SENATE
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DATE	D-PG	OFFICIAL STATUS
02/20/2018	6134	Introduction and first reading Referred to Health and Human Services Finance and Policy
04/23/2018	7821a	Comm report: To pass as amended and re-refer to Finance

A bill for an act

relating to state government; modifying provisions relating to health care; modifying Department of Human Services administrative funds transfer; establishing a Minnesota Health Policy Commission; repealing preferred incontinence program in medical assistance; increasing reimbursement rates for doula services; modifying telemedicine service limits; modifying EPSDT screening payments; modifying capitation payment delay; modifying provisions relating to wells and borings; adding security screening systems to ionizing radiation-producing equipment regulation; authorizing statewide tobacco cessation services; establishing an opioid reduction pilot program; establishing a low-value health services study; requiring coverage of 3D mammograms; requiring disclosure of facility fees; establishing a step therapy override process; requiring the synchronization of prescription refills; prohibiting a health plan company from preventing a pharmacist from informing a patient of a price differential; converting allied health professionals to a birth month renewal cycle; modifying temporary license suspensions and background checks for health-related professions; requiring a prescriber to access the prescription monitoring program before prescribing certain controlled substances; authorizing the Board of Pharmacy to impose a fee from a prescriber or pharmacist accessing prescription monitoring data through a service offered by the board's vendor; requiring administrative changes at the Office of Health Facility Complaints; providing access to information and data sharing; making technical changes; requiring reports; making forecasted adjustments; appropriating money; amending Minnesota Statutes 2016, sections 3.3005, subdivision 8; 62A.30, by adding a subdivision; 103I.301, subdivision 6; 144.121, subdivision 1a, by adding a subdivision; 144A.53, subdivision 2; 147.012; 147.02, by adding a subdivision; 147A.06; 147A.07; 147B.02, subdivision 9, by adding a subdivision; 147C.15, subdivision 7, by adding a subdivision; 147D.17, subdivision 6, by adding a subdivision; 147D.27, by adding a subdivision; 147E.15, subdivision 5, by adding a subdivision; 147E.40, subdivision 1; 147F.07, subdivision 5, by adding subdivisions; 147F.17, subdivision 1; 148.7815, subdivision 1; 151.065, by adding a subdivision; 151.214; 151.71, by adding a subdivision; 152.126, subdivisions 6, 10; 214.075, subdivisions 1, 4, 5, 6; 214.077; 214.10, subdivision 8; 256.01, by adding a subdivision; 256B.04, subdivision 14; 256B.0625, subdivision 58; Minnesota Statutes 2017 Supplement, sections 103I.005, subdivisions 2, 8a, 17a; 103I.205, subdivisions 1, 4; 103I.208, subdivision 1; 103I.235, subdivision 3; 103I.601, subdivision 4; 147.01, subdivision 7; 147A.28; 147B.08; 147C.40; 152.105, subdivision 2; 256B.0625, subdivision 3b; 364.09; Laws 2017, First Special Session chapter 6, article 4, section 61; article 10, section 144; proposing coding for new law in Minnesota Statutes, chapters 62J; 62Q; 144; 147A; 147B;

147C; 147D; 147E; 147F; 256B; repealing Minnesota Statutes 2016, section 214.075, subdivision 8; Minnesota Statutes 2017 Supplement, section 256B.0625, subdivision 31c; Minnesota Rules, part 5600.0605, subparts 5, 8.

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

ARTICLE 1

HEALTH CARE

Section 1. Minnesota Statutes 2016, section 3.3005, subdivision 8, is amended to read:

Subd. 8. **Request contents.** A request to spend federal funds submitted under this section must include the name of the federal grant, the federal agency from which the funds are available, a federal identification number, a brief description of the purpose of the grant, the amounts expected by fiscal year, an indication if any state match is required, an indication if there is a maintenance of effort requirement, and the number of full-time equivalent positions needed to implement the grant. For new grants, the request must provide a narrative description of the short- and long-term commitments required, including whether continuation of any full-time equivalent positions will be a condition of receiving the federal award.

Sec. 2. **[62J.90] MINNESOTA HEALTH POLICY COMMISSION.**

Subdivision 1. **Definition.** For purposes of this section, "commission" means the Minnesota Health Policy Commission.

Subd. 2. **Commission membership.** The commission shall consist of 15 voting members, appointed by the Legislative Coordinating Commission as provided in subdivision 9, as follows:

(1) one member with demonstrated expertise in health care finance;

(2) one member with demonstrated expertise in health economics;

(3) one member with demonstrated expertise in actuarial science;

(4) one member with demonstrated expertise in health plan management and finance;

(5) one member with demonstrated expertise in health care system management;

(6) one member with demonstrated expertise as a purchaser, or a representative of a purchaser, of employer-sponsored health care services or employer-sponsored health insurance;

(7) one member with demonstrated expertise in the development and utilization of innovative medical technologies;

(8) one member with demonstrated expertise as a health care consumer advocate;

(9) one member who is a primary care physician;

(10) one member who provides long-term care services through medical assistance;

(11) one member with direct experience as an enrollee, or parent or caregiver of an enrollee, in MinnesotaCare or medical assistance;

(12) two members of the senate, including one member appointed by the majority leader and one member from the minority party appointed by the minority leader; and

(13) two members of the house of representatives, including one member appointed by the speaker of the house and one member from the minority party appointed by the minority leader.

Subd. 3. **Duties.** (a) The commission shall:

(1) compare Minnesota's private market health care costs and public health care program spending to that of the other states;

(2) compare Minnesota's private market health care costs and public health care program spending in any given year to its costs and spending in previous years;

(3) identify factors that influence and contribute to Minnesota's ranking for private market health care costs and public health care program spending, including the year over year and trend line change in total costs and spending in the state;

(4) continually monitor efforts to reform the health care delivery and payment system in Minnesota to understand emerging trends in the health insurance market, including the private health care market, large self-insured employers, and the state's public health care programs in order to identify opportunities for state action to achieve:

(i) improved patient experience of care, including quality and satisfaction;

(ii) improved health of all populations; and

(iii) reduced per capita cost of health care;

(5) make recommendations for legislative policy, the health care market, or any other reforms to:

(i) lower the rate of growth in private market health care costs and public health care program spending in the state;

(ii) positively impact the state's ranking in the areas listed in this subdivision; and

(iii) improve the quality and value of care for all Minnesotans; and

(6) conduct any additional reviews requested by the legislature.

(b) In making recommendations to the legislature, the commission shall consider:

(i) how the recommendations might positively impact the cost-shifting interplay between public payer reimbursement rates and health insurance premiums; and

(ii) how public health care programs, where appropriate, may be utilized as a means to help prepare enrollees for an eventual transition to the private health care market.

Subd. 4. **Report.** The commission shall submit recommendations for changes in health care policy and financing by June 15 each year to the chairs and ranking minority members of the legislative committees with primary jurisdiction over health care. The report shall include any draft legislation to implement the commission's recommendations.

Subd. 5. **Staff.** The commission shall hire a director who may employ or contract for professional and technical assistance as the commission determines necessary to perform its duties. The commission may also contract with private entities with expertise in health economics, health finance, and actuarial science to secure additional information, data, research, or modeling that may be necessary for the commission to carry out its duties.

Subd. 6. **Access to information.** The commission may secure directly from a state department or agency de-identified information and data that is necessary for the commission to carry out its duties. For purposes of this section, "de-identified" means the process used to prevent the identity of a person or business from being connected with information and ensuring all identifiable information has been removed.

Subd. 7. **Terms; vacancies; compensation.** (a) Public members of the commission shall serve four-year terms. The public members may not serve for more than two consecutive terms.

(b) The legislative members shall serve on the commission as long as the member or the appointing authority holds office.

(c) The removal of members and filling of vacancies on the commission are as provided in section 15.059.

(d) Public members may receive compensation and expenses as provided in section 15.059, subdivision 3.

Subd. 8. **Chairs; officers.** The commission shall elect a chair annually. The commission may elect other officers necessary for the performance of its duties.

Subd. 9. **Selection of members; advisory council.** The Legislative Coordinating Commission shall take applications from members of the public who are qualified and interested to serve in one of the listed positions. The applications must be reviewed by a health policy commission advisory council comprised of four members as follows: the state economist, legislative auditor, state demographer, and the president of the Federal Reserve Bank of Minneapolis or a designee of the president. The advisory council shall recommend two applicants for each of the specified positions by September 30 in the calendar year preceding the end of the members' terms. The Legislative Coordinating Commission shall appoint one of the two recommended applicants to the commission.

Subd. 10. **Meetings.** The commission shall meet at least four times each year. Commission meetings are subject to chapter 13D.

Subd. 11. **Conflict of interest.** A member of the commission may not participate in or vote on a decision of the commission relating to an organization in which the member has either a direct or indirect financial interest.

Subd. 12. **Expiration.** The commission shall expire on June 15, 2024.

Sec. 3. Minnesota Statutes 2016, section 256.01, is amended by adding a subdivision to read:

Subd. 17a. **Transfers for routine administrative operations.** (a) Unless specifically authorized by law, the commissioner may only transfer money from the general fund to any other fund for routine administrative operations and may not transfer money from the general fund to any other fund without approval from the commissioner of management and budget. If the commissioner of management and budget determines that a transfer proposed by the commissioner is necessary for routine administrative operations of the Department of Human Services, the commissioner may approve the transfer. If the commissioner of management and budget determines that the transfer proposed by the commissioner is not necessary for routine administrative operations of the Department of Human Services, the commissioner may not approve the transfer unless the requirements of paragraph (b) are met.

