug copayment (currently $6 generic/$20 brand name).

(d) For persons with coverage through a health plan, requires the pharmacy to process the insulin according to the health plan.

(e) Requires pharmacies, when dispensing insulin to an eligible individual, to provide the address for the web page established under section 151.06, subdivision 3, paragraph (a).

38 **Insulin assistance account.**

Adds § 256.938.

Subd. 1. Establishment. Establishes the insulin account in the special revenue fund in the state treasury. Requires insulin registration fees collected by the Board of Pharmacy to be deposited into the account.

Subd. 2. Use of account funds. For fiscal year 2021 and subsequent fiscal years, appropriates money in the account to the commissioner of human services to fund the insulin assistance program.

39 **Service delivery.**

Amends § 256B.69, subd. 6. Requires managed care plans and county-based purchasing plans under Medical Assistance to comply with section 62Q.83 (time limits for filling specialty drug prescriptions).

Section	Description – Article 10: Prescription Drugs
40	**Severability.** Provides that if a provision related to PBM licensure is held invalid or unenforceable, the remaining sections are not affected and the provisions are severable.
41	**Citation.** States that specified sections of this article may be cited as "The Alec Smith Emergency Insulin Act."
42	**Repealer.** Repeals the following statutory provisions: ▪ 151.214, subdivision 2 – prohibition on disclosure by pharmacy ▪ 151.60, 151,61, 151.62, 151.63, 151.64, 151.65, 151.66, 151.67, 151.68, 151.69, and 151.70 – pharmacy audit integrity program ▪ 151.71 – maximum allowable cost pricing

Article 11: Health-Related Licensing Boards

This article modifies fees for the following health-related licensing boards and professions by moving fees from rule to statute, increasing licensing fees, or adding new fees:

- Board of Nursing Home Administrators
- Traditional midwives
- Naturopathic doctors
- Genetic counselors
- Board of Optometry
- Board of Occupational Therapy Practice
- Athletic trainers
- Board of Psychology
- Board of Social Work
- Board of Dentistry
- Board of Pharmacy

The article also makes changes related to the Pharmacy Practice Act and to the Prescription Monitoring Program.

Section	Description – Article 11: Health-Related Licensing Boards
1	**Fees.** Proposes coding for § 144A.39. Moves the Board of Nursing Home Administrators fees from Minnesota Rules, part 6400.6970 to this section, adds fees, and increases fee amounts.
2	**Additional fees.** Amends § 147D.27 by adding subd. 5. Makes technical correction to codify all current traditional midwife licensing fees. Makes this section effective the day following final enactment.
3	**Fees.** Amends § 147E.40, subd. 1. Makes technical correction to codify all current naturopathic doctor licensing fees. Makes this section effective the day following final enactment.

Section	Description – Article 11: Health-Related Licensing Boards
4	**Fees.** Amends § 147F.17, subd. 1. Makes technical correction to codify all current genetic counselor licensing fees. Makes this section effective the day following final enactment.
5	**License renewal; license and registration fees.** Amends § 148.59. Increases Board of Optometry annual licensure renewal fee; adds fees for state juris prudence examination and miscellaneous labels and data retrieval.
6	**Initial licensure fee.** Amends § 148.6445, subd. 1. Increases initial licensure fee for occupational therapists and occupational therapy assistants.
7	**Licensure renewal fee.** Amends § 148.6445, subd. 2. Increases biennial licensure renewal fee for occupational therapists and occupational therapy assistants.
8	**Duplicate license fee.** Amends § 148.6445, subd. 2a. Increases occupational therapy duplicate license fee.
9	**Late fee.** Amends § 148.6445, subd. 3. Increases occupational therapy late renewal fee.
10	**Temporary licensure fee.** Amends § 148.6445, subd. 4. Increases occupational therapy temporary licensure fee.
11	**Limited licensure fee.** Amends § 148.6445, subd. 5. Increases occupational therapy limited licensure fee.
12	**Fee for course approval after lapse of licensure.** Amends § 148.6445, subd. 6. Increases occupational therapy fee for course approval after lapse of licensure.
13	**Use of fees.** Amends § 148.6445, subd. 10. Specifies that occupational therapy licensure fees are for the exclusive use of the board and shall not exceed the amounts listed in the section.

Section	Description – Article 11: Health-Related Licensing Boards
14	**Fees.** Amends § 148.7815, subd. 1. Makes technical correction to codify all current athletic trainer licensing fees. Makes this section effective the day following final enactment.
15	**Fees.** Proposes coding for § 148.981. **Subd. 1. Licensing fees.** Moves psychology licensure fees from rule to statute. Adds fee for optional post-doctoral supervised experience pre-approval. **Subd. 2. Continuing education sponsor fee.** Moves fee from rule to statute. Makes this section effective the day following final enactment.
16	**Fee amounts.** A**mends § 148E.180.** **Subd. 1. Application fees.** Increases social work licensing application fees. **Subd. 2. License fees.** Increases social work licensing fees. **Subd. 3. Renewal fees.** Increases social work licensure renewal fees. **Subd. 4. Continuing education provider fees.** Clarifies that fees are nonrefundable. **Subd. 5. Late fees.** Clarifies that fees are nonrefundable. **Subd. 6. License cards and wall certificates.** Clarifies that fees are nonrefundable. **Subd. 7. Reactivation fees.** Clarifies that fees are nonrefundable.
17	**Emeritus inactive license.** Amends § 150A.06 by adding subd. 10. Establishes an emeritus inactive license for a licensed dental professional who retires from active practice. Specifies that the emeritus inactive licensee may not practice in a dental profession, and that the license is a formal recognition of the completion of the licensee's career in good standing. Requires onetime fee for an emeritus inactive license. Makes this section effective July 1, 2019.

Section	Description – Article 11: Health-Related Licensing Boards
18	**Emeritus active license.** Amends § 150A.06 by adding subd. 11. Establishes an emeritus active license for a licensed dental professional who retires, to practice only on a pro bono or volunteer basis, or limited paid consulting or supervision practice. Requires application fee. Specifies practice limitations and renewal requirements. Makes this section effective July 1, 2019.
19	**Emeritus inactive license.** Amends § 150A.091 by adding subd. 19. Adds application fee for emeritus inactive dental license. Makes this section effective July 1, 2019.
20	**Emeritus active license.** Amends § 150A.091 by adding subd. 20. Adds application fees for emeritus active licenses in dentistry, dental therapy, dental hygiene, and dental assisting. Makes this section effective July 1, 2019.
21	**Central service pharmacy.** Amends § 151.01, subd. 31. Clarifies the definition of “central service pharmacy.”
22	**Compounding.** Amends § 151.01, subd. 35. Clarifies that for mixing or reconstituting a drug according to a product’s label or manufacturer directions, the label must be approved by the FDA or manufacturer must be licensed.
23	**Syringe services provider.** Amends § 151.01 by adding subd. 42. Adds definition for “syringe services provider.”
24	**Application fees.** Amends § 151.065, subd. 1. Increases Board of Pharmacy licensure and registration application fees. Modifies application fees by removing drug wholesalers and adding third-party logistics providers, and removing drug manufacturer application fees.
25	**Original license fee.** Amends § 151.065, subd. 2. Increases pharmacist original licensure fee.

Section	Description – Article 11: Health-Related Licensing Boards
26	**Annual renewal fees.** Amends § 151.065, subd. 3. Increases Board of Pharmacy annual renewal fees. Modifies annual renewal fees by removing drug wholesalers and adding third-party logistics providers, and removing drug manufacturer renewal fees.
27	**Reinstatement fees.** Amends § 151.065, subd. 6. Clarifies language for Board of Pharmacy controlled substance registrant reinstatement. Modifies license reinstatement fees by adding third-party logistics providers.
28	**Grounds for disciplinary action.** Amends § 151.071, subd. 2. Updates terminology; adds provision to actions that constitute fee splitting addressing price setting arrangements between pharmacies and physicians, and pharmacies and veterinarians.
29	**Location.** Amends § 151.15, subd. 1. Makes clarifying change; allows a licensed pharmacist or pharmacist intern working within a hospital to receive a prescription order and access the hospital pharmacy's processing system through secure and encrypted electronic means to process the order.
30	**Receipt of emergency prescription orders.** Amends § 151.15 by adding subd. 5. Adds subdivision allowing a pharmacist to accept a prescription drug order when not present in a pharmacy, in specified circumstances.
31	**Processing of emergency prescription orders.** Amends § 151.15 by adding subd. 6. Adds subdivision outlining the required processes for accepting and filling a prescription under subdivision 5, in emergency circumstances.
32	**Pharmacy licensure requirements.** Amends § 151.19, subd. 1. Clarifies provision related to inspection prior to pharmacy licensure. Specifies that pharmacy licensing requirements do not apply to manufacturers, wholesale drug distributors, and logistics providers who distribute home dialysis supplies and devices, if: ▪ the manufacturer leases or owns the licensed manufacturing or wholesaling facility from which the dialysate or devices will be delivered; ▪ the dialysis supplies meet certain specifications; ▪ the supplies are only delivered pursuant to physician's order by a Minnesota licensed pharmacy;

Section	Description – Article 11: Health-Related Licensing Boards

- the entity keeps records for at least three years, available to the board upon request; and
- the entity delivers the supplies directly to a patient with end-stage renal disease or the patient's designee, for dialysis, or to a health care provider or institution, for the same purpose

33 **Sale of federally restricted medical gases.**

Amends § 151.19, subd. 3. Clarifies provision related to inspection prior to medical gas distributor registration.

34 **Requirements.**

Amends § 151.252, subd. 1. Clarifies provision related to inspection prior to drug manufacturing facility licensure.

35 **Outsourcing facility.**

Amends § 151.252, subd. 1a. Clarifies provisions related to inspection of outsourcing facilities for initial licensure or renewal.

36 **Payment to practitioner; reporting.**

Amends § 151.252, subd. 3. Adds outsourcing facilities to the requirement for an annual report to the board.

37 **Emergency veterinary compounding.**

A**mends § 151.253 by adding subd. 4. Allows a pharmacist working within a pharmacy licensed as a veterinary pharmacy to compound and provide a drug to a veterinarian without a patient-specific prescription when:**

4) the compounded drug is needed in an emergency situation;
5) timely access to a compounding pharmacy is not available;
6) no suitable commercially manufactured drug exists to treat the animal, or there is a shortage of the drug;
7) the compounded drug will be administered by a veterinarian or employee, or dispensed in an amount not to exceed a 10-day supply;
8) the pharmacy has selected the sterile or nonsterile compounding license category; and
9) the pharmacy is registered by the DEA when providing compounded products containing controlled substances.

38 **Citation.**

Amends § 151.32. Modifies citation and title of the Pharmacy Practice Act

Section	Description – Article 11: Health-Related Licensing Boards
39	**Generally.** Amends § 151.40, subd. 1. Modifies list of persons who may possess, control, manufacture, sell, furnish, dispense, or otherwise dispose of hypodermic syringes or needles. Adds syringe service providers and their employees; persons self-administering drugs pursuant to a prescription or practitioner direction; persons disposing of needles for certain programs; and persons who sell, possess, or handle hypodermic syringes or needles.
40	**Sales of limited quantities of clean needles and syringes.** Amends § 151.40, subd. 2. Clarifies provisions governing the sale of hypodermic needles or syringes. Removes provision prohibiting a pharmacy from advertising needles for retail sale.
41	**Scope.** Amends § 151.43. Modifies cross-reference and specifies that the sections apply to persons operating as third-party logistics providers.
42	**Definitions.** Proposes coding for § 151.441. Defines the following terms for the purposes of sections 151.43 to 151.51: ▪ "Dispenser" ▪ "Disposition" ▪ "Distribute" or "distribution" ▪ "Manufacturer" ▪ "Medical convenience kit" ▪ "Package" ▪ "Prescription drug" ▪ "Product" ▪ "Repackager" ▪ "Third-party logistics provider" ▪ "Transaction" ▪ "Wholesale distribution" ▪ "Wholesale distributor"
43	**Prohibited drug purchases or receipt.** Amends § 151.46. Adds licensed third-party logistics providers to those prohibited from dispensing or distributing drugs directly to patients.

Section	Description – Article 11: Health-Related Licensing Boards
44	**Generally.** Amends § 151.47, subd. 1. Removes requirements for wholesale drug distributors. Requires manufacturers, repackagers, wholesale distributors, and dispensers to comply with requirements in federal law.
45	**Licensing.** Amends § 151.47 by adding subd. 1a. Paragraph (a) specifies that the board will license wholesale distributors, engaged in wholesale distribution, consistent with federal law. Paragraph (b) prohibits a person to act as a wholesale distributor unless licensed by the board. Paragraph (c) requires application for a license to be made in a manner specified by the board. Paragraph (d) requires agreement to operate in compliance with state and federal law in order to be licensed. Paragraph (e) requires a wholesale distributor facility in another state to prove licensure or registration with the FDA or the state in which the facility is located, in order to be licensed in Minnesota. Paragraph (f) requires a license for each separate facility. Paragraph (g) requires an inspection for licensure. Paragraph (h) specifies additional conditions for wholesale distributor licensure. Paragraph (i) specifies that employees of wholesale distributors do not need to be licensed. Paragraph (j) authorizes and requires fingerprint-based criminal background checks for facility managers or designated representatives. Paragraph (k) prohibits a licensed wholesaler from being owned by or employing individuals who have been convicted of certain felonies or who have violated federal law or certain state licensure requirements. Paragraph (m) requires a $100,000 surety bond prior to licensing a wholesale distributor that is not government-owned and operated, and a $25,000 surety bond for an applicant with gross receipts under $10,000,000. Paragraph (n) allows for waiver of the bond requirement in certain circumstances.

Section	Description – Article 11: Health-Related Licensing Boards

Paragraph (o) specifies the purpose of the surety bond.

Paragraph (p) specifies that a single surety bond satisfies the requirement for all wholesale distributor facilities under common ownership.

46 **Third-party logistics provider requirements.**

Proposes coding for § 151.471.

Subd. 1. Generally. Requires third-party logistics providers to comply with applicable federal law.

Subd. 2. Licensing. Requires board licensure for third-party logistics provider, consistent with federal law. Specifies licensing requirements.

47 **Access to reporting system data.**

Amends § 152.126, subd. 6.

A new (k) requires the Board of Pharmacy to periodic audits, at least annually, of electronic and non-electronic access to the prescription monitoring program by permissible users, to ensure compliance with permissible use. Requires results of periodic audits to be reported to the legislature.

A new (l) requires a permissible user who has delegated prescription monitoring program data access to an agent or employee to audit the use of the electronic system at least quarterly to ensure compliance with permissible use. Requires the permissible user to immediately remove the employee's access and notify the board if the employee has inappropriately accessed data.

A new (m) requires permissible users to terminate prescription monitoring program data access by former agents or employees, within three business days of the individual leaving employment. Allows the board to conduct random audits to determine compliance.

48 **Disciplinary action.**

Amends § 152.127, subd. 7. Provides that a prescriber or dispenser authorized to access prescription monitoring program data who fails to comply with subdivision 6, paragraphs (l) or (m) is subject to disciplinary action by the appropriate health-licensing board.

49 **Patient information on record access.**

Amends § 152.126, by adding subd. 10a. Allows a patient who has been prescribed a controlled substance to access the prescription monitoring program database to obtain information on access by permissible users to the patient's data record. Requires the patient to complete, notarize, and submit a request form developed by the Board of Pharmacy. Requires the board to make the form available to the public on its website.

Section	Description – Article 11: Health-Related Licensing Boards
50	**Repealer.** Repeals Minnesota Rules, parts 6400.6970; 7200.6100; and 7200.6105 (Board of Nursing Home Administrators and Board of Psychology fees). Repeals sections 151.42, 151.44, 151.49, 151.50, 151.51, and 151.55, relating to wholesale drug distribution licensing and the cancer drug repository program. Makes this section effective the day following final enactment.

Article 12: Health Department

This article modifies Health Department programs and activities. Sections in this article dedicate certain litigation proceeds to a tobacco use prevention account to be used for tobacco use prevention, modify requirements for medical cannabis, authorize rulemaking for security screening systems, increase the annual service connection fee for public water supplies, direct the commissioner of health to administer statewide tobacco cessation services, increase the age for purchasing tobacco products to 21, make changes to home care provider laws, modify the positive abortion alternatives program, and establish home visiting, opioid prevention, community solutions for healthy child development, and domestic violence and sexual assault prevention programs.

Section	Description – Article 12: Health Department
1	**Exceptions.** Amends § 16A.151, subd. 2. Section 161A.151, subdivision 1, requires money recovered by the state in litigation or a settlement to be deposited in the general fund, and subdivision 2 establishes exceptions to this rule. Paragraph (f) establishes an additional exception, requiring money the state receives from litigation regarding annual settlement payments on transferred tobacco brands to be deposited in a new tobacco use prevention account.
2	**Industrial hemp.** Amends § 18K.02, subd. 3. Amends the definition of industrial hemp in the chapter that authorizes persons licensed by the commissioner of agriculture to grow industrial hemp for commercial purposes and authorizes the processing, selling, and buying of industrial hemp grown in Minnesota, to make that definition conform with the definition of hemp in federal law.
3	**Agricultural crop; possession authorized.** Amends § 18K.03. Allows a hemp grower licensed by the commissioner of agriculture to sell hemp to medical cannabis manufacturers.

Section	Description – Article 12: Health Department
4	**Boring.** Amends § 103I.005, subd. 2. Amends the definition of "boring" in chapter 103I (which covers wells, borings, and underground uses) to specify that it includes temporary borings.
5	**Environmental well.** Amends § 103I.005, subd. 8a. Amends the definition of "environmental well," by clarifying that it does not include an exploratory boring.
6	**Temporary boring.** Amends § 103I.005, subd. 17a. Defines "temporary boring" for chapter 103I. This term replaces the term "temporary environmental well" in this chapter.
7	**Notification required.** Amends § 103I.205, subd. 1. Provides that a person is not required to notify the commissioner before constructing a temporary boring (instead of temporary environmental well as in current law).
8	**License required.** Amends § 103I.205, subd. 4. Allows a person who is a professional engineer, hydrologist or hydrogeologist, professional geoscientist, or geologist, or who meets qualifications in rule, to construct, repair, and seal a temporary boring (in addition to an environmental well as in current law). Removes language authorizing a licensed plumber who does not have a well or boring contractor's license under chapter 103I to repair submersible pumps or water pipes connected to water well water systems if the repair location is in an area with no licensed well contractors within 50 miles.
9	**Report of work.** Amends § 103I.205, subd. 9. Modifies the deadline for submitting a report to the commissioner of health related to well or boring construction or sealing to within 60 days, rather than 30 days, of completing the work.
10	**Well notification fee.** Amends § 103I.208, subd. 1. Makes an existing $75 fee apply to the sealing of temporary borings, and provides that a single notification and $75 fee is required for all borings on a single property. Exempts temporary borings less than 25 feet in depth from the notification and fee requirements in chapter 103I. Changes a term used, from "temporary environmental well" to "temporary boring."

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11	**Temporary boring and unsuccessful well exemption.** Amends § 103I.235, subd. 3. Exempts temporary borings that were sealed by a licensed contractor (rather than temporary environmental wells as in current law) from requirements to disclose to a buyer the location of wells on the property.
12	**Temporary boring.** Adds subd. 3a to § 103I.301. Requires the owner of a property with a temporary boring to have the temporary boring sealed within 72 hours after the start of construction of the temporary boring, and specifies who is authorized to seal the temporary boring.
13	**Notification required.** Amends § 103I.301, subd. 6. Prohibits a person from sealing a temporary boring until a notification is filed with the commissioner, except that temporary borings less than 25 feet in depth are exempt from this notification requirement. Provides that a single notification is required for all temporary borings sealed on a single property.
14	**Notification and map of borings.** Amends § 103I.601, subd. 4. Provides that one site fee of $275 must be submitted for all exploratory borings marked on the proposed boring map submitted to the commissioner of health, not $275 per exploratory boring. Also specifies the paper size for the map of proposed borings to be submitted to the commissioner.
15	**Fees for ionizing radiation-producing equipment.** Amends § 144.121, subd. 1a. Requires facilities that use radiation-producing security screening systems to pay the commissioner of health a base registration fee of $100 plus $100 for each system in use. Defines security screening system for purposes on this section as radiation-producing equipment designed and used for security screening of humans who are in the custody of a correctional or detention facility, and used by the facility to image and identify contraband items concealed within or on all sides of a human body. Also defines correctional or detention facility.
16	**Exemption from examination requirements; operators of security screening systems.** Adds subd. 9 to § 144.121. Exempts employees of correctional or detention facilities who operate security screening systems and the facilities in which these systems are operated from certain statutory and regulatory requirements (e.g., operator need not have passed a national exam for limited x-ray machine operation) enforced by the Department of Health.