(b) If the commissioner of management and budget determines that a transfer under paragraph (a) is not necessary for routine administrative operations of the Department of Human Services, the commissioner may request approval of the transfer from the Legislative Advisory Commission under section 3.30. To request approval of a transfer from the Legislative Advisory Commission, the commissioner must submit a request that includes the amount of the transfer, the budget activity and fund from which money would be transferred and the budget activity and fund to which money would be transferred, an

explanation of the administrative necessity of the transfer, and a statement from the commissioner of management and budget explaining why the transfer is not necessary for routine administrative operations of the Department of Human Services. The Legislative Advisory Commission shall review the proposed transfer and make a recommendation within 20 days of the request from the commissioner. If the Legislative Advisory Commission makes a positive recommendation or no recommendation, the commissioner may approve the transfer. If the Legislative Advisory Commission makes a negative recommendation or a request for more information, the commissioner may not approve the transfer. A recommendation of the Legislative Advisory Commission must be made by a majority of the commission and must be made at a meeting of the commission unless a written recommendation is signed by a majority of the commission members required to vote on the question. If the commission makes a negative recommendation or a request for more information, the commission may withdraw or change its recommendation.

Sec. 4. Minnesota Statutes 2016, section 256B.04, subdivision 14, is amended to read:

Subd. 14. **Competitive bidding.** (a) When determined to be effective, economical, and feasible, the commissioner may utilize volume purchase through competitive bidding and negotiation under the provisions of chapter 16C, to provide items under the medical assistance program including but not limited to the following:

(1) eyeglasses;

(2) oxygen. The commissioner shall provide for oxygen needed in an emergency situation on a short-term basis, until the vendor can obtain the necessary supply from the contract dealer;

(3) hearing aids and supplies; and

(4) durable medical equipment, including but not limited to:

(i) hospital beds;

(ii) commodes;

(iii) glide-about chairs;

(iv) patient lift apparatus;

(v) wheelchairs and accessories;

(vi) oxygen administration equipment;

(vii) respiratory therapy equipment;

(viii) electronic diagnostic, therapeutic and life-support systems;

(5) nonemergency medical transportation level of need determinations, disbursement of public transportation passes and tokens, and volunteer and recipient mileage and parking reimbursements; and

(6) drugs.

(b) Rate changes and recipient cost-sharing under this chapter and chapter 256L do not affect contract payments under this subdivision unless specifically identified.

(c) The commissioner may not utilize volume purchase through competitive bidding and negotiation ~~for special transportation services~~ under the provisions of chapter 16C for special transportation services or incontinence products and related supplies.

Sec. 5. Minnesota Statutes 2017 Supplement, section 256B.0625, subdivision 3b, is amended to read:

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

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

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

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

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

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

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

(c) As a condition of payment, a licensed health care provider must document each occurrence of a health service provided by telemedicine to a medical assistance enrollee.

Health care service records for services provided by telemedicine must meet the requirements set forth in Minnesota Rules, part 9505.2175, subparts 1 and 2, and must document:

(1) the type of service provided by telemedicine;

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

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

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

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

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

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

(d) For purposes of this subdivision, unless otherwise covered under this chapter, "telemedicine" is defined as the delivery of health care services or consultations while the patient is at an originating site and the licensed health care provider is at a distant site. A communication between licensed health care providers, or a licensed health care provider and a patient that consists solely of a telephone conversation, e-mail, or facsimile transmission does not constitute telemedicine consultations or services. Telemedicine may be provided by means of real-time two-way, interactive audio and visual communications, including the application of secure video conferencing or store-and-forward technology to provide or support health care delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care.

(e) For purposes of this section, "licensed health care provider" means a licensed health care provider under section 62A.671, subdivision 6~~, and~~; a community paramedic as defined under section 144E.001, subdivision 5f; or a mental health practitioner defined under section 245.462, subdivision 17, or 245.4871, subdivision 26, working under the general supervision of a mental health professional; "health care provider" is defined under section 62A.671, subdivision 3; and "originating site" is defined under section 62A.671, subdivision 7.

(f) The limit on coverage of three telemedicine services per enrollee per calendar week does not apply if:

(1) the telemedicine services provided by the licensed health care provider are for the treatment and control of tuberculosis; and

(2) the services are provided in a manner consistent with the recommendations and best practices specified by the Centers for Disease Control and Prevention.

Sec. 6. Minnesota Statutes 2016, section 256B.0625, subdivision 58, is amended to read:

Subd. 58. **Early and periodic screening, diagnosis, and treatment services.** (a) Medical assistance covers early and periodic screening, diagnosis, and treatment services (EPSDT). The payment amount for a complete EPSDT screening shall not include charges for health care services and products that are available at no cost to the provider and shall not exceed the rate established per Minnesota Rules, part 9505.0445, item M, effective October 1, 2010.

(b) A provider is not required to perform as part of an EPSDT screening any of the recommendations that were added on or after January 1, 2017, to the child and teen checkup program periodicity schedule, in order to receive the full payment amount for a complete EPSDT screening. This paragraph expires January 1, 2021.

(c) The commissioner shall inform the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services of any new recommendations added to an EPSDT screening after January 1, 2018, that the provider is required to perform as part of an EPSDT screening to receive the full payment amount.

Sec. 7. **[256B.758] REIMBURSEMENT FOR DOULA SERVICES.**

Effective for services provided on or after July 1, 2018, payments for doula services provided by a certified doula shall be $47 per prenatal or postpartum visit, up to a total of six visits; and $488 for attending and providing doula services at a birth.

Sec. 8. Laws 2017, First Special Session chapter 6, article 4, section 61, is amended to read:

Sec. 61. **CAPITATION PAYMENT DELAY.**

(a) The commissioner of human services shall delay the medical assistance capitation payment to managed care plans and county-based purchasing plans due in May 2019 until July 1, 2019. The payment shall be made no earlier than July 1, 2019, and no later than July 31, 2019.

(b) The commissioner of human services shall delay the medical assistance capitation payment to managed care plans and county-based purchasing plans due in May 2021 until

July 1, 2021. The payment shall be made no earlier than July 1, 2021, and no later than July 31, 2021. This paragraph does not apply to the capitation payment for adults without dependent children.

Sec. 9. **MINNESOTA HEALTH POLICY COMMISSION; FIRST APPOINTMENTS; FIRST MEETING.**

The Health Policy Commission Advisory Council shall make its recommendations under Minnesota Statutes, section 62J.90, subdivision 9, for candidates to serve on the Minnesota Health Policy Commission to the Legislative Coordinating Commission by September 30, 2018. The Legislative Coordinating Commission shall make the first appointments of public members to the Minnesota Health Policy Commission under Minnesota Statutes, section 62J.90, by January 15, 2019. The Legislative Coordinating Commission shall designate five members to serve terms that are coterminous with the governor and six members to serve terms that end on the first Monday in January one year after the terms of the other members conclude. The director of the Legislative Coordinating Commission shall convene the first meeting of the Minnesota Health Policy Commission by June 15, 2019, and shall act as the chair until the commission elects a chair at its first meeting.

Sec. 10. **PAIN MANAGEMENT.**

(a) The Health Services Policy Committee established under Minnesota Statutes, section 256B.0625, subdivision 3c, shall evaluate and make recommendations on the integration of nonpharmacologic pain management that are clinically viable and sustainable; reduce or eliminate chronic pain conditions; improve functional status; and prevent addiction and reduce dependence on opiates or other pain medications. The recommendations must be based on best practices for the effective treatment of musculoskeletal pain provided by health practitioners identified in paragraph (b), and covered under medical assistance. Each health practitioner represented under paragraph (b) shall present the minimum best integrated practice recommendations, policies, and scientific evidence for nonpharmacologic treatment options for eliminating pain and improving functional status within their full professional scope. Recommendations for integration of services may include guidance regarding screening for co-occurring behavioral health diagnosis; protocols for communication between all providers treating a unique individual, including protocols for follow-up; and universal mechanisms to assess improvements in functional status.

(b) In evaluating and making recommendations, the Health Services Policy Committee shall consult and collaborate with the following health practitioners: acupuncture practitioners

licensed under Minnesota Statutes, chapter 147B; chiropractors licensed under Minnesota Statutes, sections 148.01 to 148.10; physical therapists licensed under Minnesota Statutes, sections 148.68 to 148.78; medical and osteopathic physicians licensed under Minnesota Statutes, chapter 147, and advanced practice registered nurses licensed under Minnesota Statutes, sections 148.171 to 148.285, with experience in providing primary care collaboratively within a multidisciplinary team of health care practitioners who employ nonpharmacologic pain therapies; and psychologists licensed under Minnesota Statutes, section 148.907.

(c) The commissioner shall submit a progress report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by January 15, 2019, and shall report final recommendations by August 1, 2019. The final report may also contain recommendations for developing and implementing a pilot program to assess the clinical viability, sustainability, and effectiveness of integrated nonpharmacologic, multidisciplinary treatments for managing musculoskeletal pain and improving functional status.

Sec. 11. **REPEALER.**

Minnesota Statutes 2017 Supplement, section 256B.0625, subdivision 31c, is repealed.

ARTICLE 2

HEALTH DEPARTMENT

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

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

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

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

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

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

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

(i) measure groundwater levels, including a piezometer;

(ii) determine groundwater flow direction or velocity;

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

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

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

An environmental well does not include an exploratory boring.

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

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

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

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

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

(4) determine groundwater flow direction or velocity; or

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

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

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

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

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

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

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

(1) the location of the well;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) sealing wells and borings;

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

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

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

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

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

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

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

Sec. 6. Minnesota Statutes 2017 Supplement, section 103I.208, subdivision 1, is amended to read:

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

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

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

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

(4) for construction of an environmental well, $275, which includes the state core function fee, except that a single fee of $275 is required for all environmental wells recorded on the

notification that are located on a single property, and except that no fee is required for construction of a temporary ~~environmental well~~ boring.