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17	**Data about births.** Amends § 144.225, subd. 2. Amends a subdivision governing access to birth data, to allow: ▪ a tribal health department to obtain (1) contact information for a mother who was not married to a child's father when the child was conceived and born and (2) the child's date of birth (current law allows this information to be disclosed to a county social services department or a public health member of a family services collaborative); and ▪ a tribal child support program to access birth records for child support enforcement purposes.
18	**Health data associated with birth registration.** Amends § 144.225, subd. 2a. Allows the commissioner of health to disclose to a tribal health department, health data associated with a birth registration that identifies a mother or child at high risk for serious disease, disability, or delay (current law allows the commissioner to disclose this information to a community health board).
19	**Certified birth or death record.** Amends § 144.225, subd. 7. Directs the state or local office of vital records to issue a certified birth or death record or statement of no vital record found to any tribal governmental agency upon request, if the certified vital record is needed for the governmental agency to perform its duties (current law allows local, state, and federal governmental agencies to obtain certified vital records needed to perform their duties).
20	**Fee setting.** Amends § 144.3831, subd. 1. Increases the annual service connection fee assessed by the commissioner of health for every service connection to a public water supply owned or operated by a city or town, from $6.36 to $9.72.
21	**Statewide tobacco cessation services.** Adds § 144.397. Directs the commissioner of health to administer or contract for the administration of statewide tobacco cessation services to help Minnesotans quit using tobacco products. Lists tobacco cessation services that may be provided, and requires services to be consistent with evidence-based best practices and coordinated with tobacco prevention and cessation services offered to individuals through their health insurance.
22	**Tobacco use prevention account.** Adds § 144.398. Establishes a tobacco use prevention account and annually appropriates money from that account for tobacco use prevention activities.

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Subd. 1. Account created. Creates a tobacco use prevention account in the special revenue fund, and directs the commissioner of management and budget to deposit into the account all money recovered by the state from litigation regarding annual tobacco settlement payments on transferred tobacco brands.

Subd. 2. Uses of money in account. Appropriates $12 million each year from the account to the commissioner of health for tobacco use prevention activities. If the account contains less than $12 million on July 1, appropriates the amount in the account to the commissioner.

Subd. 3. Definitions. Defines terms: consent judgment; litigation regarding annual tobacco settlement payments on transferred tobacco brands; and settlement agreement.

23 **Public policy.**

Amends § 144.412. Expands the public purposes of the Clean Indoor Air Act to include protecting employees and the public from involuntary exposure to aerosol or vapor from electronic delivery devices.

24 **Scope.**

Amends § 144.413, subd. 1. Corrects a statutory citation listing statutes to which the definitions in this section apply, to make these definitions apply to the entire Clean Indoor Air Act.

25 **Smoking.**

Amends § 144.413, subd. 4. The Clean Indoor Air Act prohibits smoking in certain locations. This subdivision amends the definition of smoking for the act, by:

- specifying that smoking includes burning or carrying a lighted or heated cigar, cigarette, pipe, or other product;
- specifying that a lighted or heated product may contain, be made from, or be derived from nicotine, tobacco, marijuana, or another plant; and
- specifying that smoking includes carrying or using an activated electronic delivery device.

26 **Day care premises.**

Amends § 144.414, subd. 2. Strikes language that includes the use of electronic delivery devices in the definition of smoking for purposes of prohibiting smoking in day care premises. (This language is no longer needed since another section adds the use of electronic delivery devices to the definition of smoking for the entire act.)

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27	**Health care facilities and clinics.** Amends § 144.414, subd. 3. Strikes language that includes the use of electronic delivery devices in the definition of smoking for purposes of prohibiting smoking in health care facilities and clinics. (This language is no longer needed since another section adds the use of electronic delivery devices to the definition of smoking for the entire act.)
28	**Responsibilities of proprietors.** Amends § 144.416. In a section establishing responsibilities under the Clean Indoor Air Act for proprietors of public places, public transportation, places of employment, and public meetings, provides that the act does not prohibit a proprietor or other person or entity in charge from taking more stringent measures to protect individuals from involuntary exposure to aerosol or vapor from electronic delivery devices.
29	**Tobacco products prohibited in public schools.** Amends § 144.4165. Makes the following changes to a section prohibiting the use or ingestion of tobacco, tobacco products, and electronic delivery devices at public schools: ▪ removes a reference to the term "tobacco product"; ▪ clarifies that a person cannot carry or use an activated electronic delivery device; ▪ prohibits the use of tobacco or electronic delivery devices at charter schools; and ▪ strikes language that prohibits persons under 18 from possessing any of these items.
30	**Tobacco products shop.** Amends § 144.4167, subd. 4. In a subdivision in the Clean Indoor Air Act that allows sampling of tobacco products in a tobacco products shop, provides that a person under age 21 cannot enter a tobacco products shop at any time and modifies the description of products sold in a tobacco products shop. Also adds electronic delivery devices to the list of products from which a tobacco products shop derives more than 90 percent of its revenue.
31	**Local government ordinances.** Amends § 144.417, subd. 4. In a subdivision governing authority of local governments under the Clean Indoor Air Act, provides that the act does not prohibit a local government from enacting more stringent measures to protect individuals from involuntary exposure to aerosol or vapor from electronic delivery devices.
32	**Eligibility for license condition.** Amends § 144.562, subd. 2. Increases the total number of swing bed days critical access hospitals are allowed per year, from 2,000 days per hospital per year to 9,125 days per hospital per year. Strikes paragraphs that allow the commissioner of health to approve

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swing bed use beyond 2,000 days in certain conditions, that allow a hospital to admit a limited number of additional patients to swing beds once the 2,000-day limit is reached without commissioner approval or being in violation of this section, and that allow a health system to allocate its total limit of swing bed days among the hospitals within the system.

33 **Newborn hearing screening advisory committee.**

Amends § 144.966, subd. 2. Under current law the newborn hearing screening advisory committee expires June 30, 2019. This bill extends the advisory committee to June 30, 2025, and adds the following two members to this committee: a representative from the Deaf Mentor Program, and a representative of the State Academy for the Deaf from the Minnesota State Academies staff, who must be appointed by September 1, 2019.

34 **Remedies available.**

Amends § 144.99. Allows the commissioner of health to enforce the medical cannabis sections (sections 152.22 to 152.37) using the tools and authority in the Health Enforcement Consolidation Act. (These provisions allow the commissioner to access information and property, list enforcement actions the commissioner may take, provide for contested case hearings, provide that a violation of a statute subject to enforcement under the act is a misdemeanor, and establish procedures for issuing administrative penalty orders.)

35 **Medication administration.**

Amends § 144A.43, subd. 11. Modifies the definition of medication administration in statutes governing home care providers.

36 **Medication reconciliation.**

Adds subd. 12a to § 144A.43. For statutes governing home care providers, defines medication reconciliation as the process of identifying the most accurate list of all medications a client is taking by comparing the client record to an external list of medications.

37 **Standby assistance.**

Amends § 144A.43, subd. 30. Modifies the definition of standby assistance in statutes governing home care providers.

38 **Change in ownership.**

Amends § 144A.472, subd. 5. Amendments to paragraph (a) clarify what constitutes a change of ownership for a home care provider business. New paragraphs (b) and (c) provide that when a change in ownership occurs, employees of the business under the old owner who continue employment with the business under the new owner are not

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required to undergo new training, except on policies of the new owner that differ from those of the old owner.

39 **Fees; application, change of ownership, renewal, and failure to notify.**

Amends § 144A.472, subd. 7. Adds a penalty of $1,000 for a home care provider with a temporary license that fails to notify the commissioner of health within five days after it begins providing services to clients.

40 **Issuance of temporary license and license renewal.**

Amends § 144A.473.

Subd. 1. Temporary license and renewal of license. Exempts temporary licenses from the requirement that home care provider licenses are valid for up to a year from the date of issuance.

Subd. 2. Temporary license. Adds a reference that temporary licenses can be extended according to subdivision 3. Requires the commissioner to survey temporary licensees within 90 calendar days after the provider begins providing services. Also changes terminology from license year to license period.

Subd. 3. Temporary licensee survey. Modifies steps the commissioner may take if a temporary licensee is not in substantial compliance with a survey: in addition to not issuing a license as provided in current law, the commissioner may terminate the temporary license, or extend the temporary license and apply conditions. Establishes a deadline by which the commissioner must receive a reconsideration request and supporting documentation from a temporary licensee. Lists the circumstances under which a temporary licensee whose license is denied may continue operating.

41 **Types of home care surveys.**

Amends § 144A.474, subd. 2. In a subdivision governing home care provider surveys, defines change in ownership survey, and requires such surveys to be completed within six months after the commissioner issues a new license due to a change in ownership.

42 **Conditions.**

Amends § 144A.475, subd. 1. Permits the commissioner to refuse to grant a license as a result of a change in ownership, if a home care provider, owner, or managerial official engages in certain conduct.

43 **Terms to suspension of conditional license.**

Amends § 144A.475, subd. 2. Provides that a home care provider operating under a suspended or conditional license according to this subdivision may continue to operate while home care clients are being transferred to other providers.

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44	**Plan required.** Amends § 144A.475, subd. 5. Provides that a home care provider whose license is being suspended or revoked according to this subdivision may continue to operate while home care clients are being transferred to other providers.
45	**Prior criminal convictions; owner and managerial officials.** Amends § 144A.476, subd. 1. Requires the commissioner to conduct a background study on owners and managerial officials of a home care provider before issuing a license due to a change in ownership.
46	**Employee records.** Amends § 144A.479, subd. 7. Makes a technical change.
47	**Home care bill of rights; notification to client.** Amends § 144A.4791, subd. 1. Clarifies that a client must receive a written notice of the home care bill of rights before the date services are first provided to the client.
48	**Statement of home care services.** Amends § 144A.4791, subd. 3. Clarifies that a home care provider must provide the client with information about the home care provider's license and the services the provider can provide before the date services are first provided to the client.
49	**Initiation of services.** Amends § 144A.4791, subd. 6. Clarifies that if a client receives services before the client receives a review or assessment, a licensed health professional or registered nurse must complete a temporary plan and orient staff to deliver services.
50	**Basic individualized client review and monitoring.** Amends § 144A.4791, subd. 7. Requires an initial review of the client's needs and preferences to be completed within 30 days after the date home care services are first provided to the client.
51	**Comprehensive assessment, monitoring, and reassessment.** Amends § 144A.4791, subd. 8. Requires an initial assessment or reassessment to occur within specified periods after the date home care services are first provided to the client.
52	**Service plan, implementation, and revisions to service plan.** Amends § 144A.4791, subd. 9. Requires a service plan to be finalized within 14 days after the date home care services are first provided, rather than after the initiation of home care services. Modifies what the service plan must include regarding staffing and supervision.

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53	**Medication management services; comprehensive home care license.** Amends § 144A.4792, subd. 1. Requires a comprehensive home care provider to have policies to ensure security and accountability for management, control, and disposition of controlled substances, if the provider stores and secures controlled substances.
54	**Provision of medication management services.** Amends § 144A.4792, subd. 2. Requires an assessment conducted before a home care provider provides medication management services, to include providing instructions to the client or a representative on interventions to manage medications and prevent medication diversion.
55	**Individualized medication management plan.** Amends § 144A.4792, subd. 5. Requires medication reconciliation to occur as part of medication management.
56	**Medication management for clients who will be away from home.** Amends § 144A.4792, subd. 10. Modifies requirements for medication management for clients who will be away from home: ▪ for unplanned time away, limits the amount of medication a client may receive to the amount needed for seven calendar days (rather than 120 hours [five calendar days] as in current law); and ▪ requires written procedures that apply during unplanned time away when a registered nurse is not available, to specify how unlicensed staff must document unused medications that are returned to the provider.
57	**Treatment and therapy orders.** Amends § 144A.4793, subd. 6. Requires treatment and therapy orders to be renewed at least every 12 months, and requires these orders to include information on the duration of the treatment or therapy.
58	**Content.** Amends § 144A.4796, subd. 2. Makes a technical change to a subdivision governing what must be covered in home care provider employee orientation.
59	**Supervision of staff providing delegated nursing or therapy home care tasks.** Amends § 144A.4797, subd. 3. Clarifies when supervision must take place for staff performing delegated tasks.

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60	**Disease prevention and infection control.** Amends § 144A.4798. Consolidates and updates disease prevention and infection control requirements for home care providers.
61	**Membership.** Amends § 144A.4799, subd. 1. Allows persons who have received home care services within the past five years to be members of the home care and assisted living program advisory council.
62	**Duties.** Amends § 144A.4799, subd. 3. Clarifies the topics on which the home care and assisted living program advisory council may provide advice to the commissioner.
63	**Integrated licensing established.** Amends § 144A.484, subd. 1. Strikes an obsolete paragraph.
64	**Eligibility for grants.** Amends § 145.4235, subd. 2. Modifies requirements for the positive abortion alternatives program to: ▪ require an organization receiving a grant to indicate in its name, signage, and printed materials that its purpose is to support women in carrying their pregnancies to term and that it does not provide counseling or referrals for abortions; and ▪ require all written materials provided by an organization receiving a grant to be medically accurate, and to require the commissioner of health to approve any written materials.
65	**Privacy protections.** Amends § 145.4235, subd. 3. Limits the information an organization receiving a positive abortion alternatives grant can release about a woman receiving services from the organization, to information releases expressly permitted in the woman's written consent. Also requires an organization to allow a woman to copy her health record onsite, provide the woman with a copy of her health record, or provide the woman with information about the location of her health record if the woman no longer holds the health record.
66	**Provision of pregnancy test results.** Amends § 145.4235, subd. 3a. Requires an organization receiving a positive abortion alternatives grant and providing pregnancy tests to women, to give women a written statement of the pregnancy test results at no cost, immediately after the test, and in the language requested by the woman.

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67	**Duties of commissioner.** Amends § 145.4235, subd. 4. Requires the commissioner to establish an evaluation process for positive abortion alternatives grants and to use that process to evaluate grants and inform grant award decisions for subsequent grant cycles.
68	**Home visiting for pregnant women and families with young children.** Adds § 145.87. Directs the commissioner of health to award grants to community health boards, nonprofit organizations, and tribal nations to start up or expand home visiting programs serving pregnant women and families with young children. **Subd. 1. Definitions.** Defines terms for this section: evidence-based home visiting program, evidence-informed home visiting program, and health equity. **Subd. 2. Grants for home visiting programs.** Directs the commissioner of health to award grants to start up or expand home visiting programs serving pregnant women and families with young children. Requires home visits provided by these programs to be provided by early childhood professionals or health professionals. Requires grant funds to be used for evidence-based home visiting programs that address health equity, or evidence-informed home visiting programs that address health equity. Also requires these programs to serve families or pregnant women who are high risk or have high needs. **Subd. 3. Grant prioritization.** Directs the commissioner to give priority in awarding grants to programs seeking to expand home visiting services with community or regional partnerships, and requires at least 75 percent of grant funds to be allocated to evidence-based home visiting programs that address health equity and up to 25 percent to be allocated to evidence-informed home visiting programs that address health equity. **Subd. 4. No supplanting of existing funds.** Requires funds distributed under this section to supplement, and not supplant, existing funding for evidence-based or evidence-informed home visiting programs. **Subd. 5. Administrative costs.** Allows the commissioner to use up to 10 percent of the annual appropriation for training and technical assistance and to administer and evaluate the program, and allows the commissioner to contract for the performance of some of these activities.
69	**Community-based opioid prevention; pilot grant program.** Adds § 145.9275. Directs the commissioner to establish a grant program to fund community opioid abuse prevention pilot grants to reduce emergency room and health care provider visits results from opioid use or abuse and to reduce rates of opioid addiction. Lists activities that may be funded using these grants.

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70	**Goal; establishment.** Amends § 145.928. Adds access to and utilization of high-quality prenatal care, to the list of priority areas in the eliminating health disparities program operated by the commissioner of health.
71	**Community grant program; immunization rates, prenatal care access and utilization, and infant mortality rates.** Amends § 145.928, subd. 7. Allows the commissioner of health to award grants through the eliminating health disparities grant program, for projects to decrease racial and ethnic disparities in access to and utilization of high-quality prenatal care.
72	**Community solutions for healthy child development grant program.** Adds § 145.9285. Establishes the program, establishes duties for the commissioner of health, creates a Community Solutions Advisory Council, specifies organizations eligible for grants, requires the commissioner to develop a request for proposals for grants, requires grants to be prioritized and awarded to organizations and entities in counties with higher proportions of people of color and American Indians, and requires grant recipients to report grant outcomes to the commissioner. **Subd. 1. Establishment.** Directs the commissioner of health to establish the community solutions for healthy child development grant program, and establishes purposes for the program. **Subd. 2. Commissioner's duties.** Requires the commissioner of health to develop a request for proposals for this program; provide outreach, technical assistance, and program development; review responses to the RFP; communicate with the ethnic councils, the Minnesota Indian Affairs Council, and the governor's early learning council; establish an accountability process; maintain outcomes data; and contract with a third party to conduct evaluations. **Subd. 3. Community Solutions Advisory Council.** Requires the commissioner to appoint 12 people to a Community Solutions Advisory Council, requires at least 3 of these members to come from greater Minnesota, and lists duties for the advisory council. Also provides for compensation of advisory council members. **Subd. 4. Eligible grantees.** Provides that organizations eligible to receive grants include organizations that work with communities of color and American Indian communities, tribal nations and tribal organizations, and organizations focused on supporting healthy child development. **Subd. 5. Strategic considerations and priority of proposals; eligible populations; grant awards.** Directs the commissioner, in developing the RFP, to consider building on community capacity to promote child development and family well-being and to address social determinants of healthy child development. In awarding grants, requires the commissioner to give priority to proposals from organizations led by and serving people of color, led by and serving American

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Indians, with proposals focused on prenatal to grade 3 healthy development, with proposals focused on multigenerational solutions, located in or proposing to serve communities in moderate to high risk counties, or community-based organizations that have historically served communities of color and American Indians but have not had access to state grant funding. Requires initial grants to be awarded by April 15, 2020, and annually thereafter, and provides that grants are awarded for third-year periods.

Subd. 6. Geographic distribution of grants. Requires the commissioner and the advisory council to ensure that grants are prioritized and awarded to organizations in counties with a higher proportion of people of color and American Indians than the state average, to the extent possible.

Subd. 7. Report. Requires grant recipients to report grant outcomes to the commissioner.

73 **Domestic violence and sexual assault prevention program.**

Adds § 145.987. Directs the commissioner of health to award grants to nonprofit organizations for domestic violence and sexual assault prevention activities.

Subd. 1. Program established. Directs the commissioner of health to administer a domestic violence and sexual assault prevention program.

Subd. 2. Grant criteria. Directs the commissioner to award grants to nonprofit organizations to develop new programs or sustain or expand existing programs, to prevent domestic violence and sexual assault. Lists activities that may be funded with these grants.

Subd. 3. Definition. Defines domestic violence and sexual assault to include intimate partner violence, sex trafficking, domestic abuse, criminal sexual conduct crimes, abusive international marriage, forced marriage, and female genital mutilation.

Subd. 4. Promotion; administration. Allows the commissioner to spend up to 15 percent of program funding each fiscal year to promote and administer the program.

Subd. 4. Nonstate sources. Allows the commissioner to accept contributions from nonstate sources, and appropriates those contributions to the commissioner for this program.