Sec. 7. Minnesota Statutes 2017 Supplement, section 103I.235, subdivision 3, is amended to read:

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

Sec. 8. Minnesota Statutes 2016, section 103I.301, subdivision 6, is amended to read:

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

Sec. 9. Minnesota Statutes 2017 Supplement, section 103I.601, subdivision 4, is amended to read:

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

(b) By ten days before beginning exploratory boring, an explorer must submit to the commissioners of health and natural resources a county road map on a single sheet of paper that is 8-1/2 inches by 11 inches in size and having a scale of one-half inch equal to one mile, as prepared by the Department of Transportation, or a 7.5 minute series topographic map (1:24,000 scale), as prepared by the United States Geological Survey, showing the location of each proposed exploratory boring to the nearest estimated 40 acre parcel. Exploratory boring that is proposed on the map may not be commenced later than 180 days after submission of the map, unless a new map is submitted.

Sec. 10. Minnesota Statutes 2016, section 144.121, subdivision 1a, is amended to read:

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

(1) medical or veterinary equipment $ 100

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

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

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

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

Sec. 11. Minnesota Statutes 2016, section 144.121, is amended by adding a subdivision to read:

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

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

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

Sec. 12. **[144.397] STATEWIDE TOBACCO CESSATION SERVICES.**

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

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

(1) telephone-based coaching and counseling;

(2) referrals;

(3) written materials mailed upon request;

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

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

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

Sec. 13. Laws 2017, First Special Session chapter 6, article 10, section 144, is amended to read:

Sec. 144. **OPIOID ABUSE PREVENTION PILOT PROJECTS.**

(a) The commissioner of health shall establish opioid abuse prevention pilot projects in geographic areas throughout the state based on the most recently available data on opioid overdose and abuse rates, to reduce opioid abuse through the use of controlled substance care teams and community-wide coordination of abuse-prevention initiatives. The commissioner shall award grants to health care providers, health plan companies, local units of government, tribal governments, or other entities to establish pilot projects.

(b) Each pilot project must:

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

(2) establish multidisciplinary controlled substance care teams, that may consist of physicians, pharmacists, social workers, nurse care coordinators, and mental health professionals;

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

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

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

(6) promote the adoption of best practices related to opioid disposal and reducing opportunities for illegal access to opioids; and

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

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

(d) The contract under paragraph (c) shall require the accountable community for health to evaluate the extent to which the pilot projects were successful in reducing the inappropriate use of opioids. The evaluation must analyze changes in the number of opioid prescriptions, the number of emergency room visits related to opioid use, and other relevant measures. The accountable community for health shall report evaluation results to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance and public safety by December 15, 2019, for projects that received funding in fiscal year 2018, and by December 15, 2021, for projects that received funding in fiscal year 2019.

(e) The commissioner may award one grant that, in addition to the other requirements of this section, allows a root cause approach to reduce opioid abuse in an American Indian community.

Sec. 14. **LOW-VALUE HEALTH SERVICES STUDY.**

(a) The commissioner of health shall examine and analyze:

(1) the alignment in health care delivery with specific best practices guidelines or recommendations; and

(2) health care services and procedures for purposes of identifying, measuring, and potentially eliminating those services or procedures with low value and little benefit to patients. The commissioner shall update and expand on previous work completed by the Department of Health on the prevalence and costs of low-value health care services in Minnesota.

(b) Notwithstanding Minnesota Statutes, section 62U.04, subdivision 11, the commissioner may use the Minnesota All Payer Claims Database (MN APCD) to conduct the analysis using the most recent data available and may limit the claims research to the Minnesota All Payer Claims Database.

(c) The commissioner may convene a work group of no more than eight members with demonstrated knowledge and expertise in health care delivery systems, clinical experience, or research experience to make recommendations on services and procedures for the commissioner to analyze under paragraph (a).

(d) The commissioner shall submit a preliminary report to the chairs and ranking minority members of the legislative committees with jurisdiction over health care by February 1, 2019, outlining the work group's recommendations and any early findings from the analysis. The commissioner shall submit a final report containing the completed analysis by January 15, 2020. The commissioner may release select research findings as a result of this study throughout the study and analytic process and shall provide the public an opportunity to comment on any research findings before the release of any finding.

Sec. 15. **OPIOID OVERDOSE REDUCTION PILOT PROGRAM.**

Subdivision 1. **Establishment.** The commissioner of health shall provide grants to ambulance services to fund activities by community paramedic teams to reduce opioid overdoses in the state. Under this pilot program, ambulance services shall develop and implement projects in which community paramedics connect with patients who are discharged from a hospital or emergency department following an opioid overdose episode, develop personalized care plans for those patients in consultation with the ambulance service medical director, and provide follow-up services to those patients.

Subd. 2. **Priority areas; services.** (a) In a project developed under this section, an ambulance service must target community paramedic team services to portions of the service area with high levels of opioid use, high death rates from opioid overdoses, and urgent needs for interventions.

(b) In a project developed under this section, a community paramedic team shall:

(1) provide services to patients released from a hospital or emergency department following an opioid overdose episode and place priority on serving patients who were administered the opiate antagonist naloxone hydrochloride by emergency medical services personnel in response to a 911 call during the opioid overdose episode;

(2) provide the following evaluations during an initial home visit: (i) a home safety assessment including whether there is a need to dispose of prescription drugs that are expired or no longer needed; (ii) medication compliance; (iii) an HIV risk assessment; (iv) instruction on the use of naloxone hydrochloride; and (v) a basic needs assessment;

(3) provide patients with health assessments, chronic disease monitoring and education, and assistance in following hospital discharge orders; and

(4) work with a multidisciplinary team to address the overall physical and mental health needs of patients and health needs related to substance use disorder treatment.

(c) An ambulance service receiving a grant under this section may use grant funds to cover the cost of evidence-based training in opioid addiction and recovery treatment.

Subd. 3. **Evaluation.** An ambulance service that receives a grant under this section shall evaluate the extent to which the project was successful in reducing the number of opioid overdoses and opioid overdose deaths among patients who received services and in reducing the inappropriate use of opioids by patients who received services. The commissioner of health shall develop specific evaluation measures and reporting timelines for ambulance services receiving grants. Ambulance services shall submit the information required by the commissioner to the commissioner and the commissioner shall submit a summary of the information reported by the ambulance services to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services by December 1, 2019.

Sec. 16. **RULEMAKING; SECURITY SCREENING SYSTEMS.**

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

Rulemaking authority under this section is not continuing authority to amend or repeal the rule. Any additional action on rules once adopted must be pursuant to specific statutory authority to take the additional action.

ARTICLE 3

HEALTH COVERAGE

Section 1. Minnesota Statutes 2016, section 62A.30, is amended by adding a subdivision to read:

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

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

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

(2) testing positive for BRCA1 or BRCA2 mutations;

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

(4) having a previous diagnosis of breast cancer.

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

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

Sec. 2. **[62J.824] FACILITY FEE DISCLOSURE.**

(a) Prior to the delivery of nonemergency services, a provider-based clinic that charges a facility fee shall provide notice to any patient stating that the clinic is part of a hospital and the patient may receive a separate charge or billing for the facility component, which may result in a higher out-of-pocket expense.

(b) Each health care facility must post prominently in locations easily accessible to and visible by patients, including its Web site, a statement that the provider-based clinic is part of a hospital and the patient may receive a separate charge or billing for the facility, which may result in a higher out-of-pocket expense.

(c) This section does not apply to laboratory services, imaging services, or other ancillary health services that are provided by staff who are not employed by the health care facility or clinic.

(d) For purposes of this section:

(1) "facility fee" means any separate charge or billing by a provider-based clinic in addition to a professional fee for physicians' services that is intended to cover building, electronic medical records systems, billing, and other administrative and operational expenses; and

(2) "provider-based clinic" means the site of an off-campus clinic or provider office located at least 250 yards from the main hospital buildings or as determined by the Centers for Medicare and Medicaid Services, that is owned by a hospital licensed under chapter 144 or a health system that operates one or more hospitals licensed under chapter 144, and is primarily engaged in providing diagnostic and therapeutic care, including medical history, physical examinations, assessment of health status, and treatment monitoring. This definition does not include clinics that are exclusively providing laboratory, x-ray, testing, therapy, pharmacy, or educational services and does not include facilities designated as rural health clinics.

Sec. 3. **[62Q.184] STEP THERAPY OVERRIDE.**

Subdivision 1. **Definitions.** (a) For the purposes of this section, the terms in this subdivision have the meanings given them.

(b) "Clinical practice guideline" means a systematically developed statement to assist health care providers and enrollees in making decisions about appropriate health care services for specific clinical circumstances and conditions developed independently of a health plan company, pharmaceutical manufacturer, or any entity with a conflict of interest.

(c) "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols, and clinical practice guidelines used by a health plan company to determine the medical necessity and appropriateness of health care services.

(d) "Health plan company" has the meaning given in section 62Q.01, subdivision 4, but does not include a managed care organization or county-based purchasing plan participating

in a public program under chapter 256B or 256L, or an integrated health partnership under section 256B.0755.

(e) "Step therapy protocol" means a protocol or program that establishes the specific sequence in which prescription drugs for a specified medical condition, including self-administered and physician-administered drugs, are medically appropriate for a particular enrollee and are covered under a health plan.

(f) "Step therapy override" means that the step therapy protocol is overridden in favor of coverage of the selected prescription drug of the prescribing health care provider because at least one of the conditions of subdivision 3, paragraph (a), exists.

Subd. 2. **Establishment of a step therapy protocol.** A health plan company shall consider available recognized evidence-based and peer-reviewed clinical practice guidelines when establishing a step therapy protocol. Upon written request of an enrollee, a health plan company shall provide any clinical review criteria applicable to a specific prescription drug covered by the health plan.

Subd. 3. **Step therapy override process; transparency.** (a) When coverage of a prescription drug for the treatment of a medical condition is restricted for use by a health plan company through the use of a step therapy protocol, enrollees and prescribing health care providers shall have access to a clear, readily accessible, and convenient process to request a step therapy override. The process shall be made easily accessible on the health plan company's Web site. A health plan company may use its existing medical exceptions process to satisfy this requirement. A health plan company shall grant an override to the step therapy protocol if at least one of the following conditions exist:

(1) the prescription drug required under the step therapy protocol is contraindicated pursuant to the pharmaceutical manufacturer's prescribing information for the drug or, due to a documented adverse event with a previous use or a documented medical condition, including a comorbid condition, is likely to do any of the following:

(i) cause an adverse reaction in the enrollee;

(ii) decrease the ability of the enrollee to achieve or maintain reasonable functional ability in performing daily activities; or

(iii) cause physical or mental harm to the enrollee;

(2) the enrollee has had a trial of the required prescription drug covered by their current or previous health plan, or another prescription drug in the same pharmacologic class or with the same mechanism of action, and was adherent during such trial for a period of time

sufficient to allow for a positive treatment outcome, and the prescription drug was discontinued by the enrollee's health care provider due to lack of effectiveness, or an adverse event. This clause does not prohibit a health plan company from requiring an enrollee to try another drug in the same pharmacologic class or with the same mechanism of action if that therapy sequence is supported by the evidence-based and peer-reviewed clinical practice guideline, Food and Drug Administration label, or pharmaceutical manufacturer's prescribing information; or

(3) the enrollee is currently receiving a positive therapeutic outcome on a prescription drug for the medical condition under consideration if, while on their current health plan or the immediately preceding health plan, the enrollee received coverage for the prescription drug and the enrollee's prescribing health care provider gives documentation to the health plan company that the change in prescription drug required by the step therapy protocol is expected to be ineffective or cause harm to the enrollee based on the known characteristics of the specific enrollee and the known characteristics of the required prescription drug.

(b) Upon granting a step therapy override, a health plan company shall authorize coverage for the prescription drug if the prescription drug is a covered prescription drug under the enrollee's health plan.

(c) The enrollee, or the prescribing health care provider if designated by the enrollee, may appeal the denial of a step therapy override by a health plan company using the complaint procedure under sections 62Q.68 to 62Q.73.

(d) In a denial of an override request and any subsequent appeal, a health plan company's decision must specifically state why the step therapy override request did not meet the condition under paragraph (a) cited by the prescribing health care provider in requesting the step therapy override and information regarding the procedure to request external review of the denial pursuant to section 62Q.73. A denial of a request for a step therapy override that is upheld on appeal is a final adverse determination for purposes of section 62Q.73 and is eligible for a request for external review by an enrollee pursuant to section 62Q.73.

(e) A health plan company shall respond to a step therapy override request or an appeal within five days of receipt of a complete request. In cases where exigent circumstances exist, a health plan company shall respond within 72 hours of receipt of a complete request. If a health plan company does not send a response to the enrollee or prescribing health care provider if designated by the enrollee within the time allotted, the override request or appeal is granted and binding on the health plan company.

(f) Step therapy override requests must be accessible to and submitted by health care providers, and accepted by group purchasers electronically through secure electronic transmission, as described under section 62J.497, subdivision 5.

(g) Nothing in this section prohibits a health plan company from:

(1) requesting relevant documentation from an enrollee's medical record in support of a step therapy override request; or

(2) requiring an enrollee to try a generic equivalent drug pursuant to section 151.21, or a biosimilar, as defined under United States Code, title 42, section 262(i)(2), prior to providing coverage for the equivalent branded prescription drug.

(h) This section shall not be construed to allow the use of a pharmaceutical sample for the primary purpose of meeting the requirements for a step therapy override.

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

Sec. 4. Minnesota Statutes 2016, section 151.214, is amended to read:

151.214 PAYMENT DISCLOSURE.

Subdivision 1. **Explanation of pharmacy benefits.** A pharmacist licensed under this chapter must provide to a patient, for each prescription dispensed where part or all of the cost of the prescription is being paid or reimbursed by an employer-sponsored plan or health plan company, or its contracted pharmacy benefit manager, the patient's co-payment amount ~~and~~, the pharmacy's own usual and customary price of the prescription ~~or~~, and the net amount the pharmacy will ~~be paid for the prescription drug~~ receive from all sources for dispensing the prescription drug, once the claim has been completed by the patient's employer-sponsored plan or health plan company, or its contracted pharmacy benefit manager.

Subd. 2. **No prohibition on disclosure.** No contracting agreement between an employer-sponsored health plan or health plan company, or its contracted pharmacy benefit manager, and a resident or nonresident pharmacy ~~registered~~ licensed under this chapter, may prohibit ~~the~~:

(1) a pharmacy from disclosing to patients information a pharmacy is required or given the option to provide under subdivision 1; or

(2) a pharmacist from informing a patient when the amount the patient is required to pay under the patient's health plan for a particular drug is greater than the amount the patient

would be required to pay for the same drug if purchased out-of-pocket at the pharmacy's usual and customary price.

Sec. 5. Minnesota Statutes 2016, section 151.71, is amended by adding a subdivision to read:

Subd. 3. **Synchronization of refills.** (a) For purposes of this subdivision, "synchronization" means the coordination of prescription drug refills for a patient taking two or more medications for one or more chronic conditions, to allow the patient's medications to be refilled on the same schedule for a given period of time.

(b) A contract between a pharmacy benefit manager and a pharmacy must allow for synchronization of prescription drug refills for a patient on at least one occasion per year, if the following criteria are met:

(1) the prescription drugs are covered under the patient's health plan or have been approved by a formulary exceptions process;

(2) the prescription drugs are maintenance medications as defined by the health plan and have one or more refills available at the time of synchronization;

(3) the prescription drugs are not Schedule II, III, or IV controlled substances;

(4) the patient meets all utilization management criteria relevant to the prescription drug at the time of synchronization;

(5) the prescription drugs are of a formulation that can be safely split into short-fill periods to achieve synchronization; and

(6) the prescription drugs do not have special handling or sourcing needs that require a single, designated pharmacy to fill or refill the prescription.

(c) When necessary to permit synchronization, the pharmacy benefit manager shall apply a prorated, daily patient cost-sharing rate to any prescription drug dispensed by a pharmacy under this subdivision. The dispensing fee shall not be prorated, and all dispensing fees shall be based on the number of prescriptions filled or refilled.

Sec. 6. Minnesota Statutes 2017 Supplement, section 152.105, subdivision 2, is amended to read:

Subd. 2. **Sheriff to maintain collection receptacle or medicine disposal program.** (a) The sheriff of each county shall maintain or contract for the maintenance of at least one collection receptacle or implement a medicine disposal program for the disposal of

noncontrolled substances, pharmaceutical controlled substances, and other legend drugs, as permitted by federal law. For purposes of this section, "legend drug" has the meaning given in section 151.01, subdivision 17. The collection receptacle and medicine disposal program must comply with federal law. In maintaining and operating the collection receptacle or medicine disposal program, the sheriff shall follow all applicable provisions of Code of Federal Regulations, title 21, parts 1300, 1301, 1304, 1305, 1307, and 1317, as amended through May 1, 2017.

(b) For purposes of this subdivision:

(1) a medicine disposal program means providing to the public educational information, and making materials available for safely destroying unwanted legend drugs, including, but not limited to, drug destruction bags or drops; and

(2) a collection receptacle means the operation and maintenance of at least one drop-off receptacle.

ARTICLE 4

HEALTH-RELATED LICENSING BOARDS

Section 1. Minnesota Statutes 2017 Supplement, section 147.01, subdivision 7, is amended to read:

Subd. 7. **Physician application and license fees.** (a) The board may charge the following nonrefundable application and license fees processed pursuant to sections 147.02, 147.03, 147.037, 147.0375, and 147.38:

(1) physician application fee, $200;

(2) physician annual registration renewal fee, $192;

(3) physician endorsement to other states, $40;

(4) physician emeritus license, $50;

(5) physician temporary license, $60;

(6) physician late fee, $60;

(7) duplicate license fee, $20;

(8) certification letter fee, $25;

(9) education or training program approval fee, $100;

(10) report creation and generation fee, $60 per hour;

(11) examination administration fee (half day), $50;

(12) examination administration fee (full day), $80; ~~and~~

(13) fees developed by the Interstate Commission for determining physician qualification to register and participate in the interstate medical licensure compact, as established in rules authorized in and pursuant to section 147.38, not to exceed $1,000~~.~~;

(14) verification fee, $25; and

(15) criminal background check fee, $32.

(b) The board may prorate the initial annual license fee. All licensees are required to pay the full fee upon license renewal. The revenue generated from the fee must be deposited in an account in the state government special revenue fund.

Sec. 2. Minnesota Statutes 2016, section 147.012, is amended to read:

147.012 OVERSIGHT OF ALLIED HEALTH PROFESSIONS.

The board has responsibility for the oversight of the following allied health professions: physician assistants under chapter 147A~~,~~; acupuncture practitioners under chapter 147B~~,~~; respiratory care practitioners under chapter 147C~~,~~; traditional midwives under chapter 147D~~,~~; registered naturopathic doctors under chapter 147E~~,~~, genetic counselors under chapter 147F, and athletic trainers under sections 148.7801 to 148.7815.

Sec. 3. Minnesota Statutes 2016, section 147.02, is amended by adding a subdivision to read:

Subd. 7. **Additional renewal requirements.** (a) The licensee must maintain a correct mailing address with the board for receiving board communications, notices, and licensure renewal documents. Placing the license renewal application in first class United States mail, addressed to the licensee at the licensee's last known address with postage prepaid, constitutes valid service. Failure to receive the renewal documents does not relieve a license holder of the obligation to comply with this section.

(b) The names of licensees who do not return a complete license renewal application, the annual license fee, or the late application fee within 30 days shall be removed from the list of individuals authorized to practice medicine and surgery during the current renewal period. Upon reinstatement of licensure, the licensee's name will be placed on the list of individuals authorized to practice medicine and surgery.

Sec. 4. Minnesota Statutes 2016, section 147A.06, is amended to read:

147A.06 CANCELLATION OF LICENSE FOR NONRENEWAL.