Subd. 5. Program evaluation. Requires the commissioner to report by February 28 of each even-numbered year to the legislative committees governing health, on grants made under this section. Directs the commissioner to evaluate the effectiveness of the program, and to use the evaluation information to inform existing and proposed department policies and programs. Requires an

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	organization receiving a grant to make available to MDH aggregate data on activities funded by the grant.
74	**Hemp.** Adds subd. 5a to § 152.22. Defines hemp for purposes of the medical cannabis statutes, by referring to the definition of industrial hemp in chapter 18K.
75	**Hemp grower.** Adds subd. 5b to § 152.22. Defines hemp grower for purposes of the medical cannabis statutes.
76	**Medical cannabis.** Amends § 152.22, subd. 6. Amends the definition of medical cannabis that applies to the medical cannabis statutes, to add raw cannabis delivered using a vaporized delivery method as an allowable delivery form. (Current law allows medical cannabis to be delivered through liquid, pill, a topical application, or a vaporized delivery method using liquid or oil, and the use of dried leaves or plant form is not permitted.) Makes this section effective August 1, 2020, or earlier if the commissioner of health certifies that the department has the procedures and guidelines in place to implement this section.
77	**Registered designated caregiver.** Amends § 152.22, subd. 11. Amends the definition of registered designated caregiver, requiring a caregiver to be 18 or older rather than 21 or older as in current law and modifying the description of a patient's disability that necessitates a designated caregiver.
78	**Registry verification.** Amends § 152.22, subd. 13. Amends the definition of registry verification, to provide that it does not list the patient's qualifying medical condition and to list the patient's spouse if the spouse is acting as caregiver to the patient.
79	**Qualifying medical condition.** Amends § 152.22, subd. 15. Amends the definition of qualifying medical condition that applies to the medical cannabis statutes, to: ▪ remove the additional qualifications that a person with cancer or terminal illness must satisfy in order to obtain medical cannabis (under current law, a person with cancer or terminal illness may obtain medical cannabis only if the condition or treatment produces severe or chronic pain, nausea or severe vomiting, or cachexia or severe wasting. The amendment to this subdivision removes those additional requirements.); and ▪ add (1) any chronic condition for which an opiate could otherwise be prescribed, and (2) chronic pain or intractable pain, as qualifying medical

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conditions. (The commissioner of health added intractable pain to the list of qualifying medical conditions in December 2015, and patients with intractable pain were eligible to obtain medical cannabis beginning August 1, 2016. Chronic pain is a new qualifying medical condition being added by this amendment.)

Makes this section effective August 1, 2020.

80 **Medical cannabis manufacturer registration.**

Amends § 152.25, subd. 1. Provides that a registration agreement between a medical cannabis manufacturer and the commissioner is not transferable.

81 **Revocation or nonrenewal of a medical cannabis manufacturer registration.**

Amends § 152.25, subd. 1a. Makes a conforming change with the amendment to section 152.25, subdivision 1, which makes registration agreements not transferrable.

82 **Notice to patients.**

Amends § 152.25, subd. 1c. Includes spouses acting as caregivers to patients enrolled in the medical cannabis program, in a subdivision requiring the commissioner to notify certain people if the commissioner takes action that may affect a manufacturer's ability to provide medical cannabis.

83 **Reports.**

Amends § 152.25, subd. 4. Directs the commissioner to provide updates to certain legislative committees and to the task force on medical cannabis therapeutic research on (1) changes in federal law regarding the use of hemp, and (2) the market demand and supply for products made from hemp that can be used for medicinal purposes.

84 **Commissioner duties.**

Amends § 152.27, subd. 2. In a subdivision that in part requires the commissioner to create a certification for health care practitioners to use to certify whether a patient with a qualifying medical condition needs a designated caregiver, modifies the description of a patient's disability that necessitates a designated caregiver.

85 **Patient application.**

Amends § 152.27, subd. 3. In a subdivision establishing requirements for patients to apply for enrollment in the medical cannabis program, modifies the description of a patient's disability that necessitates a designated caregiver. Also adds spouses as patient caregivers to the certification from a health care practitioner regarding the patient's qualifying medical condition and need for a caregiver.

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86	**Registered designated caregiver.** Amends § 152.27, subd. 4. In a subdivision establishing procedures and requirements for designated caregivers to be registered under the medical cannabis program, lowers the age for a caregiver from 21 to 18; modifies the description of a patient's disability that necessitates a designated caregiver; requires a designated caregiver's background check to be renewed every two years; and provides that a registered designated caregiver may also be a patient enrolled in the registry program and may possess and use medical cannabis as a patient.
87	**Parents, legal guardians, and spouses.** Amends § 152.27, subd. 5. Adds spouses of patients to the list of people who may act as a patient caregiver without having to register as a designated caregiver.
88	**Patient enrollment.** Amends § 152.27, subd. 6. Removes a patient's qualifying medical condition from the information listed on the patient's registry verification. Also adds a patient's spouse if acting as a patient caregiver, to the information included on a registry verification.
89	**Health care practitioner duties.** Amends § 152.28, subd. 1. Allows a health care practitioner to use telemedicine to conduct a patient assessment to issue a recertification that a patient has a qualifying medical condition. Also modifies the description of a patient's disability that necessitates a designated caregiver.
90	**Manufacturer; requirements.** Amends § 152.29, subd. 1. Increases the number of medical cannabis distribution facilities that must be operated in the state from four to eight. Directs the commissioner to designate geographic service areas served by each manufacturer, and prohibits a manufacturer from having more than two distribution facilities located in each geographic service area. Allows a manufacturer to obtain hemp from a hemp grower, and process that hemp into an allowable form of medical cannabis. Provides that hemp is subject to quality control, security and testing, and other requirements that apply to medical cannabis plant material, and requires a manufacturer to verify that a hemp grower is licensed by the commissioner of agriculture before obtaining hemp from the hemp grower.
91	**Manufacturer; production.** Amends § 152.29, subd. 2. Requires hemp processing to take place in a secure setting, and allows a manufacturer to use hemp to provide a reliable, ongoing supply of medical cannabis. Requires hemp plant material to be processed into an allowable form of medical cannabis before it is distributed to patients.

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92	**Manufacturer; distribution.** Amends § 152.29, subd. 3. Allows a manufacturer to transport medical cannabis or medical cannabis products to another manufacturer for the receiving manufacturer to distribute. Allows a manufacturer to distribute up to a 90-day supply of medical cannabis, rather than a 30-day supply as in current law. Makes a conforming change.
93	**Data practices.** Amends § 152.31. Allows the commissioner to execute data sharing arrangements with the commissioner of agriculture to verify licensing, inspection, and compliance information related to hemp growers.
94	**Criminal and civil protections.** Amends § 152.32, subd. 2. Makes a change to conform with other language allowing patient spouses to serve as caregivers to patients enrolled in the medical cannabis program.
95	**Intentional diversion; criminal penalty.** Amends § 152.33, subd. 1. Specifies that transferring medical cannabis to another registered manufacturer or to a spouse caregiver of a patient does not subject a manufacturer to criminal penalties.
96	**Diversion by patient, registered designated caregiver, parent, legal guardian, or patient's spouse; criminal penalty.** Amends § 152.33, subd. 2. Adds patient spouses serving as caregivers to the list of patient caregivers subject to criminal penalties if they divert medical cannabis to a person other than the intended patient.
97	**Health care facilities.** Amends § 152.34. Allows hospice providers, supervised living facilities, and other health facilities regulated by the commissioner of health to adopt reasonable restrictions on the use of medical cannabis.
98	**Impact assessment.** Amends 152.36, subd. 2. Directs the task force on medical cannabis therapeutic research to evaluate the impact of using hemp and Minnesota's activities involving hemp.
99	**Suspension; illegal purchase of alcohol or tobacco.** Amends § 171.171. In a section requiring the commissioner of public safety to suspend a person's driver's license for illegally purchasing alcohol or tobacco, strikes a clause referring to a petty misdemeanor penalty being eliminated in the bill for using false identification to purchase tobacco. Also provides that if a person lends a license or other identification to a person under 21 (rather than under 18 as in current law) for certain

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purchases, the commissioner must suspend the lender's license, and modifies the purchases covered by this clause to include tobacco, a tobacco-related device, an electronic delivery device, or a nicotine or lobelia delivery product (rather than a tobacco product as in current law).

100 **Commissioner of health data.**

Amends § 214.25, subd. 2. Makes a technical change to a subdivision classifying data collected or maintained by the commissioner in administering the HIV/HBV/HCB prevention program (a program being repealed in this article), and strikes paragraphs authorizing disclosure of certain data under this program that are obsolete if the program is repealed.

101 **Administrative penalty for sales and furnishing; licensees.**

Amends § 461.12, subd. 2. In a subdivision establishing penalties for certain conduct by a retail seller of tobacco, tobacco-related devices, electronic delivery devices, and nicotine or lobelia delivery products, makes the following changes:

- changes the age at or above which a person can purchase tobacco, tobacco-related devices, electronic delivery devices, and nicotine delivery devices from 18 to 21;
- makes the penalties apply for giving or furnishing these items, in addition to selling these items as in current law; and
- increases the penalties imposed for selling, giving, or furnishing to a person under age 21, and allows a license to be revoked for a third or subsequent violation.

102 **Administrative penalty for sales and furnishing; individuals.**

Amends § 461.12, subd. 3. In a subdivision establishing penalties for certain conduct by an individual, makes the following changes:

- makes the $50 penalty apply to giving or furnishing tobacco, tobacco-related devices, electronic delivery devices, or nicotine or lobelia delivery products to an underage person, in addition to selling these items as in current law;
- changes the age at or above which an individual can buy these items from another individual, from 18 to 21; and
- makes imposition of the administrative penalty optional rather than mandatory.

103 **Alternative penalties for use of false identification; persons under age 21.**

Amends § 461.12, subd. 4. In a subdivision allowing local units of government to consult with interested persons to develop alternative penalties for using a false ID to buy tobacco, tobacco-related devices, electronic delivery devices, or nicotine or lobelia delivery products, makes the following changes:

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- changes references to “children” or “minors” to “persons under the age of 21 years”; and
- provides that the penalties must be alternative civil penalties and prohibits alternative penalties from including fines or monetary penalties.

104 **Compliance checks.**

Amends § 461.12, subd. 5. In a subdivision governing compliance checks conducted on retail sellers of tobacco products and related items, changes the ages of persons who may be involved in compliance checks (from over age 15 but under age 18 as in current law, to at least 17 but under age 21). Requires a person under age 18 to get a parent’s prior written consent to participate in compliance checks. Requires the local unit of government licensing retail sellers of tobacco products to report violations to the commissioner of human services by January 15 each year, and lists information these reports must include and may include. Requires the commissioner to make information in reports from the past five years publicly available, to make the most recent list of licensees publicly available, and to update this information at least annually.

105 **Defense.**

Amends § 461.12, subd. 6. Amends a subdivision establishing an affirmative defense to a charge of selling tobacco or related items to an underage person, by changing the age at which a person can purchase tobacco or related items from 18 to 21.

106 **Notice to commissioner; information shared with commissioner of human services.**

Amends § 461.12, subd. 8. By January 15 of each year, requires the commissioner of revenue to provide the commissioner of human services with a list of tobacco retailers currently licensed by local jurisdictions. (Local jurisdictions report this information to the commissioner of revenue within 30 days of issuing a license.)

107 **Ban on self-service sales; exceptions.**

Amends § 461.18. In a subdivision prohibiting self-service sales of tobacco and related items, amends the description of tobacco products shop to conform with language in section 144.4167, subdivision 4; changes the age at which a person can enter a tobacco products shop from 18 to 21; and adds sales of electronic delivery devices to the list of items sold at a tobacco products shop. Provides that a subdivision prohibiting the sale of tobacco products and related items from vending machines does not apply to vending machines in locations that cannot be entered by persons under age 21, rather than under age 18 as in current law. Also updates a citation to a provision in the Code of Federal Regulations, which governs tobacco product sales via vending machines, self-service displays, and mail-order sales.

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108	**Age verification and signage required.** Adds § 461.22. **Subd. 1. Signage.** Requires all locations where tobacco, tobacco-related devices, electronic delivery devices, and nicotine or lobelia delivery products are sold, to display a sign in plain view that selling these products to a person under age 21 is illegal. Makes this sign provide notice to people selling these products that they must verify the age of any person under age 30 who wants to buy one of these products. **Subd. 2. Age verification.** Requires a retail seller of tobacco products to verify that a person seeking to buy tobacco or a related item is at least age 21. Provides that verification is not required if the purchaser appears to be age 30 or older.
109	**Sale of tobacco to persons under age 21.** Amends § 609.685. **Subd. 1. Definitions.** Modifies the description of items that are not tobacco. Makes a technical change to the definition of tobacco-related devices. Amends the definition of electronic delivery device by adding a reference to inhaling aerosol and removing language that a person uses an electronic delivery device to simulate smoking in the delivery of nicotine or another substance. Lists items that are included in the definition of electronic delivery device, and updates language describing products that are not electronic delivery devices **Subd.1a. Penalty to sell or furnish.** Changes the penalty from a misdemeanor to a petty misdemeanor for a first violation if a person gives or furnishes tobacco or related items, in addition to selling these items as in current law, to an underage person, and changes the age from 18 to 21. Lowers the penalty for a subsequent violation from a gross misdemeanor to a misdemeanor. **Subd. 2. Use of false identification.** Strikes language regarding furnishing tobacco or related items to persons under age 18. Changes the penalty from a misdemeanor to an alternative civil penalty if a person under age 21 (rather than under 18 as in current law) buys or attempts to buy tobacco or a related item using a false ID. **Subd. 2a. Alternative penalties.** Directs law enforcement and court systems representatives to consult with interested persons to develop alternative penalties for persons under 21 who violate this section, and lists options for alternative penalties. Prohibits alternative penalties from including fines or monetary penalties.

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Subd. 3. Petty misdemeanor. Strikes a subdivision establishing a petty misdemeanor penalty for a person under age 18 who possesses or purchases tobacco or related items.

Subd. 4. Effect on local ordinances. Updates references to a range of subdivisions since subdivision 3 is being stricken.

Subd. 5. Exceptions. Updates the age of an Indian who may receive tobacco as part of a traditional spiritual or cultural ceremony, from under 18 to under 21, and updates the age of persons exempt from the penalties if the person purchases tobacco or related items for training, enforcement, education, or research purposes, from under 18 to under 21.

Subd. 6. Seizure of false identification. In a subdivision allowing seizure of false identification, changes a term from retailer to licensee.

110 **Sale of nicotine delivery products to persons under age 21.**

Amends § 609.6855.

Subd. 1. Penalty to sell or furnish. Changes the penalty from a misdemeanor to a petty misdemeanor for a first violation if a person gives or furnishes, in addition to sells as in current law, a product containing or delivering nicotine or lobelia to a person under age 21 (rather than 18 as in current law). Allows a product containing or delivering nicotine or lobelia to be sold to a person under age 21 if the product is a drug, device, or combination product authorized for sale by the U.S. Food and Drug Administration.

Subd. 2. Use of false identification. Changes the penalty from a misdemeanor to an alternative civil penalty if a person under 21 (rather than under 18 as in current law) buys or attempts to buy a nicotine or lobelia delivery product. Provides that penalties do not apply if a person under age 21 buys or attempts to buy these products for training, education, research, or enforcement purposes.

Subd. 3. Alternative penalties. Strikes language establishing a penalty for a person under age 18 who possesses or purchases a nicotine or lobelia delivery product. Directs law enforcement and court systems representatives to develop alternative penalties for persons under age 21 who violate this section, and lists options for alternative penalties. Prohibits alternative penalties from including fines or monetary penalties.

111 **Skin lightening products public awareness and education grant program.**

Subd. 1. Establishment; purpose. Directs the commissioner of health to develop a grant program to increase public awareness and educate communities on the health dangers of using skin lightening products that contain mercury.

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	Subd. 2. Grants authorized. Directs the commissioner to award grants to community-based organizations serving ethnic communities, local public health entities, and nonprofit organizations that provide health care and public health services to minorities, and requires the commissioner to prioritize awarding grants to organizations that have historically served communities at significant risk from these products and that have not had access to state grant funding. **Subd. 3. Grant allocation.** Requires grant funds to be used to conduct public awareness and education activities on the dangers of these products, the symptoms and health effects of mercury poisoning, and how to dispose of products with mercury. Lists information a grant application must include.
112	**Revisor instruction.** Directs the commissioner of health to correct cross-references in statute to conform with the repeal of the HIV/HBV/HCV prevention program.
113	**Repealer.** Para (a) repeals §§ 144.414, subd. 5 (prohibiting the use of electronic delivery devices in certain specific locations and authorizing political subdivisions and businesses to adopt more stringent prohibitions on the use of electronic delivery devices); 144A.45, subd 6, and 144A.481 (obsolete provisions regarding tuberculosis prevention and control for home care providers and the transition to a new licensing structure for home care providers). Para (b) repeals the HIV/HBV/HCV prevention program statutes January 1, 2020.

Article 13: Health Coverage

This article modifies provisions governing health coverage, health maintenance organizations, and health service plan corporations. The article includes provisions modifying loss ratio standards, requiring coverage for certain services and treatments, requiring attorney general review and approval of nonprofit health care entity conversions, requiring HMOs to be nonprofit corporations, regulating the use of HMO net earnings, establishing network adequacy requirements, providing for mental health parity, prohibiting the use of step therapy for metastatic cancer, providing for coverage of contraceptive methods and services, and extending the moratorium on nonprofit HMO and nonprofit service plan corporation conversion transactions.

Section	Description – Article 13: Health Coverage
1	**Loss ratio standards.** Adds subd. 1 to § 62A.021. (a) Requires individual health plans to provide benefits to enrollees that equal at least 80 percent of premiums earned. (b) Requires small employer health plans to provide benefits to enrollees that equal at least 82 percent of premiums earned. (c) Requires health plans issued to large groups to provide benefits to enrollees that equal at least 85 percent of the premiums earned. (d) Requires short-term health plans to provide benefits to enrollees that equal at least 80 percent of premiums earned. (e) Provides information on how to calculate loss ratios for health plans issued by an HMO. (f) Requires health carriers to submit evidence of compliance with paragraphs (a) to (d) to the commissioner by June 1 of every year for the previous year. (g) Requires the commissioner to review the reports required under paragraph (f) for reasonable, soundness, and compliance with this section. Requires the commissioner to resolve issues in the report with the health carrier, and if they cannot be resolved, to require the carrier to issue an appropriate rebate. (h) Provides that a health plan that does not comply with the requirements in paragraphs (a) to (d) is unfair and deceptive and subject to penalties. (i) Requires the commissioners of health and commerce to issue a public report on loss ratios every year.

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2	**Rebate.** Adds subd. 2a to § 62A.021 (a) Requires a health carrier to issue a rebate to each enrollee if the carrier does not meet the loss ratio requirements in section 1. (b) Provides that the rebate must be the aggregate amount of premiums earned multiplied by the difference between the health carrier's actual loss ratio and the loss ratio required under section 1. (c) Requires a health carrier to issue the rebate by August 1 of the year following the year the loss ratio was insufficient. (d) Requires the rebate to be in a lump-sum payment or direct deduction to the current plan year's premium, as appropriate.
3	**Prohibiting subtractions from loss ratio calculations.** Adds subd. 3a to § 62A.021. Prohibits a health carrier from including the following in its loss ratio calculations under section 62A.021, subdivision 1a: (1) reinsurance payments received under section 62E.23; and (2) payments from the commissioner of commerce to health carriers to cover the cost of mandating coverage of treatments for ectodermal dysplasias, PANDAS, and PANS.
4	**Required coverage.** Amends § 62A.25, subd. 2. Requires health plans to provide coverage of reconstructive breast surgery when breast tissue is absent due to ecotodermal dysplasia. Provides that the commissioner of commerce shall reimburse health carriers for coverage for ectodermal dysplasias under this section at the medical assistance rate, and limits reimbursement to coverage that would not have otherwise been provided by the carrier without the requirements of this section. Prohibits a provider from billing an enrollee any amount in excess of the medical assistance rate, but permits the provider to bill the enrollee for the applicable copayment, deductible, or coinsurance. Effective date. This section is effective January 1, 2020, and applies to health plans issued on or after that date.
5	**Required coverage.** Amends § 62A.28, subd. 1. Requires health plans to provide coverage for prosthetic hair when hair loss is due to ectodermal dysplasias. Provides that the commissioner of commerce shall reimburse health carriers for coverage for ectodermal dysplasias under this section at the medical assistance rate, and limits reimbursement to coverage that would not have otherwise been provided by the carrier without the requirements of this section. Prohibits a provider from billing an enrollee any amount in excess of the medical assistance rate, but permits the provider to bill the enrollee for the applicable copayment, deductible, or coinsurance.