Subdivision 1. **Cancellation of license.** The board shall not renew, reissue, reinstate, or restore a license that has lapsed on or after July 1, 1996, and has not been renewed within two annual renewal cycles starting July 1, 1997. A licensee whose license is canceled for nonrenewal must obtain a new license by applying for licensure and fulfilling all requirements then in existence for an initial license to practice as a physician assistant.

Subd. 2. **Licensure following lapse of licensed status; transition.** (a) A licensee whose license has lapsed under subdivision 1 before January 1, 2019, and who seeks to regain licensed status after January 1, 2019, shall be treated as a first-time licensee only for purposes of establishing a license renewal schedule, and shall not be subject to the license cycle conversion provisions in section 147A.29.

(b) This subdivision expires July 1, 2021.

Sec. 5. Minnesota Statutes 2016, section 147A.07, is amended to read:

147A.07 RENEWAL.

(a) A person who holds a license as a physician assistant shall annually, upon notification from the board, renew the license by:

(1) submitting the appropriate fee as determined by the board;

(2) completing the appropriate forms; and

(3) meeting any other requirements of the board.

(b) A licensee must maintain a correct mailing address with the board for receiving board communications, notices, and license renewal documents. Placing the license renewal application in first class United States mail, addressed to the licensee at the licensee's last known address with postage prepaid, constitutes valid service. Failure to receive the renewal documents does not relieve a licensee of the obligation to comply with this section.

(c) The name of a licensee who does not return a complete license renewal application, annual license fee, or late application fee, as applicable, within the time period required by this section shall be removed from the list of individuals authorized to practice during the current renewal period. If the licensee's license is reinstated, the licensee's name shall be placed on the list of individuals authorized to practice.

Sec. 6. Minnesota Statutes 2017 Supplement, section 147A.28, is amended to read:

147A.28 PHYSICIAN ASSISTANT APPLICATION AND LICENSE FEES.

(a) The board may charge the following nonrefundable fees:

(1) physician assistant application fee, $120;

(2) physician assistant annual registration renewal fee (prescribing authority), $135;

(3) physician assistant annual registration renewal fee (no prescribing authority), $115;

(4) physician assistant temporary registration, $115;

(5) physician assistant temporary permit, $60;

(6) physician assistant locum tenens permit, $25;

(7) physician assistant late fee, $50;

(8) duplicate license fee, $20;

(9) certification letter fee, $25;

(10) education or training program approval fee, $100; ~~and~~

(11) report creation and generation fee, $60~~.~~ per hour;

(12) verification fee, $25; and

(13) criminal background check fee, $32.

(b) The board may prorate the initial annual license fee. All licensees are required to pay the full fee upon license renewal. The revenue generated from the fees must be deposited in an account in the state government special revenue fund.

Sec. 7. **[147A.29] LICENSE RENEWAL CYCLE CONVERSION.**

Subdivision 1. **Generally.** The license renewal cycle for physician assistant licensees is converted to an annual cycle where renewal is due on the last day of the licensee's month of birth. Conversion pursuant to this section begins January 1, 2019. This section governs license renewal procedures for licensees who were licensed before December 31, 2018. The conversion renewal cycle is the renewal cycle following the first license renewal after January 1, 2019. The conversion license period is the license period for the conversion renewal cycle. The conversion license period is between six and 17 months and ends on the last day of the licensee's month of birth in either 2019 or 2020, as described in subdivision 2.

Subd. 2. **Conversion of license renewal cycle for current licensees.** For a licensee whose license is current as of December 31, 2018, the licensee's conversion license period begins on January 1, 2019, and ends on the last day of the licensee's month of birth in 2019, except that for licensees whose month of birth is January, February, March, April, May, or June, the licensee's renewal cycle ends on the last day of the licensee's month of birth in 2020.

Subd. 3. **Conversion of license renewal cycle for noncurrent licensees.** This subdivision applies to an individual who was licensed before December 31, 2018, but whose license is not current as of December 31, 2018. When the individual first renews the license after January 1, 2019, the conversion renewal cycle begins on the date the individual applies for renewal and ends on the last day of the licensee's month of birth in the same year, except that if the last day of the individual's month of birth is less than six months after the date the individual applies for renewal, then the renewal period ends on the last day of the individual's month of birth in the following year.

Subd. 4. **Subsequent renewal cycles.** After the licensee's conversion renewal cycle under subdivision 2 or 3, subsequent renewal cycles are annual and begin on the last day of the month of the licensee's birth.

Subd. 5. **Conversion period and fees.** (a) A licensee who holds a license issued before January 1, 2019, and who renews that license pursuant to subdivision 2 or 3, shall pay a renewal fee as required in this subdivision.

(b) A licensee shall be charged the annual license fee listed in section 147A.28 for the conversion license period.

(c) For a licensee whose conversion license period is six to 11 months, the first annual license fee charged after the conversion license period shall be adjusted to credit the excess fee payment made during the conversion license period. The credit is calculated by: (1) subtracting the number of months of the licensee's conversion license period from 12; and (2) multiplying the result of clause (1) by 1/12 of the annual fee rounded up to the next dollar.

(d) For a licensee whose conversion license period is 12 months, the first annual license fee charged after the conversion license period shall not be adjusted.

(e) For a licensee whose conversion license period is 13 to 17 months, the first annual license fee charged after the conversion license period shall be adjusted to add the annual license fee payment for the months that were not included in the annual license fee paid for the conversion license period. The added payment is calculated by: (1) subtracting 12 from

the number of months of the licensee's conversion license period; and (2) multiplying the result of clause (1) by 1/12 of the annual fee rounded up to the next dollar.

(f) For the second and all subsequent license renewals made after the conversion license period, the licensee's annual license fee is as listed in section 147A.28.

Subd. 6. **Expiration.** This section expires July 1, 2021.

Sec. 8. Minnesota Statutes 2016, section 147B.02, subdivision 9, is amended to read:

Subd. 9. **Renewal.** (a) To renew a license an applicant must:

(1) annually, or as determined by the board, complete a renewal application on a form provided by the board;

(2) submit the renewal fee;

(3) provide documentation of current and active NCCAOM certification; or

(4) if licensed under subdivision 5 or 6, meet the same NCCAOM professional development activity requirements as those licensed under subdivision 7.

(b) An applicant shall submit any additional information requested by the board to clarify information presented in the renewal application. The information must be submitted within 30 days after the board's request, or the renewal request is nullified.

(c) An applicant must maintain a correct mailing address with the board for receiving board communications, notices, and license renewal documents. Placing the license renewal application in first class United States mail, addressed to the applicant at the applicant's last known address with postage prepaid, constitutes valid service. Failure to receive the renewal documents does not relieve an applicant of the obligation to comply with this section.

(d) The name of an applicant who does not return a complete license renewal application, annual license fee, or late application fee, as applicable, within the time period required by this section shall be removed from the list of individuals authorized to practice during the current renewal period. If the applicant's license is reinstated, the applicant's name shall be placed on the list of individuals authorized to practice.

Sec. 9. Minnesota Statutes 2016, section 147B.02, is amended by adding a subdivision to read:

Subd. 12a. **Licensure following lapse of licensed status; transition.** (a) A licensee whose license has lapsed under subdivision 12 before January 1, 2019, and who seeks to regain licensed status after January 1, 2019, shall be treated as a first-time licensee only for

purposes of establishing a license renewal schedule, and shall not be subject to the license cycle conversion provisions in section 147B.09.

(b) This subdivision expires July 1, 2021.

Sec. 10. Minnesota Statutes 2017 Supplement, section 147B.08, is amended to read:

147B.08 FEES.

Subd. 4. **Acupuncturist application and license fees.** (a) The board may charge the following nonrefundable fees:

(1) acupuncturist application fee, $150;

(2) acupuncturist annual registration renewal fee, $150;

(3) acupuncturist temporary registration fee, $60;

(4) acupuncturist inactive status fee, $50;

(5) acupuncturist late fee, $50;

(6) duplicate license fee, $20;

(7) certification letter fee, $25;

(8) education or training program approval fee, $100; ~~and~~

(9) report creation and generation fee, $60~~.~~ per hour;

(10) verification fee, $25; and

(11) criminal background check fee, $32.

(b) The board may prorate the initial annual license fee. All licensees are required to pay the full fee upon license renewal. The revenue generated from the fees must be deposited in an account in the state government special revenue fund.

Sec. 11. **[147B.09] LICENSE RENEWAL CYCLE CONVERSION.**

Subdivision 1. **Generally.** The license renewal cycle for acupuncture practitioner licensees is converted to an annual cycle where renewal is due on the last day of the licensee's month of birth. Conversion pursuant to this section begins January 1, 2019. This section governs license renewal procedures for licensees who were licensed before December 31, 2018. The conversion renewal cycle is the renewal cycle following the first license renewal after January 1, 2019. The conversion license period is the license period for the conversion renewal cycle. The conversion license period is between six and 17 months and ends on the

last day of the licensee's month of birth in either 2019 or 2020, as described in subdivision 2.

Subd. 2. **Conversion of license renewal cycle for current licensees.** For a licensee whose license is current as of December 31, 2018, the licensee's conversion license period begins on January 1, 2019, and ends on the last day of the licensee's month of birth in 2019, except that for licensees whose month of birth is January, February, March, April, May, or June, the licensee's renewal cycle ends on the last day of the licensee's month of birth in 2020.

Subd. 3. **Conversion of license renewal cycle for noncurrent licensees.** This subdivision applies to an individual who was licensed before December 31, 2018, but whose license is not current as of December 31, 2018. When the individual first renews the license after January 1, 2019, the conversion renewal cycle begins on the date the individual applies for renewal and ends on the last day of the licensee's month of birth in the same year, except that if the last day of the individual's month of birth is less than six months after the date the individual applies for renewal, then the renewal period ends on the last day of the individual's month of birth in the following year.