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Effective date. This section is effective January 1, 2020, and applies to health plans issued on or after that date.

6 **Mammograms.**

Adds subd. 4 to § 62A.30. (a) Clarifies that coverage for an annual preventative mammogram screening includes digital breast tomosynthesis if the enrollee is at risk for breast cancer. This screening is at the option of the enrollee and at no cost to the enrollee.

(b) Defines "digital breast tomosynthesis" and "at risk for breast cancer".

(c) States that this subdivision does not apply to public health care programs under chapter 256B (medical assistance) or 256L (MinnesotaCare).

(d) Clarifies that nothing in this subdivision limits the coverage of digital breast tomosynthesis for health plans in effect prior to January 1, 2020.

(e) Clarifies that nothing in this subdivision prohibits a health plan from providing coverage for digital breast tomosynthesis to enrollees who are not at risk for breast cancer.

Effective date. This section is effective January 1, 2020, and applies to health plans on or after that date.

7 **Coverage for ectodermal dysplasias.**

Adds § 62A.3096.

Subd. 1. Definitions. Defines ectodermal dysplasias.

Subd. 2. Coverage. Requires health plans to provide coverage for ectodermal dysplasias.

Subd. 3. Dental coverage. (a) Requires health plans to provide coverage for dental treatments, including bone grafts, dental implants, orthodontia, dental prosthodontics, and dental maintenance, when related to ectodermal dysplasias.

(b) States that if the dental treatment is covered by a dental insurance plan or other health plan, the coverage provided under this section is secondary.

Subd. 4. Reimbursement. Provides that the commissioner of commerce shall reimburse health carriers for coverage for ectodermal dysplasias under this section at the medical assistance rate, and limits reimbursement to coverage that would not have otherwise been provided by the carrier without the requirements of this section. Prohibits a provider from billing an enrollee any

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amount in excess of the medical assistance rate, but permits the provider to bill the enrollee for the applicable copayment, deductible, or coinsurance.

Effective date. This section is effective January 1, 2020, and applies to health plans issued on or after that date.

8 **Pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and pediatric acute-onset neuropsychiatric syndrome (PANS) treatment; coverage.**

Adds § 62A.3097.

Subd. 1. Definitions. Provides definitions for PANDAS and PANS.

Subd. 2. Scope of coverage. Applies this section to all health plans that provide coverage to Minnesota residents.

Subd. 3. Required coverage. Requires all health plans to provide coverage for PANDAS and PANS, including antibiotics, medication, behavioral therapies, plasma exchange, and immunoglobulin.

Subd. 4. Reimbursement. Provides that the commissioner of commerce shall reimburse health carriers for coverage for PANDAS and PANS under this section at the medical assistance rate, and limits reimbursement to coverage that would not have otherwise been provided by the carrier without the requirements of this section. Prohibits a provider from billing an enrollee any amount in excess of the medical assistance rate, but permits the provider to bill the enrollee for the applicable copayment, deductible, or coinsurance.

Effective date. This section is effective January 1, 2020, and applies to health plans issued on or after that date.

9 **Short-term coverage.**

Amends § 62A.65, subd. 7. Modifies the definition of short-term coverage by (1) allowing short-term coverage to provide coverage for 90 days or less, rather than 185 days or less as in current law; and (2) limiting the period of coverage under short-term coverage to a total of 185 days, rather than 365 days as in current law, out of any 555-day period.

10 **Application of other laws.**

Adds § 62C.045. Provides that the new chapter governing nonprofit health care entity conversion transactions, and extending the moratorium on conversion transactions, apply to nonprofit health service plan corporations operating under chapter 62C.

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11	**Health maintenance organization.** Amends § 62D.02, subd. 4. Amends the definition of health maintenance organization for chapter 62D, to require them to operate as nonprofit corporations organized under chapter 317A.
12	**Certificate of authority required.** Amends § 62D.03, subd. 1. Provides that a corporation applying to the commissioner of health for an HMO license must be a nonprofit corporation.
13	**Application of other law.** Adds § 62D.046. Provides that the new chapter governing nonprofit health care entity conversion transactions applies to nonprofit HMOs operating under chapter 62D.
14	**Authority granted.** Amend § 62D.05, subd. 1. Provides that a corporation that obtains a certificate of authority to operate an HMO must be nonprofit.
15	**Governing body composition; enrollee advisory board.** Amends § 62D.05, subd. 1. Makes a conforming change to conform with a section requiring HMOs to be organized as nonprofit corporations.
16	**Net earnings.** Adds subd. 8a to § 62D.12. Requires a nonprofit health maintenance organization to use its net earnings to provide comprehensive health care. Prohibits an organization from paying net earnings as a dividend or rebate to a person for any reason other than providing comprehensive health care. An exception to this is that the organization can make certain payments to health care providers. Requires the commissioner of health to revoke an organization's certificate of authority if it violates this subdivision.
17	**Emergency care; primary care; mental health services; general hospital services.** Amends § 62D.124, subd. 1. Requires emergency care to be available to HMO enrollees 24 hours a day, 7 days a week and establishes appointment wait time requirements for primary care services and for mental health and substance use disorder treatment services.
18	**Other health services.** Amends § 62D.124, subd. 2. Establishes appointment wait times for HMO enrollees for nonurgent specialty care and for dental, optometry, laboratory, and x-ray services for regular appointments and urgent care.

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19	**Waiver.** Amends § 62D.124, subd. 3. Allows an HMO to apply for a waiver of the network geographic accessibility requirements, by submitting to the commissioner an application and an application fee of $1,000 per county per year. Specifies application and approval requirements. Allows the commissioner to approve a waiver if the HMO proposes to address network inadequacy through the use of telemedicine, when there are no providers of a specific type or specialty in the county. States that a waiver expires after four years and cannot be renewed; plans must instead submit a new application. Specifies review requirements for new applications. Requires application fees to be deposited in the state government special revenue fund.
20	**Complaints alleging violation of network adequacy requirements; investigation.** Amends § 62D.124, by adding subd. 6. Allows enrollees to file complaints with the commissioner regarding noncompliance of the network geographic accessibility standards. Requires the commissioner to investigate complaints, and allows the commissioner to use the program established under section 62K.105, subdivision 2, to do so.
21	**Provider network notifications.** Amends § 62D.124, by adding subd. 7. Requires an HMO to provide on the organization's website the provider network for each product, and update the website at least once per month. Also requires the HMO to provide on the website a list of current waivers of the network geographic accessibility standard.
22	**Administrative penalty.** Amends § 62D.17, subd. 1. Allows the commissioner to impose an administrative penalty of $100 per day for violations of the network geographic accessibility requirements, and take other enforcement action, but prohibits the commissioner from also imposing an administrative penalty under section 62K.105, subdivision 3.
23	**Unreasonable expenses.** Amends § 62D.19. Makes a conforming change to conform with a section requiring HMOs to be organized as nonprofit corporations.
24	**Rural demonstration project.** Amends § 62D.30, subd. 8. Modifies a cross-reference to a subdivision related to loss ratios, from a subdivision being repealed to a new subdivision.
25	**Health maintenance organization.** Amends § 62E.02, subd. 3. Makes a conforming change to conform with a section requiring HMOs to be organized as nonprofit corporations.

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26	**Calculation of reinsurance payments.** Amends § 62E.23, subd. 4. Prohibits a health carrier from including claims costs for coverage of ectodermal dysplasias, PANDAS, or PANS that are eligible for reimbursement by the commissioner of commerce, when the health carrier calculates claims costs incurred for an individual enrollee for purposes of reinsurance payments.
27	**Provider network notifications.** Amends § 62K.075. Requires health carriers to provide on the carrier's website the provider network for each product, and to update the website at least once a month. Also requires the carrier to provide on the website a list of current waivers of the network geographic accessibility standard.
28	**Emergency care; primary care; mental health services; general hospital services.** Amends § 62K.10, subd. 2. Requires emergency care to be available to enrollees of individual or small group health plans 24 hours a day, 7 days a week and provides that the appointment wait times that apply to HMO enrollees for primary care services, mental health services, and substance use disorder treatment services also apply to these enrollees.
29	**Other health services.** Amends § 62K.10, subd. 3. Provides that the appointment wait times that apply to HMO enrollees for nonurgent specialty care and for dental, optometry, laboratory, and x-ray services also apply to enrollees of individual or small group health plans.
30	**Network adequacy.** Amends § 62K.10, subd. 4. Directs the commissioner to ensure a provider network is sufficient to satisfy the appointment wait time requirements in this section, as part of the commissioner's evaluation of network adequacy.
31	**Waiver.** Amends § 62K.10, subd. 5. Requires health carriers applying for a waiver of the network geographic accessibility standard to submit an application fee of $1,000 per county for which a waiver is sought, and provide specified information. Sets requirements for the commissioner related to reviewing and approving waiver applications. Allows the commissioner to approve a waiver if the HMO proposes to address network inadequacy through the use of telemedicine, when there are no providers of a specific type or specialty in the county. Also specifies requirements related to the submittal and review of new waiver applications. Requires application fees to be deposited in the state government special revenue fund.

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32	**Network adequacy complaints and investigations.** Adds § 62K.105. **Subd. 1. Complaints.** Requires the commissioner to establish a process for accepting complaints from enrollees regarding health carrier and preferred provider organization network adequacy. Requires the commissioner to investigate all complaints. **Subd. 2. Commissioner investigations of provider networks.** Requires the commissioner to establish a "secret shopper" program to determine whether covered services are available to enrollees without unreasonable delay, and whether a network complies with maximum distance and travel time requirements. Requires the commissioner to develop a schedule to ensure periodic examinations of all health carriers and preferred provider organizations, and to use this program to investigate network adequacy complaints under subdivision 1. **Subd. 3. Administrative penalties.** Requires the commissioner to impose on a health carrier or preferred provider organization an administrative penalty of at least $100 a day for violations of network adequacy requirements. Allows the commissioner to take other administrative actions, except that the commissioner shall not also impose an administrative penalty under section 62D.17, subdivision 1. Applies the factors and procedures in section 62D.17, subdivision 1, to the administrative penalties imposed under this subdivision.
33	**Nonquantitative treatment limitations or NQTLs.** Adds subd. 6b to § 62Q.01. Defines "nonquantitative treatment limitations" or "NQTLs" as processes, strategies, or evidentially standards that limit the scope or duration of benefits for treatment. NQTLs may include medical management standards, formulary design, network tiers, requirements for providers, manner of determining charges, step therapy protocols, exclusions, restrictions, reimbursement rates, and other health plan design features.
34	**Prohibition on use of step therapy for metastatic cancer.** Adds § 62Q.1841. **Subd. 1. Definitions.** Defines the following terms: health plan, stage four metastatic cancer, and step therapy protocol. **Subd. 2. Prohibition on use of step therapy protocols.** Prohibits a health plan that provides coverage for the treatment of stage four advanced metastatic cancer or associated conditions from limiting or excluding coverage for a drug approved by the Food and Drug Administration (FDA) that is on the plan's formulary, by mandating that the enrollees follow a step therapy protocol, if the use of the approved drug is consistent with: (1) a FDA-approved indication; and

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(2) a clinical practice guideline published by the National Comprehensive Care Network.

States that the section is effective January 1, 2020, and applies to health plans offered, issued, or renewed on or after that date.

35 **Alcoholism, mental health, and chemical dependency services.**

Amends § 62Q.47. (d) Prohibits a health plan from imposing NQTLs for mental health and substance use disorders that are not-comparable or more stringent than those applied to medical and surgical benefits in the same classification.

(f) Requires health plan companies to provide certain information to the commissioner of commerce to confirm that the mental health parity required by this section is being implemented by health plan companies.

(g) Provides that mental health therapy visits and medication maintenance visits are primary care for purposes of applying patient cost-sharing requirements under a health plan. Requires the commissioner of commerce in consultation with the commissioner of health to issue a report to the legislature every year including detailed information about the commissioner's compliance procedures, enforcement actions, corrective actions, and public information initiatives regarding mental health parity.

36 **Coverage of contraceptive methods and services.**

Adds § 62Q.521.

Subd. 1. Definitions. Provides definitions for closely held for-profit, contraceptive method, contraceptive service, eligible organization, medical necessity, religious employer, and therapeutic equivalent version.

Subd. 2. Required coverage; cost sharing prohibited. (a) Requires health plans to cover contraceptive methods and services.

(b) Prohibits health plan companies for imposing cost-sharing on contraceptive methods and services.

(c) Requires high-deductible health plans with a health savings account to include cost-sharing for contraceptive methods and services at the minimum amount necessary for the enrollee to make tax exempt contributions and withdrawals from the health savings account.

(d) Prohibits a health plan company from imposing referral requirements, restrictions, or delays for contraceptive methods and services.

(e) Requires a health plan company to include at least one type of each FDA approved contraceptive method in its formulary. Clarifies that all therapeutic equivalent versions do not need to be included in the formulary.

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(f) Requires health plan companies to list the contraceptive methods and services that are covered without cost-sharing in an easily accessible manner. Requires the list to be promptly updated to reflect changes.

(g) Requires a health plan company to defer to a health care provider, and provide coverage without cost-sharing, if the provider recommends a particular contraceptive method or service based on medical necessity for the enrollee.

Subd. 3. Religious employers; exempt. (a) Allows a religious employer to not cover contraceptive methods or services if the employer has religious objections. Requires a religious employer to notify employees as part of the hiring process and all employees as least 30 days before enrollment in the health plan or the effective date of the health plan, whichever is first.

(b) Provides that if the religious employer covers some contraceptive methods or services, the notice in paragraph (a) must include a list of what the employer refuses to cover.

Subd. 4. Accommodation for eligible organizations. (a) Allows an eligible organization to not cover contraceptive methods or services if the eligible organizations notifies the health plan company.

(b) Requires the notice from an eligible organization to include certain information.

(c) Requires an eligible organization to provide notice to prospective employees and all employees at least 30 days before enrollment in the health plan or the effective date of the health plan, whichever is first.

(d) Requires a health plan company that receives notice from an eligible organization to exclude coverage for some or all of the contraceptive methods and services and provide separate payment for any method or service required to be covered under subdivision 2.

(e) Prohibits a health plan company from imposing any cost sharing requirements or premium or other charge for contraceptive services or methods to the eligible organization, health plan, or enrollee.

(f) Requires a health plan company to provide the commissioner of commerce with the number of eligible organization accommodations granted under this subdivision each year.

Effective date. This section is effective January 2021, and applies to coverage on or after that date.

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37 **Coverage for prescription contraceptives; supply requirements.**

Adds § 62Q.522.

Subd. 1. Scope of coverage. Requires all health plans that provide prescription coverage to comply with this section, excluding religious organizations.

Subd. 2. Definition. Defines prescription contraceptive as any FDA approved drug or device that prevents pregnancy, but does not include emergency contraceptive drugs.

Subd. 3. Required coverage. (a) Requires health plans to cover a 12-month supply of prescription contraceptives.

(b) Allows the prescribing health care provider to determine the appropriate number of months to prescribe for, up to 12.

Effective date. This section is effective January 2021, and applies to coverage on or after that date.

38 **Essential health benefits package requirements.**

Amends § 62Q.81. Amends a section requiring individual and small group health plans to include an essential health benefits package, by striking requirements that the essential health benefits package comply with requirements in the Affordable Care Act and instead requiring the essential health benefits package to comply with requirements in this section.

Subd. 1. Essential health benefits package. Strikes references to the Affordable Care Act in the definition of essential health benefits package, and instead requires an essential health benefits package to comply with this section.

Subd. 2. Cost-sharing; coverage for enrollees under the age of 21. Lists what is included in cost-sharing, and limits cost-sharing for individual health plans and small group health plans.

Subd. 3. Levels of coverage; alternative compliance for catastrophic plans. Specifies levels of coverage for bronze level, silver level, gold level, and platinum level health plans, and establishes requirements for individuals eligible to enroll in catastrophic plans and the health benefits that a catastrophic plan must offer.

Subd. 4. Essential health benefits; definition. Removes references to the ACA in the definition of essential health benefits, and limits essential health benefits to items listed in paragraph (a) rather than including items listed in paragraph (a). Requires emergency services to be provided without imposing prior authorization requirement or limitation on coverage that is more restrictive than emergency services provided from an in-network provider. Requires cost sharing for out-of-network and in-network emergency services to be the same. Requires the scope of essential health benefits to equal the scope of benefits provided

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	under a typical employer plan. Also requires essential health benefits to reflect an appropriate balance among categories; prohibits coverage decisions or reimbursement rate determinations that discriminate based on age, disability, or life expectance; requires diverse segments of the population to be taken into account, and prohibits essential health benefits from being subject to denial based on any of the listed conditions. **Subd. 5. Exception.** Replaces a reference to the ACA in a subdivision establishing an exception, and instead specifies that the exception applies to pediatric dental plans.
39	**Drugs.** Amends § 256B.0625, subd. 13. Requires medical assistance and MinnesotaCare to provide the prescription coverage under section 62Q.522. Effective date. This section applies to medical assistance and MinnesotaCare coverage effective January 1, 2021.
40	**Prior authorization.** Amends § 256B.0625, subd. 13f. Requires any step therapy protocol requirements established by the Commissioner of Human Services to comply with section 62Q.1841. Provides a January 1, 2020, effective date.
41	**Coverage for treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and pediatric acute-onset neuropsychiatric syndrome (PANS).** Adds subd. 66 to § 256B.0625. Requires MA to cover treatments for PANDAS or PANS according to protocols developed by the Health Services Policy Committee.
42	**Ectodermal dysplasias.** Adds subd. 67 to § 256B.0625. Lists services for the treatment of ectodermal dysplasias covered by MA.
43	**Access standards; appointment wait times.** Adds subd. 6e to § 256B.69. Requires managed care and county-based purchasing plans to comply with the access standards for emergency care and the appointment wait times that apply to HMO enrollees.
44	**Coordination with state-administered health programs.** Amends § 256L.121, subd. 3. Requires the commissioner of human services to coordinate compliance with appointment wait time standards under the MinnesotaCare program with the same standards that apply to MA.

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45	**Nonprofit health care entity; notice and approval required.** Adds subd. 1a to § 317A.811. Adds language to a section requiring notice to the attorney general and a waiting period when a nonprofit corporation intends to dissolve, merge, consolidate, convert, or transfer all or substantially all of its assets. This new subdivision requires a nonprofit health care entity to also comply with sections 62D.046 and 62D.047 for certain transactions.
46	**Nonprofit health care entity conversions; definitions.** Adds § 317B.01. Defines terms for sections governing nonprofit health care entity conversion transactions: commissioner, conversion benefit entity, conversion transaction or transaction, corporation, director, family member, full and fair value, key employee, material amount, member, nonprofit health care entity, officer, public benefit assets, and related organization. **Subd. 3. Conversion benefit entity.** Defines conversion benefit entity as an entity that receives the value of a nonprofit health care entity's public benefit assets, in connection with a conversion transaction. **Subd. 4. Conversion transaction or transaction.** Defines conversion transaction or transaction as a transaction in which a nonprofit health care entity merges, consolidates, converts, or transfers (singly or in a series of separate transfers) all or a material amount of the nonprofit health care entity's assets to an entity that is not a tax-exempt nonprofit corporation operating under chapter 317A or 322C, or in which the nonprofit health care entity adds or substitutes officers, directors, or members in a way that transfers control or governance of the nonprofit health care entity to an entity that is not a tax-exempt nonprofit corporation operating under chapter 317A or 322C. **Subd. 5. Corporation.** Defines corporation to mean a nonprofit corporation organized under chapter 317A or a nonprofit limited liability company organized under chapter 322C. **Subd. 9. Material amount.** Defines material amount to mean the lesser of 10 percent of a nonprofit health care entity's total admitted net assets as of the end of the preceding calendar year, or $10,000,000. **Subd. 12. Nonprofit health care entity.** Defines nonprofit health care entity to mean a nonprofit health service plan corporation, a nonprofit health maintenance organization, a nonprofit corporation that can exercise control over a nonprofit health service plan corporation or a nonprofit HMO, or an entity controlled by a corporation operating a nonprofit health service plan corporation or a nonprofit HMO.

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Subd. 14. Public benefit assets. Defines public benefit assets as the entirety of a nonprofit health care entity's tangible or intangible assets, including its goodwill and anticipated future revenue.

47 **Nonprofit health care entity conversion transactions; review, notice, approval.**

Adds § 317B.02. Prohibits certain conversion transactions, requires the attorney general to receive notice of a conversion transaction and to review the transaction, requires attorney general approval of conversion transactions, and requires a nonprofit health care entity to transfer the value of its public benefit assets to one or more conversion benefit entities as part of the transaction.

Subd. 1. Certain conversion transactions prohibited. Prohibits a nonprofit health care entity from entering into a conversion transaction if a person who was an officer, director, or key employee of the nonprofit health care entity or of a related organization, or a family member, has received or will receive or has held or will hold one of the listed types of compensation, financial benefit, or financial interest in connection with the conversion transaction.

Subd. 2. Attorney general notice required. Requires a nonprofit health care entity to notify the attorney general as required in section 317A.811 before entering into a conversion transaction. Lists additional information the nonprofit health care entity must provide to the attorney general with the notice. Also requires the nonprofit health care entity to provide the notice and information to the commissioner, along with any other information provided to the attorney general at the attorney general's request.

Subd. 3. Review elements. Allows the attorney general to approve, conditionally approve, or disapprove a proposed conversion transaction. Requires the attorney general to consider all relevant factors in evaluating whether the proposed transaction is in the public interest, and lists factors to be considered. Also requires the attorney general to consider public comments received and to consult with the appropriate commissioner before making a decision.

Subd. 4. Conversion benefit entity requirements. Paragraph (a) requires a conversion benefit entity to be an existing or new domestic, tax-exempt nonprofit corporation operating under chapter 317A; have in place policies to prohibit conflicts of interest, including conflicts of interest related to grantmaking activities that may benefit the listed individuals or entities; operate to benefit the health of the people of the state; and have in place policies that prohibit certain individuals from serving in certain positions or benefiting from the conversion transaction.

Paragraph (b) prohibits a conversion benefit entity from making grants or payments or providing financial benefit to an entity that receives public benefit assets, or to a related organization.

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Paragraph (c) prohibits any person who has been an officer, director, or key employee of an entity receiving public benefit assets from serving as an officer, director, or key employee of the conversion benefit entity.

Paragraph (d) requires the attorney general to review and approve the governance structure of the conversion benefit entity before it receives the value of public benefit assets.

Paragraph (e) requires the attorney general to establish a community advisory committee for a conversion benefit entity receiving the value of public benefit assets.

Subd. 5. Hearing; public comment; maintenance of records. Before issuing a decision, requires the attorney general to hold one or more hearings to solicit public comments regarding the conversion transaction. Establishes a notice requirement for public hearings. Also requires the attorney general to develop a summary of comments received, obtain answers to questions posed, and provide those materials to people who request them.

Subd. 6. Approval required; period for approval or disapproval; extension. Paragraph (a) prohibits a nonprofit health care entity from entering into a conversion transaction until (1) 150 days after providing notice to the attorney general, unless all or part of this waiting period is waived; and (2) the attorney general approves the transaction, or conditionally approves the transaction and the conditions are satisfied.

Paragraph (b) requires the attorney general to approve, conditionally approve, or disapprove the conversion transaction during the waiting period, requires the attorney general to provide notice of the decision to the nonprofit health care entity, and allows the attorney general to extend the waiting period.

Paragraph (c) suspends the waiting period while a request for additional information is pending.

Subd. 7. Transfer of value of assets required. If a proposed conversion transaction is approved or conditionally approved, requires the nonprofit health care entity to transfer the full and fair value of its public benefit assets to one or more conversion benefit entities as part of the transaction.

Subd. 8. Assessment of costs. Requires the nonprofit health care entity to reimburse the attorney general or a state agency for costs incurred by the attorney general or state agency in reviewing the proposed conversion transaction and exercising enforcement remedies. Specifies what is included in costs, requires submission of a statement of costs, and establishes requirements for the nonprofit health care entity to pay or dispute the costs. Deposits payments made by the nonprofit health care entity into the general fund, and

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appropriates this money to the attorney general or state agency for costs paid or incurred.

Subd. 9. Challenge to disapproval or conditional approval. Allows a nonprofit health care entity to bring an action in district court to challenge the attorney general's disapproval or conditional approval, and to prevail, requires the nonprofit health care entity to establish that the decision was arbitrary and capricious and unnecessary to protect the public health.

Subd. 10. Penalties; remedies. Allows the attorney general to bring an action to unwind a conversion transaction that violates subdivision 1, establishes civil penalties, and allows the attorney general to enforce this section under section 8.31.

Subd. 11. Relation to other law. Provides that this section does not affect or limit a power, remedy, or responsibility of an HMO, service plan corporation, conversion benefit entity, the attorney general, the commissioner of commerce, or the commissioner of health under other law. Also states that this section does not allow a nonprofit health care entity to enter into a conversion transaction prohibited under other law.

48 **Moratorium on conversion transactions.**

Amends Laws 2017 first special session chapter 6, article 5, section 11. Extends the existing moratorium on conversion transactions for nonprofit service plan corporations and nonprofit health maintenance organizations from June 30, 2019, to June 30, 2029. Provides that an entity subject to this section includes a parent, subsidiary, or affiliate of a nonprofit HMO or nonprofit service plan corporation. Also provides that the transactions governed by this section include a transfer of a material amount of the entity's assets as part of a single transaction or a series of transactions within the past 24 months, and defines material amount as the lesser of 10 percent of the entity's total admitted net assets as of the previous December 31, or $10,000,000. Makes this section effective the day following final enactment.

49 **Findings.**

Establishes legislative findings regarding nonprofit health care entities and their assets, and states that it is necessary for the attorney general to approve a nonprofit health care entity's transfer of assets to ensure the public interest is protected.

50 **Report; denials of coverage for treatment for pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and pediatric acute-onset neuropsychiatric syndrome (PANS).**

Subd. 1. Definitions. Provides definitions for health carrier, health plan, PANDAS, and PANS.

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Subd. 2. Report required. Requires health carriers that offer health plans to Minnesota residents to report to the commissioner of health the number of times they deny coverage for the treatment of PANDAS and PANS, and the specific treatment for which coverage was denied. Requires the commissioner of health to post a report with this information to the department's website by November 1, 2019.

Effective date. This section is effective the day following final enactment.

51 **Coverage for ectodermal dysplasias and PANDAS or PANS.**

Requires a health carrier to use a health plan's coverage as of January 1, 2019, to determine whether the health carrier would not have provided coverage for ectodermal dysplasias, PANDAS, or PANS, and states that treatments and services covered by a health plan as of January 1, 2019, are not eligible for reimbursement by the commissioner of commerce.

52 **Revisor instruction.**

Directs the revisor to codify the moratorium on conversion transactions section in chapter 62D (the chapter governing HMOs).

53 **Repealer.**

Repeals Minnesota Statutes, section 62A.021, subdivisions 1 and 3 (loss ratio standards, loss ratio disclosure).

Article 14: Resident Rights and Consumer Protections

This article establishes resident rights and consumer protections for residents of assisted living facilities, and in certain cases for residents of nursing homes, housing with services establishments, or boarding care homes. Sections in this article prohibit retaliation against facility residents and employees, prohibit deceptive marketing and business practices, state resident rights, authorize electronic monitoring, establish a procedure for a facility to terminate a resident's housing or services, require disclosure of forced arbitration provisions in contracts, and provide remedies for violations of certain sections.

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1 **Retaliation in nursing homes prohibited.**

Adds § 144.6512. Prohibits retaliation against nursing home residents and employees.

Subd. 1. Definitions. Defines nursing home and resident.

Subd. 2. Retaliation prohibited. Prohibits a nursing home from retaliating against a resident or employee if the resident, employee, or person acting in their behalf files a complaint, asserts a right, indicates an intention to file a complaint, files a maltreatment report, seeks help from or reports a crime to the nursing home or others, seeks advocacy assistance, files a civil action, participates in an investigation, contracts with a service provider other than the nursing home, or places an electronic monitoring device in the resident's private space.

Subd. 3. Retaliation against a resident. Lists actions that constitute retaliation against a resident.

Subd. 4. Retaliation against an employee. Lists actions that constitute retaliation against an employee.

Subd. 5. Rebuttable presumption of retaliation. Paragraph (a) provides that there is a rebuttable presumption that the listed acts against residents and employees, if taken within 90 days of an initial action, constitute retaliation. Paragraphs (b) to (d) specify exceptions in which this presumption does not apply.

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2 **Retaliation prohibited.**

Adds § 144G.07. Prohibits retaliation against residents and employees of housing with services establishments that use assisted living title protection.

Subd. 1. Definitions. Defines facility and resident for this section and section 144G.08.

Subd. 2. Retaliation prohibited. Prohibits a housing with services establishment using assisted living title protection from retaliating against a resident or employee if the resident, employee, or person acting in their behalf files a complaint, asserts a right, indicates an intention to file a complaint, files a maltreatment report, seeks help from or reports a crime to the housing with services establishment or others, seeks advocacy assistance, files a civil action, participates in an investigation, contracts with a service provider other than the housing with services establishment, or places an electronic monitoring device in the resident's private space.

Subd. 3. Retaliation against a resident. Lists actions that constitute retaliation against a resident.

Subd. 4. Retaliation against an employee. Lists actions that constitute retaliation against an employee.

Subd. 5. Rebuttable presumption of retaliation. Paragraph (a) provides that there is a rebuttable presumption that the listed acts against residents and employees, if taken within 90 days of an initial action, constitute retaliation. Paragraphs (b) to (d) specify exceptions in which this presumption does not apply.

Subd. 6. Remedy. Allows a resident who is a senior citizen or person with disabilities and is injured by a violation of this section to bring a civil action for damages.

3 **Deceptive marketing and business practices prohibited.**

Amends § 144G.08.

Subd. 1. Prohibitions. Prohibits an employee or agent of a housing with services establishment that uses assisted living title protection from making false, fraudulent, deceptive, or misleading statements, representations, or material omissions in marketing, advertising, or another description of care or services. Prohibits a housing with services contract from being deceptive, and prohibits a facility from advertising or representing that the facility has a dementia care unit without complying with the disclosure requirements for those units in other law.

Subd. 2. Remedies. Allows the attorney general to enforce this section by seeking an injunction in district court. Also allows a resident who is a senior

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citizen or person with disabilities and is injured by a violation of this section to bring a civil action for damages.

4 **Definitions.**

Adds § 144J.01. Defines terms for a chapter establishing resident rights and consumer protections for residents of assisted living facilities: assisted living contract, assisted living facility, assisted living facility with dementia care, assisted living services, attorney-in-fact, conservator, designated representative, facility, guardian, health care agent, legal representative, licensed health care professional, resident, resident record, and service plan.

5 **Resident rights.**

Adds § 144J.02.

Subd. 1. Applicability. Provides that this section applies to assisted living facility residents.

Subd. 2. Legislative intent. States legislative intent for this section.

Subd. 3. Information about rights and facility policies. Before receiving services, provides that residents have the right to receive written information about rights in plain language and in terms residents can understand. Requires reasonable accommodations for residents with communication disabilities or who speak languages other than English. Lists what information must be provided. Also allows residents to request current policies, inspection findings, and further explanations of the rights provided under this section.

Subd. 4. Courteous treatment. Provides that residents have the right to be treated with courtesy and respect and to have their property treated with respect.

Subd. 5. Appropriate care and services. Provides that residents have the right to care and services that are appropriate according to a current plan for care and services, and the right to receive medical and personal care and services with continuity from properly trained, competent people.

Subd. 6. Participating in care and service planning. Provides that residents have the right to actively participate in planning, modifying, and evaluating their care and services.

Subd. 7. Information about individuals providing services. Provides that residents, before receiving services, have the right to be told about the type and discipline of staff who will provide the services, the frequency of proposed visits, and other choices to address the resident's needs.

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Subd. 8. Information about health care treatment. Provides that residents have the right to complete, current information about their diagnosis, cognitive functioning level, treatment, alternatives, risks, and prognosis.

Subd. 9. Information about other providers and services. Provides that residents have the right to be informed by the facility that the resident has the right to purchase or obtain services from a provider other than the assisted living facility or a related provider.

Subd. 10. Information about charges. Provides that residents have the right to certain information about charges for services, payments from health insurance or a public health care program, and charges for which the resident may be responsible.

Subd. 11. Refusal of care or services. Provides that residents have the right to refuse services or care, and requires these refusals to be documented in the resident's record.

Subd. 12. Freedom from maltreatment. Provides that residents have the right to be free from maltreatment.

Subd. 13. Personal and treatment privacy. Provides that residents have the listed rights to personal privacy and privacy in their treatment.

Subd. 14. Communication privacy. Provides that residents have the right to communicate privately with persons of their choice.

Subd. 15. Confidentiality of records. Provides that residents have the right to have personal, financial, and medical information kept private, to approve or refuse to approve releases of information, and to be informed of policies and procedures for disclosure of information. Also requires residents to be notified when an outside party requests personal records, and states that residents have the right to access their own records.

Subd. 16. Grievances and inquiries. Provides that residents have the right to make complaints and receive a timely response to complaints, and to know the person at the facility designated to handle and resolve complaints. Requires facilities to promptly investigate and try to resolve complaints.

Subd. 17. Visitors and social participation. Provides that residents have the right to protection and advocacy services, to receive and meet with visitors, and to participate in commercial, religious, social, community, and political activities.

Subd. 18. Access to counsel and advocacy services. Provides that residents have the right to immediate access to legal counsel and representatives of the protection and advocacy system.

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Subd. 19. Right to come and go freely. Provides that residents have the right to enter and leave the facility as they choose.

Subd. 20. Access to technology. Provides that residents have the right to access Internet technology at their own expense, unless offered by the facility.

Subd. 21. Resident councils. Provides that residents have the right to organize and participate in resident councils, and specifies facility functions and duties for these councils.

Subd. 22. Family councils. Provides that residents have the right to organize and participate in family councils, and specifies facility functions and duties for these councils.

6 **Retaliation prohibited.**

Adds § 144J.03. Prohibits retaliation against residents and employees of assisted living facilities.

Subd. 1. Retaliation prohibited. Prohibits an assisted living facility from retaliating against a resident or employee if the resident, employee, or person acting in their behalf files a complaint, asserts a right, indicates an intention to file a complaint, files a maltreatment report, seeks help from or reports a crime to the facility or others, seeks advocacy assistance, files a civil action, participates in an investigation, contracts with a service provider other than the facility, or places an electronic monitoring device in the resident's private space.

Subd. 2. Retaliation against a resident. Lists actions that constitute retaliation against a resident.

Subd. 3. Retaliation against an employee. Lists actions that constitute retaliation against an employee.

Subd. 4. Rebuttable presumption of retaliation. Paragraph (a) provides that there is a rebuttable presumption that the listed acts against residents and employees, if taken within 90 days of an initial action, constitute retaliation. Paragraphs (b) to (d) specify exceptions in which this presumption does not apply.

Subd. 5. Other laws. States that this section does not affect the rights of a resident under the maltreatment of vulnerable adults act.

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7 **Deceptive marketing and business practices prohibited.**

Adds § 144J.04. Prohibits a facility employee or agent from making false, fraudulent, deceptive, or misleading statements, representations, or material omissions in marketing, advertising, or another description of care or services. Prohibits an assisted living contract from being deceptive, and prohibits a facility from advertising or representing that the facility has a dementia care unit without complying with the disclosure requirements for those units in other law. Allows the attorney general to enforce this section by seeking an injunction in district court.

8 **Electronic monitoring in certain facilities.**

Adds § 144J.05. Authorizes electronic monitoring in certain facilities.

Subd. 1. Definitions. Defines terms for this section: commissioner, department, electronic monitoring, electronic monitoring device, facility, resident, resident representative.

Subd. 2. Electronic monitoring authorized. Requires a facility to allow a resident or resident representative to conduct electronic monitoring in the resident's room or private living space. Provides that this section does not preclude electronic monitoring in health care as allowed under other law.

Subd. 3. Consent to electronic monitoring. Requires a resident to consent to electronic monitoring in writing on a notification and consent form, unless an exception applies. If a resident does not affirmatively object to electronic monitoring and if the resident cannot understand the nature and consequences of electronic monitoring, allows a resident representative to consent to electronic monitoring on behalf of the resident. Before consenting on behalf of a resident, lists information the resident representative must explain to the resident. Allows a resident to set conditions for the use of electronic monitoring, to request that electronic monitoring is turned off or blocked in certain circumstances, or to withdraw consent for electronic monitoring. Before implementing electronic monitoring, requires a resident or resident representative to obtain written consent from all roommates. Allows a resident representative to consent on behalf of a roommate.

Subd. 4. Refusal of roommate to consent. If a resident residing in a shared room wants to conduct electronic monitoring and a roommate refuses to consent, requires a facility to make reasonable attempts to accommodate the resident who wants to conduct electronic monitoring by offering to move the resident to another available shared room. Requires a resident to pay the private room rate if the resident chooses to reside in a private room in order to accommodate the use of an electronic monitoring device. If the facility cannot accommodate the resident due to lack of space, requires the facility to reevaluate the situation periodically until the request is fulfilled.

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Subd. 5. Notice to facility; exceptions. Before beginning electronic monitoring, requires a resident or resident representative to submit a notification and consent form to the facility, except the resident or resident representative is not required to submit the notification and consent form for up to 30 days if:

- the resident or resident representative fears retaliation, submits the notification and consent form to the Office of Ombudsman for Long-Term Care, and submits a maltreatment report to the common entry point upon evidence from the electronic monitoring device of suspected maltreatment;
- there has not been a timely written response from the facility to a written communication from the resident or resident representative expressing a concern that prompted placement of an electronic monitoring device and the notification and consent form was submitted to the Office of Ombudsman for Long-Term Care; or
- the resident or resident representative has already submitted a maltreatment report to the common entry point or police regarding the concerns that prompted placement of an electronic monitoring device and the notification and consent form was submitted to the Office of Ombudsman for Long-Term Care.

Specifies steps when a resident, roommate, or resident representative wants to alter the conditions of consent to electronic monitoring, and specifies what happens when a new roommate moves into a room where electronic monitoring is taking place and when consent is withdrawn to electronic monitoring.

Subd. 6. Form requirements. Lists what must be included on the notification and consent form.

Subd. 7. Costs and installation. Requires a resident choosing to conduct electronic monitoring to pay for purchasing and installing the electronic monitoring device. Provides that the resident may also be responsible for paying for Internet service, and requires a facility to make a reasonable attempt to accommodate the resident's installation needs.

Subd. 8. Notice to visitors. Requires a facility to post a sign at each entrance accessible to visitors stating that electronic monitoring devices may be present.

Subd. 9. Obstruction of electronic monitoring devices. Prohibits a person from obstructing an electronic monitoring device without permission from the resident or resident representative, but allows the device to be turned off or blocked if the resident or resident representative so directs, or if consent has been withdrawn.

Subd. 10. Dissemination of recordings. Prohibits a person from accessing any data created through electronic monitoring without written consent from the resident or resident representative. Allows data created through electronic monitoring to be disseminated only to address health, safety, or welfare

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concerns of residents. Disseminating data from electronic monitoring in violation of this section may be grounds for civil or criminal liability.

Subd. 11. Admissibility of evidence. Provides that records created through electronic monitoring may be admitted into evidence in a civil, criminal, or administrative proceeding.

Subd. 12. Liability. States that the mere presence of electronic monitoring is not a violation of a resident's right to privacy and that a facility is not liable if a resident discloses a recording.

Subd. 13. Immunity from liability. Provides for immunity from liability for the Office of Ombudsman for Long-Term Care.