Subd. 4. **Subsequent renewal cycles.** After the licensee's conversion renewal cycle under subdivision 2 or 3, subsequent renewal cycles are annual and begin on the last day of the month of the licensee's birth.

Subd. 5. **Conversion period and fees.** (a) A licensee who holds a license issued before January 1, 2019, and who renews that license pursuant to subdivision 2 or 3, shall pay a renewal fee as required in this subdivision.

(b) A licensee shall be charged the annual license fee listed in section 147B.08 for the conversion license period.

(c) For a licensee whose conversion license period is six to 11 months, the first annual license fee charged after the conversion license period shall be adjusted to credit the excess fee payment made during the conversion license period. The credit is calculated by: (1) subtracting the number of months of the licensee's conversion license period from 12; and (2) multiplying the result of clause (1) by 1/12 of the annual fee rounded up to the next dollar.

(d) For a licensee whose conversion license period is 12 months, the first annual license fee charged after the conversion license period shall not be adjusted.

(e) For a licensee whose conversion license period is 13 to 17 months, the first annual license fee charged after the conversion license period shall be adjusted to add the annual license fee payment for the months that were not included in the annual license fee paid for the conversion license period. The added payment is calculated by: (1) subtracting 12 from the number of months of the licensee's conversion license period; and (2) multiplying the result of clause (1) by 1/12 of the annual fee rounded up to the next dollar.

(f) For the second and all subsequent license renewals made after the conversion license period, the licensee's annual license fee is as listed in section 147B.08.

Subd. 6. **Expiration.** This section expires July 1, 2021.

Sec. 12. Minnesota Statutes 2016, section 147C.15, subdivision 7, is amended to read:

Subd. 7. **Renewal.** (a) To be eligible for license renewal a licensee must:

(1) annually, or as determined by the board, complete a renewal application on a form provided by the board;

(2) submit the renewal fee;

(3) provide evidence every two years of a total of 24 hours of continuing education approved by the board as described in section 147C.25; and

(4) submit any additional information requested by the board to clarify information presented in the renewal application. The information must be submitted within 30 days after the board's request, or the renewal request is nullified.

(b) Applicants for renewal who have not practiced the equivalent of eight full weeks during the past five years must achieve a passing score on retaking the credentialing examination.

(c) A licensee must maintain a correct mailing address with the board for receiving board communications, notices, and license renewal documents. Placing the license renewal application in first class United States mail, addressed to the licensee at the licensee's last known address with postage prepaid, constitutes valid service. Failure to receive the renewal documents does not relieve a licensee of the obligation to comply with this section.

(d) The name of a licensee who does not return a complete license renewal application, annual license fee, or late application fee, as applicable, within the time period required by this section shall be removed from the list of individuals authorized to practice during the current renewal period. If the licensee's license is reinstated, the licensee's name shall be placed on the list of individuals authorized to practice.

Sec. 13. Minnesota Statutes 2016, section 147C.15, is amended by adding a subdivision to read:

Subd. 12a. **Licensure following lapse of licensed status; transition.** (a) A licensee whose license has lapsed under subdivision 12 before January 1, 2019, and who seeks to regain licensed status after January 1, 2019, shall be treated as a first-time licensee only for purposes of establishing a license renewal schedule, and shall not be subject to the license cycle conversion provisions in section 147C.45.

(b) This subdivision expires July 1, 2021.

Sec. 14. Minnesota Statutes 2017 Supplement, section 147C.40, is amended to read:

147C.40 FEES.

Subd. 5. **Respiratory therapist application and license fees.** (a) The board may charge the following nonrefundable fees:

(1) respiratory therapist application fee, $100;

(2) respiratory therapist annual registration renewal fee, $90;

(3) respiratory therapist inactive status fee, $50;

(4) respiratory therapist temporary registration fee, $90;

(5) respiratory therapist temporary permit, $60;

(6) respiratory therapist late fee, $50;

(7) duplicate license fee, $20;

(8) certification letter fee, $25;

(9) education or training program approval fee, $100; ~~and~~

(10) report creation and generation fee, $60~~.~~ per hour;

(11) verification fee, $25; and

(12) criminal background check fee, $32.

(b) The board may prorate the initial annual license fee. All licensees are required to pay the full fee upon license renewal. The revenue generated from the fees must be deposited in an account in the state government special revenue fund.

Sec. 15. **[147C.45] LICENSE RENEWAL CYCLE CONVERSION.**

Subdivision 1. **Generally.** The license renewal cycle for respiratory care practitioner licensees is converted to an annual cycle where renewal is due on the last day of the licensee's month of birth. Conversion pursuant to this section begins January 1, 2019. This section governs license renewal procedures for licensees who were licensed before December 31, 2018. The conversion renewal cycle is the renewal cycle following the first license renewal after January 1, 2019. The conversion license period is the license period for the conversion renewal cycle. The conversion license period is between six and 17 months and ends on the last day of the licensee's month of birth in either 2019 or 2020, as described in subdivision 2.

Subd. 2. **Conversion of license renewal cycle for current licensees.** For a licensee whose license is current as of December 31, 2018, the licensee's conversion license period begins on January 1, 2019, and ends on the last day of the licensee's month of birth in 2019, except that for licensees whose month of birth is January, February, March, April, May, or June, the licensee's renewal cycle ends on the last day of the licensee's month of birth in 2020.

Subd. 3. **Conversion of license renewal cycle for noncurrent licensees.** This subdivision applies to an individual who was licensed before December 31, 2018, but whose license is not current as of December 31, 2018. When the individual first renews the license after January 1, 2019, the conversion renewal cycle begins on the date the individual applies for renewal and ends on the last day of the licensee's month of birth in the same year, except that if the last day of the individual's month of birth is less than six months after the date the individual applies for renewal, then the renewal period ends on the last day of the individual's month of birth in the following year.

Subd. 4. **Subsequent renewal cycles.** After the licensee's conversion renewal cycle under subdivision 2 or 3, subsequent renewal cycles are annual and begin on the last day of the month of the licensee's birth.

Subd. 5. **Conversion period and fees.** (a) A licensee who holds a license issued before January 1, 2019, and who renews that license pursuant to subdivision 2 or 3, shall pay a renewal fee as required in this subdivision.

(b) A licensee shall be charged the annual license fee listed in section 147C.40 for the conversion license period.

(c) For a licensee whose conversion license period is six to 11 months, the first annual license fee charged after the conversion license period shall be adjusted to credit the excess

fee payment made during the conversion license period. The credit is calculated by: (1) subtracting the number of months of the licensee's conversion license period from 12; and (2) multiplying the result of clause (1) by 1/12 of the annual fee rounded up to the next dollar.

(d) For a licensee whose conversion license period is 12 months, the first annual license fee charged after the conversion license period shall not be adjusted.

(e) For a licensee whose conversion license period is 13 to 17 months, the first annual license fee charged after the conversion license period shall be adjusted to add the annual license fee payment for the months that were not included in the annual license fee paid for the conversion license period. The added payment is calculated by: (1) subtracting 12 from the number of months of the licensee's conversion license period; and (2) multiplying the result of clause (1) by 1/12 of the annual fee rounded up to the next dollar.

(f) For the second and all subsequent license renewals made after the conversion license period, the licensee's annual license fee is as listed in section 147C.40.

Subd. 6. **Expiration.** This section expires July 1, 2021.

Sec. 16. Minnesota Statutes 2016, section 147D.17, subdivision 6, is amended to read:

Subd. 6. **Renewal.** (a) To be eligible for license renewal, a licensed traditional midwife must:

(1) complete a renewal application on a form provided by the board;

(2) submit the renewal fee;

(3) provide evidence every three years of a total of 30 hours of continuing education approved by the board as described in section 147D.21;

(4) submit evidence of an annual peer review and update of the licensed traditional midwife's medical consultation plan; and

(5) submit any additional information requested by the board. The information must be submitted within 30 days after the board's request, or the renewal request is nullified.

(b) A licensee must maintain a correct mailing address with the board for receiving board communications, notices, and license renewal documents. Placing the license renewal application in first class United States mail, addressed to the licensee at the licensee's last known address with postage prepaid, constitutes valid service. Failure to receive the renewal documents does not relieve a licensee of the obligation to comply with this section.

(c) The name of a licensee who does not return a complete license renewal application, annual license fee, or late application fee, as applicable, within the time period required by this section shall be removed from the list of individuals authorized to practice during the current renewal period. If the licensee's license is reinstated, the licensee's name shall be placed on the list of individuals authorized to practice.

Sec. 17. Minnesota Statutes 2016, section 147D.17, is amended by adding a subdivision to read:

Subd. 11a. **Licensure following lapse of licensed status; transition.** (a) A licensee whose license has lapsed under subdivision 11 before January 1, 2019, and who seeks to regain licensed status after January 1, 2019, shall be treated as a first-time licensee only for purposes of establishing a license renewal schedule, and shall not be subject to the license cycle conversion provisions in section 147D.29.

(b) This subdivision expires July 1, 2021.

Sec. 18. Minnesota Statutes 2016, section 147D.27, is amended by adding a subdivision to read:

Subd. 5. **Additional fees.** The board may also charge the following nonrefundable fees:

(1) verification fee, $25;

(2) certification letter fee, $25;

(3) education or training program approval fee, $100;

(4) report creation and generation fee, $60 per hour;

(5) duplicate license fee, $20; and

(6) criminal background check fee, $32.

Sec. 19. **[147D.29] LICENSE RENEWAL CYCLE CONVERSION.**

Subdivision 1. **Generally.** The license renewal cycle for traditional midwife licensees is converted to an annual cycle where renewal is due on the last day of the licensee's month of birth. Conversion pursuant to this section begins January 1, 2019. This section governs license renewal procedures for licensees who were licensed before December 31, 2018. The conversion renewal cycle is the renewal cycle following the first license renewal after January 1, 2019. The conversion license period is the license period for the conversion renewal cycle. The conversion license period is between six and 17 months and ends on the

last day of the licensee's month of birth in either 2019 or 2020, as described in subdivision 2.