Subd. 14. Resident protections. Prohibits a facility from refusing to admit a resident or removing a resident if the facility disagrees with a decision regarding electronic monitoring; retaliating against a resident for consenting or refusing to consent to electronic monitoring; or preventing the placement or use of electronic monitoring.

Subd. 15. Employee discipline. Allows a facility employee to access electronic monitoring if it is being used as evidence in a disciplinary action against the employee. Prohibits an employee from further disseminating the recording.

Subd. 16. Penalties. Allows the commissioner to issue a correction order if the facility fails to comply with requirements to store the notification and consent form and give the resident a copy, make the form available for changes, remove the device if roommate consent is not obtained, notify residents of the option of conducting electronic monitoring, accommodate resident installation needs, provide notice to visitors, prohibit obstruction of devices, prevent unauthorized dissemination of recordings, and comply with resident protections.

9 **No discrimination based on source of payment.**

Adds § 144J.06. Requires facilities to provide equal access to quality care and maintain identical policies for residency, transfers, and provision and termination of services, regardless of the source of payment.

10 **Consumer advocacy and legal services.**

Adds § 144J.07. Requires a facility to provide the resident and certain representatives with the names and contact information of nonprofit organizations that provide advocacy or legal services and the Office of Ombudsman for Long-Term Care.

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11 **Involuntary discharges and service terminations.**

Adds § 144J.08.

Subd. 1. Definitions. Defines terms for this section: facility, refusal to readmit, termination of housing or services.

Subds. 2-3. Prerequisites to termination of housing or services; permissible reasons to terminate housing or services. Prohibits an assisted living facility from terminating housing or services, except if the termination is necessary for one of the listed reasons or if the resident's needs exceed the scope of services for which the resident contracted or the scope of the assisted living facility's license. Allows a facility to initiate discharge, eviction, or termination proceedings for nonpayment, provided other criteria are met.

Subd. 4. Notice of termination required. Requires at least 30 days' advance notice to the resident and the Office of Ombudsman for Long-Term Care of a termination of housing or services, except in emergencies or if the facility's license is restricted by the commissioner or if the facility ceases operations.

Subd. 5. Content of notice. Lists what the advance notice of a termination of housing or services must include

Subd. 6. Exceptions for emergencies. Specifies when an assisted living facility may relocate a resident from the facility with less than 30 days' notice.

12 **Appeal of termination of housing or services.**

Adds § 144J.09.

Subd. 1. Right to appeal termination of housing or services. Gives a facility resident and certain others the right to appeal a termination of housing or services or a refusal to readmit a resident after an emergency relocation.

Subd. 2. Appeals process. Requires an appeal and request for a contested case hearing to be filed as authorized by the chief administrative law judge, and requires the Office of Administrative Hearings to conduct an expedited hearing within 14 calendar days after receipt of the hearing request. Places the burden of proof on the facility to establish that the termination or refusal to readmit is permissible and does not constitute retaliation. Provides for appeals from final determinations.

Subd. 3. Representation at a hearing. Allows but does not require parties to be represented by counsel at a contested case hearing.

Subd. 4. Service provision while appeal pending. Prohibits housing or services from being terminated while an appeal is ongoing.

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13	**Housing and service termination; relocation planning.** Adds § 144J.10. **Subd. 1. Duties of facility.** If a facility terminates housing or services, intends to cease operations, or is subject to a restricted license, requires the facility to ensure a coordinated transfer of residents to a safe location or appropriate service provider. Also requires the facility to cooperate and consult with the resident and others. **Subd. 2. Safe location.** Lists places that are not considered safe locations, so residents cannot be transferred to those places. Prohibits a facility from terminating housing or services if the resident will become homeless. **Subd. 3. Written relocation plan required.** Requires a facility to prepare a written relocation plan. **Subd. 4. No relocation without receiving setting accepting.** Prohibits relocation unless the receiving setting indicates it will accept the resident. **Subd. 5. No termination of services without another provider.** Prohibits a termination of services unless another provider has indicated it will provide those services. **Subd. 6. Information that must be conveyed.** Lists resident information that the facility must provide to the receiving facility. **Subd. 7. Final accounting; return of money and property.** Within a certain time period, requires the facility to provide the resident whose housing or services are being terminated with a final statement of account, any refunds due, the return of valuables held by the facility, and a refund of the resident's security deposit.
14	**Forced arbitration.** Adds § 144J.11. Requires an assisted living facility to affirmatively disclose to the resident any forced arbitration provision; and prohibits a forced arbitration provision from including a choice of law or choice of venue provision or from being unconscionable.

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15	**Violation of rights.** Adds § 144J.12. Allows a resident who is a senior citizen or person with disabilities and is injured by a violation of the following sections to bring a civil action for damages: ▪ section 144J.02, subdivisions 12, 15, and 18 (freedom from maltreatment, confidentiality of records, and access to counsel and advocacy services); ▪ section 144J.03 (retaliation prohibited), unless the resident has a cause of action under the maltreatment of vulnerable adults act; and ▪ section 144J.04 (deceptive marketing and business practices).
16	**Applicability of other laws.** Adds § 144J.13. Requires assisted living facilities to comply with landlord-tenant laws, and a requirement to disclose information about dementia care services provided. Provides that these facilities are not required to obtain a lodging license under chapter 157.
17	**Remedy.** Amends § 325F.72. For violations of a section requiring disclosure of information about dementia care services provided, strikes language that a private right of action is not available.

Article 15: Independent Senior Living Facilities

This article prohibits deceptive marketing and business practices in independent senior living facilities, establishes requirements for residency and services contracts, requires notice when residency and services contracts are terminated, establishes training requirements for facility managers, establishes requirements for fire protection, physical environment, and emergency planning, and provides for remedies for violations of this chapter.

Section	Description – Article 15: Independent Senior Living Facilities
1	**Definitions.** Adds § 144K.01 Defines terms for chapter 144K: dementia, designated representative, facility, independent senior living facility, manager, residency and services contract, related supportive services provider, resident, supportive services, and wellness check services.

Section	Description – Article 15: Independent Senior Living Facilities

2 **Deceptive marketing and business practices prohibited.**

Adds § 144K.02. Prohibits employees and agents of independent senior living facilities from making false, fraudulent, deceptive, or misleading statements or representations or material omissions in marketing, advertising, or describing care or services. Prohibits a residency and services contract from including a provision that is deceptive, unlawful, or unenforceable. Prohibits a facility from representing that it is an assisted living facility or assisted living facility with dementia care.

3 **Required disclosure by facility.**

Adds § 144K.025. Requires an independent senior living facility to disclose to prospective residents and residents that the facility is not licensed as an assisted living facility and is not permitted to provide assisted living services directly or through a business relationship with a provider.

4 **Residency and services contract.**

Adds § 144K.03.

Subd. 1. Contract required. Requires an independent senior living facility to execute written contracts with each resident and to operate within the terms of the contract. Requires the contract to contain all the terms of the provision of housing or services.

Subd. 2. Contents of contract. Lists elements that must be included in a residency and services contract.

Subd. 3. Designation of representative. Requires a facility to offer the resident a chance to designate a representative in the contract.

Subd. 4. Contracts are consumer contracts. Provides that residency and services contracts are consumer contracts governed by sections in chapter 325G.

Subd. 5. Additions and amendments to contract. Provides that a resident must agree in writing to additions or amendments to the contract.

Subd. 6. Contracts in permanent files. Requires contracts to be maintained in facility files from the date of execution until three years after the contract is terminated.

Subd. 7. Waiver of liability prohibited. Prohibits the contract from including a waiver of facility liability for the health, safety, or personal property of residents. Also prohibits provisions that are deceptive, unlawful, or unenforceable.

Subd. 8. Contract restriction. Prohibits an independent senior living facility from offering wellness check services.

Section	Description – Article 15: Independent Senior Living Facilities
5	**Termination of residency and services contract.** Adds § 144K.04. **Subd. 1. Notice required.** Requires a facility to provide at least 30 days' notice of a termination of a residency and services contract. **Subd. 2. Content of notice.** Lists what the notice must contain.
6	**Manager requirements.** Adds § 144K.05. Requires a manager of a facility to obtain at least 30 hours of continuing education every two years on topics relevant to the operation of the facility. Requires continuing education to include training on dementia, activities of daily living, challenging behaviors, and communications skills. Requires the facility to maintain records for at least three years demonstrating the manager is in compliance with the requirements of this section.
7	**Fire protection and physical environment.** Adds § 144K.06. Requires a facility to have a comprehensive fire protection system, and lists what that system includes. Also requires fire drills to be conducted.
8	**Emergency planning.** Adds § 144K.07. **Subd. 1. Requirements.** Requires a facility to have and post an emergency disaster plan, provide emergency exit diagrams to all residents and post those diagrams, and have a written policy regarding missing residents. **Subd. 2. Emergency and disaster training.** Requires a facility to provide staff with emergency and disaster training during initial orientation and annually thereafter.
9	**Other laws.** Adds § 144K.08. Requires a facility to comply with landlord-tenant laws and maintain all required licenses and government approvals.
10	**Enforcement.** Adds § 144K.09. Provides that a violation of this chapter is a deceptive practice that may be enjoined by the attorney general under section 325F.70. Permits a resident of a facility who is a senior citizen or person with disabilities and who is injured by a violation of this chapter, to bring a civil action for damages and other relief.

Article 16: Assisted Living Licensure

This article establishes a framework for the licensure of facilities that provide assisted living services by the commissioner of health. A facility that provides assisted living services must be licensed under the new chapter established in this section, chapter 144I, effective August 1, 2021. There are two categories of facilities subject to licensure:

- an assisted living facility, which provides housing and offers or provides basic care services and comprehensive assisted living services; and
- an assisted living facility with dementia care, which provides housing and offers or provides dementia care services along with basic care services and comprehensive care services, and which may have a secure dementia unit.

This article establishes requirements and procedures for licensure and licensure renewal; provides for denial, suspension, or revocation of licenses, injunctive relief, and fines and correction orders; requires surveys and inspections; establishes fees in blank amounts; prohibits transfers of licenses; establishes terms for management agreements; requires background studies; establishes requirements for facility business operations and administrators; requires resident evaluations and assessments; provides for staff supervision, support, and training, including dementia care training; establishes medication management and treatment and therapy management requirements; provides for recordkeeping and notices, information, and complaints; establishes physical plant requirements; permits innovation variances; establishes an advisory group; and authorizes expedited rulemaking.

Section	Description – Article 16: Assisted Living Licensure
1	**License, permit, and survey fees.** Amends § 144.122. Establishes licensing fees for assisted living facilities and assisted living facilities with dementia care, at a blank base amount plus a blank amount per bed for each facility type.
2	**Definitions.** Adds § 144I.01. Defines terms for this chapter. **Subd. 6. Assisted living facility.** Defines assisted living facility as a licensed facility that provides sleeping accommodations to one or more adults and provides basic care services and comprehensive assisted living services. **Subd. 7. Assisted living services.** Defines assisted living services as basic care services and one or more of the listed services to address the health care needs of residents. **Subd. 8. Assisted living facility with dementia care.** Defines assisted living facility with dementia care to mean a licensed assisted living facility that also provides dementia care services and that may have a secured dementia care unit.

Section	Description – Article 16: Assisted Living Licensure

Subd. 10. Basic care services. Defines basic care services as assistive tasks provided by licensed or unlicensed personnel that include assistance with activities of daily living, standby assistance, reminders to take medications, reminders to perform treatments and exercises, preparing modified diets, having and documenting a system to check on residents at least once a day, and supportive services in addition to one of the other listed services.

Subd. 17. Dementia care services. Defines dementia care services as a form of long-term care designed to meet the specific needs of individuals with dementia.

3 **Assisted living facility license.**

Adds § 144I.02. Requires licensure of assisted living facilities, and establishes penalties for operating without a license.

Subd. 1. License required. Beginning August 1, 2021, prohibits operation of an assisted living facility unless it is licensed under this chapter.

Subd. 2. Licensure categories. Establishes two licensure categories: an assisted living category for assisted living facilities that provide basic care services and comprehensive assisted living services; and an assisted living facility with dementia care category for assisted living facilities that provide basic care services, comprehensive care services, and dementia care services.

Subd. 3. Violations; penalty. Makes operating a facility without a license a misdemeanor punishable by a fine imposed by the commissioner, and also makes a controlling individual of a facility operating without a license guilty of a misdemeanor. Provides that sanctions in this section do not restrict other available sanctions.

4 **Provisional license.**

Adds § 144I.03. Establishes requirements for provisional licenses for assisted living facilities.

Subd. 1. Provisional license. Beginning August 1, 2021, for new applicants, requires the commissioner to issue a provisional license, and makes provisional licenses valid for one year unless extended. Makes assisted living facilities subject to evaluation and approval of its physical environment and operational aspects before a change in ownership or capacity, or an addition of services that necessitates a change in physical environment.

Subd. 2. Initial survey; licensure. Requires the commissioner to survey the licensee during the provisional license period, after the provisional licensee has residents and is providing services. Requires the provisional licensee to notify the commissioner when it begins serving residents. Allows the commissioner to extend the provisional license in certain circumstances. Provides if the provisional licensee is in substantial compliance with the survey the

Section	Description – Article 16: Assisted Living Licensure

commissioner shall issue a license, and specifies what happens if the provisional licensee is not in substantial compliance.

Subd. 3. Reconsideration. Allows a provisional licensee that disagrees with the commissioner's conclusions in denying licensure or conditioning licensure, to request reconsideration. Specifies reconsideration procedures.

Subd. 4. Continued operation. Lists circumstances under which a provisional licensee whose license is denied may continue operating.

Subd. 5. Requirements for notice and transfer. Requires a provisional licensee whose license is denied to comply with the requirements for notification and transfer of residents.

Subd. 6. Fines. Establishes a fine of $1,000 if a provisional licensee fails to comply with notification requirements when relocating a resident.

5 **Application for licensure.**

Adds § 144I.04. Establishes requirements for applications for licensure.

Subd. 1. License applications. Lists information that an applicant for licensure must provide to the commissioner in an application.

Subd. 2. Agents. Requires an application for licensure or license renewal to specify the individuals responsible for dealing with the commissioner regarding compliance with licensing requirements, and on whom personal service of notices and orders shall be made.

Subd. 3. Fees. Requires an applicant for initial licensure, license renewal, or filing a change of ownership to submit the required application fee, and establishes a penalty for late submission of a renewal application. Specifies where fees and fines are deposited, and annually appropriates money from fines to the commissioner to implement recommendations of the home care and assisted living advisory council.

6 **Transfers of license.**

Adds § 144I.05.

Subd. 1. Transfers prohibited. Prohibits a facility license from being transferred to another party.

Subd. 2. New license required. Requires a facility to obtain a new license before a transfer of ownership, if the current licensee's legal organizational form or status changes, if the current licensee dissolves the business enterprise, if the current licensee consolidates or merges with another legal organization, if there is a transfer of 50 percent of more of the licensed entity, or if the licensee's

Section	Description – Article 16: Assisted Living Licensure

control of the facility is eliminated or withdrawn. Requires a licensee to provide at least 60 days' notice to the commissioner if the licensee changes.

Subd. 3. Survey required. Requires the commissioner to complete a survey within six months after a new license is issued.

7 **Background studies.**

Adds § 144I.06.

Subd. 1. Background studies required. Requires the commissioner to complete a background study on controlling individuals and managerial officials before issuing or renewing a license. Also requires background studies of employees, contractors, and volunteers at the facility.

Subd. 2. Reconsideration. Allows an individual who is disqualified to request reconsideration, and specifies the consequences if a disqualification is set aside, rescinded, or affirmed.

Subd. 3. Data classification. Classifies background study data as private data on individuals.

Subd. 4. Termination in good faith. Provides that an assisted living facility is not subject to civil liability or liability for unemployment benefits for terminating an employee in good faith reliance on background study information

8 **License renewal.**

Adds § 144I.07. Allows a license, other than a provisional license, to be renewed for up to one year upon submission of an application for renewal, required fees, information sufficient to show the applicant meets the requirements for licensure, and any other information required by the commissioner.

9 **Notification of changes in information.**

Adds § 144I.08. Requires a provisional licensee or licensee to notify the commissioner in writing before any financial or contractual change and within 60 days after any change in the information required in the application for licensure.

10 **Consideration of applications.**

Adds § 144I.09. Specifies what the commissioner must consider before issuing a provisional license, license, or license renewal. Lists grounds for the commissioner to deny, revoke, suspend, restrict, or refuse to renew a license. Requires a survey of a new licensee after a change in ownership within six months after the new license is issued.

Section	Description – Article 16: Assisted Living Licensure
11	**Minimum assisted living facility requirements.** Adds § 144I.10.

Subd. 1. Minimum requirements. Lists required services, procedures, and rights for person-centered planning, a means for residents to request assistance, delegation of health care activities to unlicensed personnel, access to food, access to visitors, being able to choose a roommate, have a lockable door, staffing plans, availability of staff 24 hours a day to respond to requests, nutritious food, social and recreational activities, and reasonable assistance with transportation to appointments, shopping, and other recreation.

Subd. 2. Policies and procedures. Lists policies and procedures a facility must have.

Subd. 3. Infection control program. Requires a facility to maintain an infection control program.

Subd. 4. Clinical nurse supervision. Requires a facility to have a clinical nurse supervisor.

Subd. 5. Resident and family or resident representative councils. Requires a facility to support the establishment of resident, family, or resident representative councils, and provides for the support and operation of a council.

Subd. 6. Resident grievances. Requires a facility to post in a conspicuous place information about the facility's grievance procedure.

Subd. 7. Protecting resident rights. Requires a facility to provide information about how to contact consumer advocacy or legal services organizations.

Subd. 8. Protection-related rights. Lists rights for residents that are in addition to the assisted living bill of rights. Provides that certain rights may be restricted only if found necessary for health and safety reasons.

Subd. 9. Payment for services under disability waivers. Provides that for new facilities, home and community-based services are not available when the new facility is adjoining to or on the same property as an institution.

Subd. 10. No discrimination based on source of payment. Regardless of the source of payment, requires a facility to provide equal access to quality care and have identical policies and practices regarding residency, transfer, and provision and termination of services.

Section	Description – Article 16: Assisted Living Licensure
12	**Facility responsibilities; housing and service-related matters.** Adds § 144I.11. **Subd. 1. Responsibility for housing and services.** Provides that the facility is directly responsible to the resident for all housing and service-related matters, and specifies what these matters include. **Subd. 2. Uniform checklist disclosure of services.** Requires a prospective resident to be provided with a written checklist listing all services permitted under the facility's license, identifying services the facility provides and services it does not provide, and an oral explanation of these services. Requires the commissioner to design this uniform checklist. **Subd. 3. Reservation of rights.** Provides that a resident is not required to use services in a facility, a facility is not prohibited from requiring a resident to pay for a package of services even if the resident does not use the services, a facility does not have to fundamentally alter the nature of the facility's operation in order to accommodate a resident, and a facility has a duty to respond to requests for reasonable accommodations.
13	**Transfer of residents within facility.** Adds § 144I.12. Requires a facility to provide for the safe, orderly, and appropriate transfer of residents within a facility. Requires 30 days' notice to the resident of the transfer, and directs the facility to minimize the number of transfers that occur because of construction or a change in operations.
14	**Facility responsibilities; business operation.** Adds § 144I.13. **Subd. 1. Display of license.** Requires the facility to display its original, current license at the facility's main entrance. **Subd. 2. Quality management.** Requires the facility to engage in quality management activities, and specifies what quality management activities include. **Subd. 3. Facility restrictions.** Except in certain cases, prohibits a facility or staff person from accepting power of attorney, appointment as a guardian or conservator, or appointment as a resident representative. **Subd. 4. Handling resident's finances and property.** Allows a facility to assist residents with housing budgeting, but otherwise prohibits a facility from managing a resident's property. Requires a facility to provide residents with receipts or documentation for purchases. Prohibits the facility or a staff person from borrowing a resident's funds or property. Allows acceptance of gifts of minimal value.

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Subd. 5. Reporting maltreatment of vulnerable adults; abuse prevention plan. Requires a facility to comply with requirements to report maltreatment of vulnerable adults, requires a procedure for ensuring cases of maltreatment are reported, and requires development of an individual abuse prevention plan for each vulnerable adult.

Subd. 6. Reporting suspected crime and maltreatment. Requires a facility to post certain information to help residents report suspected criminal activity or vulnerable adult maltreatment.

Subd. 7. Employee records. Requires a facility to maintain current records of each paid employee, volunteer, and individual contractor. Lists what the facility records for these persons must include.

Subd. 8. Compliance officer. Requires a facility to have a compliance officer.

15 **Facility responsibilities; staff.**

Adds § 144I.14.

Subd. 1. Qualifications, training, and competency. Requires staff to be trained and competent in the provision of services.

Subd. 2. Licensed health professionals and nurses. Requires licensed health professionals who are facility employees to be Minnesota-licensed, and competent in assessing resident needs, planning appropriate services, implementing services, and supervising staff.

Subd. 3. Unlicensed personnel. Lists required qualifications for unlicensed personnel.

Subd. 4. Delegation of assisted living services. Allows a registered nurse or licensed health professional to delegate tasks to staff who are competent and possess the required skills and knowledge to perform the task. Requires the facility to communicate current information to nurses or licensed health professionals regarding staff available and their competencies.

Subd. 5. Temporary staff. Requires temporary staff to meet the same requirements as facility employees.

Subd. 6. Requirements for instructors, training content, and competency evaluations for unlicensed personnel. Lists qualifications for instructors. Specifies what training and competency evaluations for unlicensed personnel must include. Requires a person delegating a task to ensure that the unlicensed personnel is trained to properly perform the task being delegated.

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Subd. 7. Tuberculosis prevention and control. Requires a facility to maintain a comprehensive tuberculosis prevention and control program.

Subd. 8. Disaster planning and emergency preparedness plan. Specifies requirements for having and posting information about emergency disaster plans, emergency exits, and procedures for missing residents. Requires emergency and disaster training for all staff during initial orientation and annually thereafter.

16 **Facility responsibilities with respect to residents.**

Adds § 144I.15.

Subd. 1. Assisted living bill of rights; notification to resident. Requires the facility to provide the resident and designated representative with a written notice of resident rights, a statement about how to file a complaint, and other contact information regarding complaints. Requires the facility to obtain written acknowledgment of the resident's receipt of this information.

Subd. 2. Notices in plain language; language accommodations. Requires a facility to provide notices in plain language and make reasonable accommodations for residents with communication disabilities or who speak languages other than English.

Subd. 3. Notice of services for dementia, Alzheimer's disease, or related disorders. Requires a facility that provides services to residents with dementia to provide a description of its employee training program.

Subd. 4. Services oversight and information. Requires a facility to provide a resident with information about who the resident can contact for assistance with health care or supportive services.

Subd. 5. Notice to residents; change in ownership or management. Requires a facility to notify a resident or designated representative of certain changes in facility ownership or management.

Subd. 6. Acceptance of residents. Prohibits a facility from accepting a person as a resident unless the facility has sufficient staff to adequately provide services agreed to in the service plan.

Subd. 7. Referrals. If a facility determines a resident needs additional services, requires the facility to consult with the resident and inform the resident of resources available to help the resident obtain additional services.

Subd. 8. Initiation of services. If an initial assessment has not been completed when a facility initiates services, requires the facility to complete a temporary plan and agreement with the resident for services.

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Subd. 9. Initial assessments and monitoring. Requires a facility to complete a nursing assessment and propose a temporary service plan before a prospective resident enters into a contract with the facility or the date the resident moves in, whichever is earlier. Requires a reassessment within 14 days after initiating services. Provides that residents receiving no services are not required to undergo an assessment. Requires the facility to provide information about long-term care consultation services.

Subd. 10. Service plan, implementation, and revisions to service plan. Requires a facility to finalize a service plan within 14 days after beginning to provide services. Establishes requirements for the service plan, and requires the facility to provide all services required by the current service plan. Requires the service plan to be entered into the resident's record, and requires staff providing services to be informed of the current service plan.

Subd. 11. Use of restraints. Requires residents to be free from any physical or chemical restraints, except if necessary for health and safety reasons identified in a resident assessment.

Subd. 12. Request for discontinuation of life-sustaining treatment. If a resident or certain others requests discontinuation of a life-sustaining treatment, requires a facility employee to inform a supervisor of the resident's request, and requires facility to inform the health care provider who ordered the treatment of the resident's request and to work with the resident and the health professional to comply with requirements in chapter 145C. Provides that this subdivision does not diminish the rights of residents to control their treatment and does not require a facility to discontinue treatment.

Subd. 13. Medical cannabis. Allows facilities to adopt reasonable restrictions on the use of medical cannabis by residents.

Subd. 14. Landlord and tenant. Requires facilities to comply with chapter 504B.

17 **Provision of services.**

Adds § 144I.16.

Subd. 1. Availability of contact person to staff. Requires assisted living facilities and assisted living facilities that provide dementia care to have a registered nurse available for consultation by staff performing delegated nursing tasks, and to have an appropriate licensed health professional available if performing other delegated services.

Subd. 2. Supervision of staff; basic care services. Requires periodic supervision of staff performing basic care services. Specifies what constitutes supervision.

Subd. 3. Supervision of staff performing delegated nursing or therapy tasks. Requires staff performing delegated nursing or therapy tasks to be supervised by

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an appropriate licensed health professional or registered nurse, and requires direct supervision in certain circumstances.

Subd. 4. Documentation. Requires a facility to document supervision activities.

18 **Medication management.**

Adds § 144I.17.

Subd. 1. Medication management services. Requires an assisted living facility that provides medication management services to have medication management policies and procedures. Specifies requirements for development of these policies and procedures, and lists what these policies and procedures must address.

Subd. 2. Provision of medication management services. Requires a resident to be assessed before a facility provides medication management services, and specifies what the assessment must include.

Subd. 3. Individualized medication monitoring and reassessment. Requires a facility to monitor and reassess a resident at least annually and when a resident presents symptoms or issues that may be medication related.

Subd. 4. Resident refusal. Requires a facility to document in the resident's record a resident's refusal of an assessment for medication management.

Subd. 5. Individualized medication management plan. Requires a facility to include information on medication management services in the resident's service plan, requires the facility to maintain an individualized medication management record for each resident, and lists what this record must include.

Subd. 6. Administration of medications. Lists personnel who may administer medications.

Subd. 7. Delegation of medication administration. Establishes requirements for delegating medication administration to unlicensed personnel.

Subd. 8. Documentation of administration of medications. Requires medications that are administered to be documented in the resident's record, and lists what the documentation must include.

Subd. 9. Documentation of medication setup. Lists the information that must be documented at the time of medication setup.

Subd. 10. Medication management for residents who will be away from home. Requires a facility to implement procedures to provide medications to residents

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during planned or unplanned time away from the facility. Lists what the procedures must include.

Subd. 11. Prescribed and nonprescribed medication. Directs a facility to determine whether the facility will require a prescription for all medications the facility manages, including over-the-counter drugs and dietary supplements.

Subd. 12. Medications; over-the-counter drugs; dietary supplements not prescribed. Requires a facility providing medication management for OTC drugs and dietary supplements to maintain those items in their original labeled containers and verify that the medications are up to date and appropriately stored.

Subd. 13. Prescriptions. Requires a prescription for each prescribed medication the facility is managing for the resident.

Subd. 14. Renewal of prescriptions. Requires a prescription to be renewed at least every 12 months or more frequently if indicated by a resident assessment.

Subd. 15. Verbal prescription orders. Requires verbal prescription orders to be received by a nurse or pharmacist and handled according to requirements for verbal prescription orders in Board of Pharmacy rules.

Subd. 16. Written or electronic prescription. Requires a written or electronic prescription to be communicated to the registered nurse in charge and placed in the resident's record.

Subd. 17. Records confidential. Requires prescriptions to be kept confidential.

Subd. 18. Medications provided by resident or family member. Requires staff to document in the resident's record any medications or dietary supplements that are being used by the resident but that are not included in the medication management assessment.

Subd. 19. Storage of medications. Requires medications to be stored in locked compartments.

Subd. 20. Prescription drugs. Requires prescription drugs to be kept in their original containers.

Subd. 21. Prohibitions. Prohibits a prescription drug supply for one resident from being used by anyone other than that resident.

Subd. 22. Disposition of medications. Requires medications to be returned to the resident or representative when the service plan ends or when medication management services are no longer being provided. Establishes requirements for disposal of medications.

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Subd. 23. Loss or spillage. Requires a facility providing medication management to implement procedures for loss or spillage of controlled substances.

19 **Treatment and therapy management services.**

Adds § 144I.18.

Subd. 1. Treatment and therapy management services. Provides that this section only applies to assisted living facilities providing comprehensive assisted living services.

Subd. 2. Policies and procedures. Requires a facility that provides treatment and therapy management services to maintain policies and procedures for these services, and specifies what the policies and procedures must include.

Subd. 3. Individualized treatment or therapy management plan. For each resident receiving treatment or therapy management, requires a facility to include in the resident's service plan a written statement of the treatment or therapy services that will be provided, and to maintain an individualized treatment and therapy management record for each resident. Lists what this record must include.

Subd. 4. Administration of treatments and therapy. Specifies who may administer therapies or treatments, and establishes requirements for delegating administration of treatments or therapies.

Subd. 5. Documentation of administration of treatments and therapies. Requires a facility to document administration of treatments and therapies in the resident's record, and lists what the documentation must include.

Subd. 6. Treatment and therapy orders. Requires there to be an order from an authorized prescriber for all treatments and therapies, and specifies what the order must include.

Subd. 7. Right to outside service provider; other payors. Provides that a resident is free to retain treatment and therapy services from an off-site service provider, and requires a facility to help residents obtain information about whether a public program will pay for these services.

20 **Resident record requirements.**

Adds § 144I.19.

Subd. 1. Resident record. Requires a facility to maintain records for each resident for whom it provides services, and requires these records to be protected from loss, tampering, or unauthorized disclosure. Prohibits a facility from disclosing any personal, financial, or medical information except in the listed circumstances.

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Subd. 2. Access to records. Requires a facility to ensure that the appropriate records are available to employees and contractors authorized to access the records and to the commissioner.

Subd. 3. Contents of resident record. Lists the information that must be included in a resident record.

Subd. 4. Transfer of resident records. Requires a facility to ensure there is a coordinated transfer of a resident's record if the resident transfers to another health care facility or provider.

Subd. 5. Record retention. Requires a facility to retain a resident record for at least five years following a resident's discharge or termination of services, or for another period of time if so required in state or federal law.

21 **Orientation and annual training requirements.**

Adds § 144I.20.

Subd. 1. Orientation of staff and supervisors. Requires staff and supervisors to complete a facility orientation before providing services to residents.

Subd. 2. Content. Lists required content for the orientation.

Subd. 3. Verification and documentation of orientation. Requires a facility to maintain documentation that staff completed the orientation.

Subd. 4. Orientation to resident. Requires staff providing services to be oriented specifically to each individual resident and their services.

Subd. 5. Training required related to dementia. Requires all direct care staff and supervisors providing direct services to receive training related to dementias, working with residents with challenging behaviors, and communicating with residents with dementia.

Subd. 6. Required annual training. Requires all staff that provide direct services to complete at least 8 hours of training annually. Lists topics the annual training must cover.

Subd. 7. Documentation. Requires a facility to maintain documentation in employee records that staff have satisfied the orientation and training requirements.

Subd. 8. Implementation. Requires a facility to implement all orientation and training topics listed in this section.

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22 **Training in dementia care required.**

Adds § 144I.21. Requires assisted living facilities and assisted living facilities providing dementia care to meet the listed training requirements for training on dementia topics. Supervisors must receive at least eight hours of training within 120 hours of beginning work and two hours annually thereafter. Direct care employees must receive at least eight hours of training within 160 hours of beginning work and two hours annually thereafter. Staff who do not provide direct care must receive at least four hours of training within 160 hours of beginning work at two hours annually thereafter.

23 **Controlling individual restrictions.**

Adds § 144I.22.

Subd. 1. Restrictions. Prohibits a facility from having any person as a controlling individual if that person was a controlling individual at a nursing home or facility that incurred specified numbers of uncorrected or repeated violations or was convicted of a felony or gross misdemeanor related to the operation of the nursing home or facility.

Subd. 2. Exception. Provides that the restrictions on controlling individuals in subdivision 1 do not apply to a controlling individual who had no legal authority to affect the operation of the nursing home or other facility.

Subd. 3. Stay of adverse action required by controlling individual restrictions. Instead of revoking, suspending, or refusing to renew a facility's license where a controlling individual was disqualified for incurring certain numbers of uncorrected or repeated violations, allows the commissioner to stay the revocation, suspension, or nonrenewal. Establishes procedures for issuing a stay, makes the controlling individual responsible for compliance with the conditions and restrictions in the stay, and specifies consequences for failure to comply with the conditions and restrictions in the stay.

24 **Management agreements; general requirements.**

Adds § 144I.23.

Subd. 1. Notification. If a licensee uses a manager, requires the facility to have a written management agreement consistent with this chapter. Specifies when the licensee must notify the commissioner of its use of a manager, and establishes timing requirements for submission of a management agreement to the commissioner.

Subd. 2. Management agreement; licensee. States that the licensee is legally responsible for daily operations and the provision of services, ensuring the facility is operated consistent with applicable laws, ensuring the manager acts in conformance with the management agreement, and ensuring that the manager does not present as the licensee. Prohibits a licensee from giving the manager responsibilities that relieve the licensee of responsibility for the facility's daily

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operations. Requires the licensee and manager to comply with the terms of the management agreement.

Subd. 3. Terms of agreement. Lists required elements of a management agreement.

Subd. 4. Commissioner review. Allows the commissioner to review management agreements at any time, and allows the department to require the provision of additional information, require changes to the agreement, or require the licensee to participate in monthly meetings and quarterly on-site visits.

Subd. 5. Resident funds. Describes duties of the licensee and the manager related to resident funds if the management agreement delegates day-to-day management of resident funds to the manager.

25 **Minimum site, physical environment and fire safety requirements.**

Adds § 144I.24.

Subd. 1. Requirements. Lists site requirements for facilities.

Subd. 2. Fire protection and physical environment. Requires facilities to have a comprehensive fire protection system and lists what that system must include. Also requires fire drills to be conducted.

Subd. 3. Local laws apply. Requires facilities to comply with state and local laws for fire safety, building, and zoning requirements.

Subd. 4. Assisted living facilities; design. Establishes minimum design standards for assisted living facilities that serve six or more residents.

Subd. 5. Assisted living facilities; life safety code. Requires an assisted living facility that serves six or more residents to comply with the specified life safety code.

Subd. 6. Assisted living facilities with dementia care units; life safety code. Requires an assisted living facility with dementia care units to comply with the specified life safety code.

Subd. 7. New construction; plans. For all new licensure and construction beginning on or after August 1, 2021, requires architectural and engineering plans and specifications, final plans and specifications, and final mechanical and electrical plans to be submitted to the commissioner. If construction is begun more than one year after approval of the plans, the drawings must be resubmitted to the commissioner. Requires the commissioner to be notified within 30 days before completion of construction so a final inspection may be arranged. Requires a set of life safety plans to be kept on file at the facility.

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Subd. 8. Variances or waivers. Allows a facility to request a variance or waiver, and establishes a process for applications, review, revocation, denial, or refusal to renew a variance or waiver, and to contest a denial, revocation, or refusal to renew.

26 **Residency and services contract requirements.**

Adds § 144I.25.

Subd. 1. Contract required. Requires a facility to execute a written contract with a resident before providing housing or services to the resident. Specifies who must sign the contract, and establishes requirements for providing prospective residents with unsigned contracts and for providing residents with a copy of the signed contract. Requires a resident to be given the opportunity to identify a designated representative or resident representative.

Subd. 2. Contents and contract; contact information. Lists information a contract must contain.

Subd. 3. Additional contract requirements. Lists additional information a contract must include, and allows a restriction in one of these listed contract terms only if determined necessary for health and safety reasons.

Subd. 4. Filing. Requires the contract and related documents to be maintained by the facility in resident files and to be available on-site for inspection by the commissioner and the resident and designated representative.

Subd. 5. Waivers of liability prohibited. Prohibits a contract from including a waiver of facility liability for the health and safety or personal property of a resident. Also prohibits deceptive, unlawful, or unenforceable provisions.

27 **Planned closures.**

Adds § 144I.27.

Subd. 1. Closure plan required. If a facility voluntarily chooses to close, requires the facility to notify the commissioner and the office of ombudsman for long-term care.

Subd. 2. Content of closure plan. Lists what a facility's closure plan must include.

Subd. 3. Commissioner's approval required prior to implementation. Makes the facility's closure plan subject to the commissioner's approval and subdivision 6.

Subd. 4. Termination planning and final accounting requirements. Before termination of housing, requires the facility to follow termination planning

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requirements and final accounting and return requirements, and requires the facility to implement the plan approved by the commissioner.

Subd. 5. Notice to residents. After the commissioner has approved a relocation plan, requires the facility to notify residents and representatives of the closure.

Subd. 6. Emergency closures. If a facility is closing because the commissioner decides it can no longer remain open, requires the facility to meet the requirements of this section unless a requirement would endanger resident health or safety.

Subd. 7. Other rights. Provides that this section and related sections do not affect the rights or remedies available to residents under chapter 504B, unless those rights or remedies are inconsistent with those in this section.

Subd. 8. Fine. Allows the commissioner to impose a fine for failing to follow the requirements of this section or related sections.

28 **Relocations within assisted living location.**

Adds § 144I.28.

Subd. 1. Notice required before relocation within location. Requires a facility to give prior notice and obtain resident consent before a proposed nonemergency relocation to a different room at the same location. If a resident consents, requires the facility to make needed modifications to the resident's new room.

Subd. 2. Evaluation. Requires a facility to evaluate the resident before deciding whether the resident will be moved.

Subd. 3. Restriction on relocation. Prohibits a resident who has been private pay and resides in a private room but whose payments will be made by MA going forward, from being relocated to a shared room without the resident's consent.

29 **Commissioner oversight and authority.**

Adds § 144I.29.

Subd. 1. Regulations. Lists aspects of facilities regulated by the commissioner.

Subd. 2. Regulatory functions. Lists the commissioner's duties related to licensing, surveying, monitoring, investigating, and taking enforcement actions.

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30	**Surveys and investigations.** Adds § 144I.30. **Subd. 1. Regulatory powers.** Names the department of health as the state agency responsible for surveying and investigating facilities and enforcing this chapter. Requires the commissioner to be given access to relevant information and records to discharge the commissioner's responsibilities. **Subd. 2. Surveys.** Requires the commissioner to survey each facility at least once a year or more frequently if needed. **Subd. 3. Follow-up surveys.** Describes circumstances and procedures for follow-up surveys. **Subd. 4. Scheduling surveys.** Requires surveys to be conducted without notice, except allows a surveyor to contact the facility the day of the survey to ensure someone is onsite. **Subd. 5. Information provided by facility.** Requires a facility to provide accurate, truthful information to the department during a survey, investigation, or other activity. **Subd. 6. Providing resident records.** Upon request, requires a facility to provide a list of current and past residents and designated representatives and their contact information. **Subd. 7. Correction orders.** Specifies circumstances in which a correction order may be issued. **Subd. 8. Required follow-up surveys.** For facilities with a level 3 or 4 violation, requires a follow-up survey within 90 days of the initial survey.
31	**Violations and fines.** Adds § 144I.31. **Subd. 1. Fine amounts.** Lists fine amounts for Level 1, Level 2, Level 3, and Level 4 violations, and for maltreatment violations. **Subd. 2. Level and scope of violation.** Provides that correction orders are categorized by both level and scope of the violation. **Subd. 3. Notice of noncompliance.** If the facility has not corrected violations by a specified date, requires the commissioner to provide a notice of noncompliance with a correction order. **Subd. 4. Immediate fine; payment.** Allows the commissioner to issue an immediate fine for every violation, in addition to any other enforcement

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mechanism. Requires the facility to notify the commissioner when the violation is corrected.

Subd. 5. Facility cannot avoid payment. Prohibits a facility from avoiding payment of a fine by closing, selling, or transferring its license.