Subd. 2. **Conversion of license renewal cycle for current licensees.** For a licensee whose license is current as of December 31, 2018, the licensee's conversion license period begins on January 1, 2019, and ends on the last day of the licensee's month of birth in 2019, except that for licensees whose month of birth is January, February, March, April, May, or June, the licensee's renewal cycle ends on the last day of the licensee's month of birth in 2020.

Subd. 3. **Conversion of license renewal cycle for noncurrent licensees.** This subdivision applies to an individual who was licensed before December 31, 2018, but whose license is not current as of December 31, 2018. When the individual first renews the license after January 1, 2019, the conversion renewal cycle begins on the date the individual applies for renewal and ends on the last day of the licensee's month of birth in the same year, except that if the last day of the individual's month of birth is less than six months after the date the individual applies for renewal, then the renewal period ends on the last day of the individual's month of birth in the following year.

Subd. 4. **Subsequent renewal cycles.** After the licensee's conversion renewal cycle under subdivision 2 or 3, subsequent renewal cycles are annual and begin on the last day of the month of the licensee's birth.

Subd. 5. **Conversion period and fees.** (a) A licensee who holds a license issued before January 1, 2019, and who renews that license pursuant to subdivision 2 or 3, shall pay a renewal fee as required in this subdivision.

(b) A licensee shall be charged the annual license fee listed in section 147D.27 for the conversion license period.

(c) For a licensee whose conversion license period is six to 11 months, the first annual license fee charged after the conversion license period shall be adjusted to credit the excess fee payment made during the conversion license period. The credit is calculated by: (1) subtracting the number of months of the licensee's conversion license period from 12; and (2) multiplying the result of clause (1) by 1/12 of the annual fee rounded up to the next dollar.

(d) For a licensee whose conversion license period is 12 months, the first annual license fee charged after the conversion license period shall not be adjusted.

(e) For a licensee whose conversion license period is 13 to 17 months, the first annual license fee charged after the conversion license period shall be adjusted to add the annual license fee payment for the months that were not included in the annual license fee paid for the conversion license period. The added payment is calculated by: (1) subtracting 12 from the number of months of the licensee's conversion license period; and (2) multiplying the result of clause (1) by 1/12 of the annual fee rounded up to the next dollar.

(f) For the second and all subsequent license renewals made after the conversion license period, the licensee's annual license fee is as listed in section 147D.27.

Subd. 6. **Expiration.** This section expires July 1, 2021.

Sec. 20. Minnesota Statutes 2016, section 147E.15, subdivision 5, is amended to read:

Subd. 5. **Renewal.** (a) To be eligible for registration renewal a registrant must:

(1) annually, or as determined by the board, complete a renewal application on a form provided by the board;

(2) submit the renewal fee;

(3) provide evidence of a total of 25 hours of continuing education approved by the board as described in section 147E.25; and

(4) submit any additional information requested by the board to clarify information presented in the renewal application. The information must be submitted within 30 days after the board's request, or the renewal request is nullified.

(b) A registrant must maintain a correct mailing address with the board for receiving board communications, notices, and registration renewal documents. Placing the registration renewal application in first class United States mail, addressed to the registrant at the registrant's last known address with postage prepaid, constitutes valid service. Failure to receive the renewal documents does not relieve a registrant of the obligation to comply with this section.

(c) The name of a registrant who does not return a complete registration renewal application, annual registration fee, or late application fee, as applicable, within the time period required by this section shall be removed from the list of individuals authorized to practice during the current renewal period. If the registrant's registration is reinstated, the registrant's name shall be placed on the list of individuals authorized to practice.

Sec. 21. Minnesota Statutes 2016, section 147E.15, is amended by adding a subdivision to read:

Subd. 10a. **Registration following lapse of registered status; transition.** (a) A registrant whose registration has lapsed under subdivision 10 before January 1, 2019, and who seeks to regain registered status after January 1, 2019, shall be treated as a first-time registrant only for purposes of establishing a registration renewal schedule, and shall not be subject to the registration cycle conversion provisions in section 147E.45.

(b) This subdivision expires July 1, 2021.

Sec. 22. Minnesota Statutes 2016, section 147E.40, subdivision 1, is amended to read:

Subdivision 1. **Fees.** Fees are as follows:

(1) registration application fee, $200;

(2) renewal fee, $150;

(3) late fee, $75;

(4) inactive status fee, $50; ~~and~~

(5) temporary permit fee, $25~~.~~;

(6) emeritus registration fee, $50;

(7) duplicate license fee, $20;

(8) certification letter fee, $25;

(9) verification fee, $25;

(10) education or training program approval fee, $100; and

(11) report creation and generation fee, $60 per hour.

Sec. 23. **[147E.45] REGISTRATION RENEWAL CYCLE CONVERSION.**

Subdivision 1. **Generally.** The registration renewal cycle for registered naturopathic doctors is converted to an annual cycle where renewal is due on the last day of the registrant's month of birth. Conversion pursuant to this section begins January 1, 2019. This section governs registration renewal procedures for registrants who were registered before December 31, 2018. The conversion renewal cycle is the renewal cycle following the first registration renewal after January 1, 2019. The conversion registration period is the registration period for the conversion renewal cycle. The conversion registration period is between six and 17

months and ends on the last day of the registrant's month of birth in either 2019 or 2020, as described in subdivision 2.

Subd. 2. **Conversion of registration renewal cycle for current registrants.** For a registrant whose registration is current as of December 31, 2018, the registrant's conversion registration period begins on January 1, 2019, and ends on the last day of the registrant's month of birth in 2019, except that for registrants whose month of birth is January, February, March, April, May, or June, the registrant's renewal cycle ends on the last day of the registrant's month of birth in 2020.

Subd. 3. **Conversion of registration renewal cycle for noncurrent registrants.** This subdivision applies to an individual who was registered before December 31, 2018, but whose registration is not current as of December 31, 2018. When the individual first renews the registration after January 1, 2019, the conversion renewal cycle begins on the date the individual applies for renewal and ends on the last day of the registrant's month of birth in the same year, except that if the last day of the individual's month of birth is less than six months after the date the individual applies for renewal, then the renewal period ends on the last day of the individual's month of birth in the following year.

Subd. 4. **Subsequent renewal cycles.** After the registrant's conversion renewal cycle under subdivision 2 or 3, subsequent renewal cycles are annual and begin on the last day of the month of the registrant's birth.

Subd. 5. **Conversion period and fees.** (a) A registrant who holds a registration issued before January 1, 2019, and who renews that registration pursuant to subdivision 2 or 3, shall pay a renewal fee as required in this subdivision.

(b) A registrant shall be charged the annual registration fee listed in section 147E.40 for the conversion registration period.

(c) For a registrant whose conversion registration period is six to 11 months, the first annual registration fee charged after the conversion registration period shall be adjusted to credit the excess fee payment made during the conversion registration period. The credit is calculated by: (1) subtracting the number of months of the registrant's conversion registration period from 12; and (2) multiplying the result of clause (1) by 1/12 of the annual fee rounded up to the next dollar.

(d) For a registrant whose conversion registration period is 12 months, the first annual registration fee charged after the conversion registration period shall not be adjusted.

(e) For a registrant whose conversion registration period is 13 to 17 months, the first annual registration fee charged after the conversion registration period shall be adjusted to add the annual registration fee payment for the months that were not included in the annual registration fee paid for the conversion registration period. The added payment is calculated by: (1) subtracting 12 from the number of months of the registrant's conversion registration period; and (2) multiplying the result of clause (1) by 1/12 of the annual fee rounded up to the next dollar.

(f) For the second and all subsequent registration renewals made after the conversion registration period, the registrant's annual registration fee is as listed in section 147E.40.

Subd. 6. **Expiration.** This section expires July 1, 2021.

Sec. 24. Minnesota Statutes 2016, section 147F.07, subdivision 5, is amended to read:

Subd. 5. **License renewal.** (a) To be eligible for license renewal, a licensed genetic counselor must submit to the board:

(1) a renewal application on a form provided by the board;

(2) the renewal fee required under section 147F.17;

(3) evidence of compliance with the continuing education requirements in section 147F.11; and

(4) any additional information requested by the board.

(b) A licensee must maintain a correct mailing address with the board for receiving board communications, notices, and license renewal documents. Placing the license renewal application in first class United States mail, addressed to the licensee at the licensee's last known address with postage prepaid, constitutes valid service. Failure to receive the renewal documents does not relieve a licensee of the obligation to comply with this section.

(c) The name of a licensee who does not return a complete license renewal application, annual license fee, or late application fee, as applicable, within the time period required by this section shall be removed from the list of individuals authorized to practice during the current renewal period. If the licensee's license is reinstated, the licensee's name shall be placed on the list of individuals authorized to practice.

Sec. 25. Minnesota Statutes 2016, section 147F.07, is amended by adding a subdivision to read:

Subd. 6. **Licensure following lapse of licensure status for two years or less.** For any individual whose licensure status has lapsed for two years or less, to regain licensure status, the individual must:

(1) apply for license renewal according to subdivision 5;

(2) document compliance with the continuing education requirements of section 147F.11 since the licensed genetic counselor's initial licensure or last renewal; and

(3) submit the fees required under section 147F.17 for the period not licensed, including the fee for late renewal.

Sec. 26. Minnesota Statutes 2016, section 147F.07, is amended by adding a subdivision to read:

Subd. 6a. **Licensure following lapse of licensed status; transition.** (a) A licensee whose license has lapsed under subdivision 6 before January 1, 2019, and who seeks to regain licensed status after January 1, 2019, shall be treated as a first-time licensee only for purposes of establishing a license renewal schedule, and shall not be subject to the license cycle conversion provisions in section 147F.19.