Subd. 6. Additional penalties. Allows the commissioner to assess an additional penalty amount based on the costs of the investigation that resulted in assessment of a fine.

Subd. 7. Deposit of fines. Provides that fines collected must be credited to an account in the state government special revenue fund and, subject to appropriation, be used for special projects to improve home care in Minnesota.

32 **Reconsideration of correction orders and fines.**

Adds § 144I.31.

Subd. 1. Reconsideration process required. Requires the commissioner to make a correction order reconsideration process available to the facility. If a facility requests reconsideration, stays the correction order during the process.

Subd. 2. Reconsideration process. Specifies what the commissioner must do to reconsider a correction order.

Subd. 3. Findings. Lists findings that a reconsideration process may issue.

Subd. 4. Updating the correction order website. If correction order findings are changed by the commissioner, requires the commissioner to update the correction order website.

Subd. 5. Provisional licensees. Provides that the reconsideration process is not available to provisional licensees.

33 **Enforcement**

Adds § 144I.33.

Subd. 1. Conditions. Allows the commissioner to deny an application for licensure or provisional licensure, refuse to renew a license, refuse to issue a license due to a change in ownership, suspend or revoke a license, or impose conditions on the license if the applicant, owner, controlling individual, or employee committed one of the listed acts.

Subd. 2. Terms to suspension or conditional license. Allows a suspension or conditional license to include terms that must be met before the suspension or designation is lifted. Lists terms that may be included.

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Subd. 3. Immediate temporary suspension. Allows the commissioner to immediately temporarily suspend a license or prohibit delivery of housing or services for up to 90 days, or issue a conditional license, if there are Level 4 violations or violations that pose an imminent risk of harm to the health or safety of residents.

Subd. 4. Mandatory revocation. Requires the commissioner to revoke a license if a controlling individual is convicted of a felony or gross misdemeanor that relates to the operation of the facility or directly affects resident safety or care.

Subd. 5. Mandatory proceedings. Requires the commissioner to initiate proceedings within 60 days of notification to suspend or revoke a facility license, or refuse to renew a facility license if the listed events occurred in the preceding two years.

Subd. 6. Notice to residents. Requires a controlling individual or designee to provide the commissioner and the ombudsman with the names and addresses of residents and their representatives, if a facility's license is being suspended, revoked, or not renewed. Also requires the controlling individual to provide updated information each month until the proceeding is concluded, and establishes penalties for failing to provide required information. Within ten business days after initiating proceedings to revoke, suspend, or refuse to renew a license, requires the commissioner to send notice of this action to facility residents and their representatives.

Subd. 7. Notice to facility. Before a suspension, revocation, or refusal to renew a license, gives a facility a right to notice and a hearing under chapter 14. Provides for temporary suspensions for Level 3 or 4 violations.

Subd. 8. Request for hearing. Establishes a time frame for a licensee to request a hearing, and establishes requirements that the request must meet.

Subd. 9. Plan required. Requires a process of suspending, revoking, or refusing to renew a license to include a plan for transferring affected residents to other providers. Lists information a facility must provide the commissioner and others within three days of being notified of a final revocation. Requires the facility to cooperate with the commissioner and others while transferring residents to qualified providers. Allows a facility to continue to operate while residents are being transferred to other providers.

Subd. 10. Hearing. Requires the commissioner to request a hearing within 15 business days of receiving a licensee's appeal of a sanction, and establishes requirements for these hearings. Also specifies circumstances in which the commissioner must immediately temporarily suspend the license while an appeal is pending.

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Subd. 11. Expedited hearing. Requires the commissioner to request assignment of an administrative law judge within five business days of a licensee's appeal of a temporary suspension or issuance of a conditional license, and establishes requirements for these hearings. Prohibits a licensee from operating pending a commissioner's final order if the order issued by the administrative law judge affirms an immediate suspension. Requires a licensee whose license is temporarily suspended to comply with requirements to notify residents and requirements to transfer residents.

Subd. 12. Time limits for appeals. Requires a facility to request a hearing within 15 business days after receiving notice of an action against a license.

Subd. 13. Owners and managerial officials; refusal to grant license. Prohibits an owner or managerial official whose facility license has been revoked or not renewed, from being granted an assisted living facility license. Also prohibits the commissioner from issuing or renewing a license, or requires a license to be suspended or revoked, if an owner or managerial official was affiliated with a facility whose licensed was not renewed or revoked in the past five years. Establishes requirements for notice and issuance of stays.

Subd. 14. Relicensing. Allows the commissioner to consider a new application for licensure from an applicant whose license was revoked, if the conditions on which the revocation were based have been corrected.

Subd. 15. Informal conference. Allows the commissioner and an applicant or facility to hold an informal conference at any time.

Subd. 16. Injunctive relief. Allows the commissioner to bring an action for injunctive relief in district court. Allows the court to grant a temporary restraining order if a person's acts would create an imminent risk of harm to a resident.

Subd. 17. Subpoena. Allows the commissioner to issue subpoenas and compel attendance of witnesses and the production of necessary documents or evidentiary materials. Provides for serving and enforcement of subpoenas.

34 **Innovation variance.**

Adds § 144.34. Defines innovation variance for this section, and allows an innovation variance to be granted to allow a facility to offer services that are innovative, will not adversely affect the health, safety, or welfare of residents, or change any resident rights. Allows the commissioner to impose conditions on granting an innovation variance and to limit the duration of an innovation variance. Lists what an application for an innovation variance must include, and specifies a timeline for granting or denying an innovation variance. Allows the commissioner to deny or revoke an innovation variance in the listed circumstances.

Section	Description – Article 16: Assisted Living Licensure
35	**Resident quality of care and outcomes improvement task force.** Adds § 144I.35. Directs the commissioner to establish a resident quality of care and outcomes improvement task force. Lists membership on the task force, and allows public members to be reimbursed. Directs the task force to periodically provide recommendations on changes needed to promote safety and quality improvement practices in long-term care settings.
36	**Expedited rulemaking authorized.** Adds § 144I.36. Directs the commissioner to adopt rules for assisted living facilities using the expedited rulemaking process. Lists items that must be addressed in the rules.
37	**Transition period.** Provides a timeline for adopting rules, preparing to license facilities, requiring existing housing with services establishments that provide home care services to convert their registrations to assisted living licensure, and licensing new assisted living facilities.
38	**Repealer.** Repeals chapter 144D (housing with services establishments) and chapter 144G (assisted living title protection) effective August 1, 2021.

Article 17: Dementia Care Services for Assisted Living Facilities with Dementia Care

This article establishes specific requirements for assisted living facilities with dementia care.

Section	Description – Article 17: Dementia Care Services for Assisted Living Facilities
1	**Additional requirements for assisted living facilities with dementia care.** Adds § 144I.37. **Subd. 1. Applicability.** Provides this section applies only to assisted living facilities with dementia care. **Subd. 2. Demonstrated capacity.** Requires an applicant to provide services in compliance with this section, and lists criteria for the commissioner to consider in determining whether the applicant can do so. If the applicant does not have experience managing residents with dementia, requires the applicant to employ a consultant for at least the first six months of operation. Requires the commissioner to conduct an on-site inspection before issuing a license.

Section	Description – Article 17: Dementia Care Services for Assisted Living Facilities

Subd. 3. Relinquishing license. Requires the facility to notify the commissioner at least 60 days before voluntarily relinquishing its license. Requires notice to residents, submission of a transitional plan, changes to service or care plans, notification to the commissioner when the process is completed, and changes to advertising materials and disclosure information to remove references to the facility being an assisted living facility with dementia care.

2 **Responsibilities of administration for assisted living facilities with dementia care.**

Adds § 144I.38.

Subd. 1. General. Makes a licensee responsible for the care and housing of people with dementia and the provision of person-centered care.

Subd. 2. Additional requirements. Requires an administrator to complete ten hours of required annual continuing education requirements related to the care of individuals with dementia.

Subd. 3. Policies. Requires an assisted living facility with dementia care to develop and implement policies related to caring for people with dementia, including how services are provided, evaluating behaviors, wandering and egress prevention, assessment of residents for the use of medications, staff training, life enrichment and family support programs, transportation, and safekeeping of resident possessions.

3 **Staffing and staff training.**

Adds § 144I.39.

Subd. 1. General. Requires a facility to use staff trained according to this section to provide services to residents with dementia, except in emergencies, and requires staffing to be sufficient to meet scheduled and unscheduled needs of residents.

Subd. 2. Staffing requirements. Requires a facility to ensure that staff who care for residents with dementia have a basic understanding of residents' emotional and health care needs, and who have satisfied training requirements developed in rule.

Subd. 3. Supervising staff training. Requires persons overseeing or training staff to have experience caring for individuals with dementia.

Subd. 4. Preservice and in-service training. Allows training to include various methods of instruction and to have a method to determine and document staff understanding of the training provided.

Section	Description – Article 17: Dementia Care Services for Assisted Living Facilities
4	**Services for residents with dementia.** Adds § 144I.40. In addition to minimum services, requires an assisted living facility with dementia care to provide assistance with activities of daily living that address the needs of residents with dementia, health care services, a daily meal program and hydration available during waking hours, and meaningful activities. Requires an evaluation of each resident's interests, abilities, skills, emotional and social needs, physical abilities and limitations, and needed adaptations. Requires an individualized activity plan to be developed for each resident, and requires a selection of daily activities to be provided. Requires an evaluation of behavioral symptoms with negative impacts, and requires access to secure outdoor space to be provided.

Article 18: Assisted Living Licensure Conforming Changes

Section	Description – Article 18: Assisted Living Licensure Conforming Changes
1	**Data classification; public data.** Amends § 144.051, subd. 4. Makes a public data classification that applies to home care provider data held by the commissioner of health, also apply to assisted living licensure data held by the commissioner of health.
2	**Data classification; confidential data.** Amends § 144.051, subd. 5. Makes a confidential data classification that applies to home care provider data held by the commissioner of health, also apply to assisted living licensure data held by the commissioner of health.
3	**Release of private or confidential data.** Amends § 144.051, subd. 6. Makes a section specifying when the commissioner may release private or confidential home care provider data held by the commissioner of health, also apply to private or confidential assisted living licensure data held by the commissioner of health.
4	**Background studies required.** Amends § 144.057, subd. 1. Includes employees of assisted living facilities and assisted living facilities with dementia care, the Department of Health background study statute that governs other employees of health facilities or providers licensed by the commissioner.

Section	Description – Article 18: Assisted Living Licensure Conforming Changes
5	**Administrators.** Amends § 144A.04, subd. 5. Changes the name of the board that licenses nursing home administrators to the Board of Executives for Long Term Services and Supports. Strikes obsolete language.
6	**Criteria.** Amends § 144A.20, subd. 1. Makes changes to conform with the board's new name, and makes other technical changes.
7	**Duties of the board.** Amends § 144A.24. Makes changes to conform with the board's new name, and strikes language requiring courses used for license renewal requirements to be designed to improve professional skills and prohibiting classroom attendance requirements of more than 50 hours per year.
8	**Reciprocity with other states and equivalency of health services executive.** Amends § 144A.26. Allows the board to issue a health services executive license to a person who has been validated by the National Association of Long Term Care Administrator Boards as a health services executive, and who has met the education and practice requirements for a nursing home administrator, assisted living administrator, and home and community-based services provider.
9	**Statement of rights.** Amends § 144A.44, subd. 1. Paragraph (a) amends the home care bill of rights to make it apply to clients who receive home care services in a licensed assisted living facility, modifies existing rights, and gives clients the right to place an electronic monitoring device in the client's space in compliance with state law. Paragraph (b) provides that a provider who violates a right is subject to fines and licensing action. Paragraph (c) requires providers to take the listed steps to help clients exercise their rights. Paragraph (d) prohibits a provider from requiring or asking a client to waive any rights listed in this subdivision.
10	**Comprehensive home care license provider.** Amends § 144A.471, subd. 7. Adds treatment and therapists to the list of services provided by a provider with a comprehensive home care license.

Section	Description – Article 18: Assisted Living Licensure Conforming Changes
11	**Exclusions from home care licensure.** Amends § 144A.471, subd. 9. Strikes clauses that allow the following without a home care provider license: an employee of a nursing home, boarding care home, or home care provider may respond to occasional emergency calls from individuals in a residential setting attached to or next to the nursing home, boarding care home, or home care services location; and an employee of a nursing home, boarding care home, or home care provider may provide occasional minor services for free to individuals in a residential setting attached to or next to the nursing home, boarding care home, or home care services location.
12	**Fees; application, change of ownership, renewal, and failure to notify.** Amends § 144A.472, subd. 7. Adds a penalty of $1,000 for a home care provider with a temporary license that fails to notify the commissioner of health within five days after it begins providing services to clients. Requires fines collected under this subdivision to be deposited in a special revenue account and appropriated to the commissioner to implement recommendations of the home care provider advisory council.
13	**Follow-up survey.** Amends § 144A.474, subd. 9. Strikes language prohibiting the commissioner from imposing a fine for a violation identified in a follow-up survey.
14	**Fines.** Amends § 144A.474, subd. 11. Provides that home care provider fines imposed under this subdivision may be imposed immediately without giving the provider an opportunity to correct the violation. Increases fine amounts for Level 2, Level 3, and Level 4 violations, and establishes fine amounts for maltreatment violations. For every violation, requires the commissioner to issue an immediate fine, and requires the provider to correct the violation within the required time frame. Allows for appeals of immediate fines. Directs fines collected under this subdivision to be deposited in a dedicated special revenue account and appropriates that money to the commissioner to implement recommendations of the home care provider advisory council.
15	**Expedited hearing.** Amends § 144A.475, subd. 3b. Adds a cross-reference to Minnesota Rules governing an expedited administrative hearing of a home care provider's appeal of a temporary license suspension or issuance of a conditional license.

Section	Description – Article 18: Assisted Living Licensure Conforming Changes
16	**Plan required.** Amends § 144A.475, subd. 5. If the commissioner refuses to renew a home care provider license, requires the process of nonrenewal to include a plan for the provider to transfer the care of affected clients to other providers. If the provider does not comply with notice requirements to clients, requires the commissioner to notify clients that the provider's license is subject to an enforcement action.
17	**Prior criminal convictions; owners and managerial officials.** Amends § 144A.476, subd. 1. Requires a background study of owners and managerial officials before the commissioner issues a home care provider license as a result of an approved change in ownership.
18	**Termination of service plan.** Amends § 144A.4791. Requires a home care provider to give 30 days' written notice when terminating a service plan with a client.
19	**Department of health licensed home care provider advisory council.** Amends § 144A.4799. Allows persons who have received home care services within five years of applying, to serve on the home care provider advisory council, and adds a member of a county health and human services department or adult protection office beginning July 1, 2021. In the advisory council's duties, directs the advisory council to provide recommendations on ways to improve protection of the public under existing law and to recommend projects to improve resident lives, support providers in providing quality care, and help providers improve their compliance with state law.
20	**Supportive housing.** Amends § 256I.03, subd. 15. Amends the definition of supportive housing in chapter 256I (housing supports).
21	**License required; staffing qualifications.** Amends § 256I.04, subd. 2a. Updates a cross-reference from chapter 144D to chapter 144I for facilities eligible to receive housing support under this chapter, and modifies language allowing certain facilities exempt from state licensure to receive housing support.
22	**Persons to whom disclosure is required.** Amends § 325F.72, subd. 1. Makes the disclosure requirements of a facility's care for persons with dementias apply to assisted living facilities with dementia care.

Section	Description – Article 18: Assisted Living Licensure Conforming Changes
23	**Content.** Amends § 325F.72, subd. 2. Modifies the name of a unit a person with dementia may reside in, from a special care unit to a dementia care unit.
24	**Facility.** Amends § 626.5572, subd. 6. Amends the definition of facility for the maltreatment of vulnerable adults act to include assisted living facilities licensed under chapter 144I. This makes the requirements for facilities in the maltreatment of vulnerable adults act apply to assisted living facilities.
25	**Revisor instruction.** Directs the revisor to change the name of the Board of Examiners for Nursing Home Administrators to the Board of Executives for Long Term Services and Supports in Minnesota Statutes.
26	**Repealer.** Paragraph (a) repeals section 144A.472, subd. 4 (requiring multiple units of a home care provider to be separately licensed if they cannot share supervision and administration from a main office). Paragraph (b) repeals sections 144A.441 (assisted living bill of rights addendum) and 144A.442 (service termination for assisted living clients).

Article 19: Miscellaneous

Section	Description – Article 19: Miscellaneous
1	**Maternal Mental Health Awareness Month.** Adds § 10.584. Designates May as Maternal Mental Health Awareness Month in Minnesota to recognize the prevalence of pregnancy and postpartum mental health issues and to educate people about identifying symptoms and seeking treatment options. Allows the governor to promote and encourage the observance of this month.
2	**Quality rating and improvement system.** Amends § 124D.142. Removes obsolete language and rescinds the quality rating from a child care provider who is disqualified from receiving child care assistance program reimbursement due to fraud or theft.

Section	Description – Article 19: Miscellaneous
3	**Early childhood program eligibility.** Amends § 124D.165, subd. 4. Modifies program eligibility for early learning scholarship funds to make ineligible programs that have been disqualified from receiving payment under the child care assistance program due to fraud or theft and programs for which the commissioner refuses to issue a child care authorization, revokes and existing authorization, stops payment issued to a program, or refuses to pay a bill. Provides a July 1, 2019, effective date.
4	**Approval of on-site education programs.** Amends § 125A.515, subd. 1. Adds psychiatric residential treatment facilities (PRTFs) to on-site education programs for youth placed in residential programs that must be approved by the commissioner of education.
5	**Responsibilities for providing education.** Amends § 125A.515, subd. 3. Adds PRTFs to the requirement for the school district in which the facility is located to provide education services to the children in the facility.
6	**Education services required.** Amends § 125A.515, subd. 4. Adds PRTFs to requirement that a student receive education services within three business days after entering a facility.
7	**Education programs for students placed in children's residential facilities.** Amends § 125A.515, subd. 5. Adds PRTFs to requirements related to students with disabilities and individualized education programs (IEPs).
8	**Minimum educational services required.** Amends § 125A.515, subd. 7. Adds PRTFs to the requirement that the providing district provide necessary education services for a school day, including summer school services if needed, with alterations depending on a student's IEP.
9	**Placement, services, and due process.** Amends § 125A.515, subd. 8. Adds PRTFs to requirements related to educational setting, integrated services, placement decisions, and disciplinary procedures.
10	**Advisory council on rare diseases.** Adds § 137.68. Requests the establishment of an advisory council on rare diseases at the University of Minnesota. **Subd. 1. Establishment.** Requests that the Board of Regents establish a Chloe Barnes Advisory Council on Rare Diseases at the University of Minnesota. Defines rare disease as any disease (1) that affects less than 200,000 people in the U.S., or (2) that affects more than 200,000 people in the U.S. and for which the cost of developing and making available a drug for that disease would not be recovered from the U.S. sales of that drug. **Subd. 2. Membership.** Lists suggested advisory council membership.

Section	Description – Article 19: Miscellaneous
	Subd. 3. Meetings. Requests the first meeting of the advisory council to occur by October 1, 2019, and requires it to meet at the call of the chair or the request of a majority of the council members. **Subd. 4. Duties.** Lists permitted duties for the advisory council. **Subd. 5. Conflicts of interest.** Makes advisory council members subject to the Board of Regents policy on conflicts of interest. **Subd. 6. Annual report.** Requires the advisory council to annually report to certain legislative committees on the council's activities and other issues on which it chooses to report.
11	**Rate increases.** Amends § 256I.05, subd. 1c. Adds paragraph (g), which allows agencies to increase rates by $100 per month for residents in certain housing with services establishments and supportive housing establishments under the housing support program.

Article 20: Forecast Adjustments

This article adjusts appropriations for fiscal year 2019 for forecasted programs administered by the Department of Human Services.

Article 21: Appropriations

This article appropriates money for fiscal years 2020 and 2021 to the Department of Human Services, Department of Health, health-related licensing boards, Council on Disability, Emergency Medical Services Regulatory Board, Ombudsman for Mental Health and Developmental Disabilities, Ombudspersons for Families, Department of Commerce, and MNsure. It also authorizes certain transfers from the premium security account.