(b) This subdivision expires July 1, 2021.

Sec. 27. Minnesota Statutes 2016, section 147F.17, subdivision 1, is amended to read:

Subdivision 1. **Fees.** Fees are as follows:

(1) license application fee, $200;

(2) initial licensure and annual renewal, $150; ~~and~~

(3) late fee, $75~~.~~;

(4) temporary license fee, $60;

(5) duplicate license fee, $20;

(6) certification letter fee, $25;

(7) education or training program approval fee, $100;

(8) report creation and generation fee, $60 per hour; and

(9) criminal background check fee, $32.

Sec. 28. **[147F.19] LICENSE RENEWAL CYCLE CONVERSION.**

Subdivision 1. **Generally.** The license renewal cycle for genetic counselor licensees is converted to an annual cycle where renewal is due on the last day of the licensee's month of birth. Conversion pursuant to this section begins January 1, 2019. This section governs license renewal procedures for licensees who were licensed before December 31, 2018. The conversion renewal cycle is the renewal cycle following the first license renewal after January 1, 2019. The conversion license period is the license period for the conversion renewal cycle. The conversion license period is between six and 17 months and ends on the last day of the licensee's month of birth in either 2019 or 2020, as described in subdivision 2.

Subd. 2. **Conversion of license renewal cycle for current licensees.** For a licensee whose license is current as of December 31, 2018, the licensee's conversion license period begins on January 1, 2019, and ends on the last day of the licensee's month of birth in 2019, except that for licensees whose month of birth is January, February, March, April, May, or June, the licensee's renewal cycle ends on the last day of the licensee's month of birth in 2020.

Subd. 3. **Conversion of license renewal cycle for noncurrent licensees.** This subdivision applies to an individual who was licensed before December 31, 2018, but whose license is not current as of December 31, 2018. When the individual first renews the license after January 1, 2019, the conversion renewal cycle begins on the date the individual applies for renewal and ends on the last day of the licensee's month of birth in the same year, except that if the last day of the individual's month of birth is less than six months after the date the individual applies for renewal, then the renewal period ends on the last day of the individual's month of birth in the following year.

Subd. 4. **Subsequent renewal cycles.** After the licensee's conversion renewal cycle under subdivision 2 or 3, subsequent renewal cycles are annual and begin on the last day of the month of the licensee's birth.

Subd. 5. **Conversion period and fees.** (a) A licensee who holds a license issued before January 1, 2019, and who renews that license pursuant to subdivision 2 or 3, shall pay a renewal fee as required in this subdivision.

(b) A licensee shall be charged the annual license fee listed in section 147F.17 for the conversion license period.

(c) For a licensee whose conversion license period is six to 11 months, the first annual license fee charged after the conversion license period shall be adjusted to credit the excess

fee payment made during the conversion license period. The credit is calculated by: (1) subtracting the number of months of the licensee's conversion license period from 12; and (2) multiplying the result of clause (1) by 1/12 of the annual fee rounded up to the next dollar.

(d) For a licensee whose conversion license period is 12 months, the first annual license fee charged after the conversion license period shall not be adjusted.

(e) For a licensee whose conversion license period is 13 to 17 months, the first annual license fee charged after the conversion license period shall be adjusted to add the annual license fee payment for the months that were not included in the annual license fee paid for the conversion license period. The added payment is calculated by: (1) subtracting 12 from the number of months of the licensee's conversion license period; and (2) multiplying the result of clause (1) by 1/12 of the annual fee rounded up to the next dollar.

(f) For the second and all subsequent license renewals made after the conversion license period, the licensee's annual license fee is as listed in section 147F.17.

Subd. 6. **Expiration.** This section expires July 1, 2021.

Sec. 29. Minnesota Statutes 2016, section 148.7815, subdivision 1, is amended to read:

Subdivision 1. **Fees.** The board shall establish fees as follows:

(1) application fee, $50;

(2) annual registration fee, $100;

(3) temporary registration, $100; ~~and~~

(4) temporary permit, $50~~.~~;

(5) late fee, $15;

(6) duplicate license fee, $20;

(7) certification letter fee, $25;

(8) verification fee, $25;

(9) education or training program approval fee, $100; and

(10) report creation and generation fee, $60 per hour.

Sec. 30. Minnesota Statutes 2016, section 214.075, subdivision 1, is amended to read:

Subdivision 1. **Applications.** (a) ~~By January 1, 2018,~~ Each health-related licensing board, as defined in section 214.01, subdivision 2, shall require ~~applicants for initial licensure, licensure by endorsement, or reinstatement or other relicensure after a lapse in licensure, as defined by the individual health-related licensing boards,~~ the following individuals to submit to a criminal history records check of state data completed by the Bureau of Criminal Apprehension (BCA) and a national criminal history records check, including a search of the records of the Federal Bureau of Investigation (FBI)~~.~~:

(1) applicants for initial licensure or licensure by endorsement. An applicant is exempt from this paragraph if the applicant submitted to a state and national criminal history records check as described in this paragraph for a license issued by the same board;

(2) applicants seeking reinstatement or relicensure, as defined by the individual health-related licensing board, if more than one year has elapsed since the applicant's license or registration expiration date; or

(3) licensees applying for eligibility to participate in an interstate licensure compact.

(b) ~~An applicant must complete a criminal background check if more than one year has elapsed since the applicant last submitted a background check to the board.~~ An applicant's criminal background check results are valid for one year from the date the background check results were received by the board. If more than one year has elapsed since the results were received by the board, then an applicant who has not completed the licensure, reinstatement, or relicensure process must complete a new background check.

Sec. 31. Minnesota Statutes 2016, section 214.075, subdivision 4, is amended to read:

Subd. 4. **Refusal to consent.** (a) The health-related licensing boards shall not issue a license to any applicant who refuses to consent to a criminal background check or fails to submit fingerprints ~~within 90 days~~ after submission of an application for licensure. Any fees paid by the applicant to the board shall be forfeited if the applicant refuses to consent to the criminal background check or fails to submit the required fingerprints.

(b) The failure of a licensee to submit to a criminal background check as provided in subdivision 3 is grounds for disciplinary action by the respective health-related licensing board.

Sec. 32. Minnesota Statutes 2016, section 214.075, subdivision 5, is amended to read:

Subd. 5. **Submission of fingerprints to the Bureau of Criminal Apprehension.** The health-related licensing board or designee shall submit applicant or licensee fingerprints to the BCA. The BCA shall perform a check for state criminal justice information and shall forward the applicant's or licensee's fingerprints to the FBI to perform a check for national criminal justice information regarding the applicant or licensee. The BCA shall report to the board the results of the state and national criminal ~~justice information~~ history records checks.

Sec. 33. Minnesota Statutes 2016, section 214.075, subdivision 6, is amended to read:

Subd. 6. **Alternatives to fingerprint-based criminal background checks.** The health-related licensing board may require an alternative method of criminal history checks for an applicant or licensee who has submitted at least ~~three~~ two sets of fingerprints in accordance with this section that have been unreadable by the BCA or the FBI.

Sec. 34. Minnesota Statutes 2016, section 214.077, is amended to read:

214.077 TEMPORARY LICENSE SUSPENSION; IMMINENT RISK OF SERIOUS HARM.

(a) Notwithstanding any provision of a health-related professional practice act, when a health-related licensing board receives a complaint regarding a regulated person and has probable cause to believe that the regulated person has violated a statute or rule that the health-related licensing board is empowered to enforce, and continued practice by the regulated person presents an imminent risk of serious harm, the health-related licensing board shall issue an order temporarily suspending the regulated person's authority to practice. The temporary suspension order shall specify the reason for the suspension, including the statute or rule alleged to have been violated. The temporary suspension order shall take effect upon personal service on the regulated person or the regulated person's attorney, or upon the third calendar day after the order is served by first class mail to the most recent address provided to the health-related licensing board for the regulated person or the regulated person's attorney.

(b) The temporary suspension shall remain in effect until the health-related licensing board or the commissioner completes an investigation, holds a contested case hearing pursuant to the Administrative Procedure Act, and issues a final order in the matter as provided for in this section.

(c) At the time it issues the temporary suspension order, the health-related licensing board shall schedule a contested case hearing, on the merits of whether discipline is warranted, to be held pursuant to the Administrative Procedure Act. The regulated person shall be provided with at least ten days' notice of any contested case hearing held pursuant to this section. The contested case hearing shall be scheduled to begin no later than 30 days after the effective service of the temporary suspension order.

(d) The administrative law judge presiding over the contested case hearing shall issue a report and recommendation to the health-related licensing board no later than 30 days after the final day of the contested case hearing. If the administrative law judge's report and recommendations are for no action, the health-related licensing board shall issue a final order pursuant to sections 14.61 and 14.62 within 30 days of receipt of the administrative law judge's report and recommendations. If the administrative law judge's report and recommendations are for action, the health-related licensing board shall issue a final order pursuant to sections 14.61 and 14.62 within 60 days of receipt of the administrative law judge's report and recommendations. Except as provided in paragraph (e), if the health-related licensing board has not issued a final order pursuant to sections 14.61 and 14.62 within 30 days of receipt of the administrative law judge's report and recommendations for no action or within 60 days of receipt of the administrative law judge's report and recommendations for action, the temporary suspension shall be lifted.

(e) If the regulated person requests a delay in the contested case proceedings provided for in paragraphs (c) and (d) for any reason, the temporary suspension shall remain in effect until the health-related licensing board issues a final order pursuant to sections 14.61 and 14.62.

(f) This section shall not apply to the Office of Unlicensed Complementary and Alternative Health Practice established under section 146A.02. The commissioner of health shall conduct temporary suspensions for complementary and alternative health care practitioners in accordance with section 146A.09.

Sec. 35. Minnesota Statutes 2016, section 214.10, subdivision 8, is amended to read:

Subd. 8. **Special requirements for health-related licensing boards.** In addition to the provisions of this section that apply to all examining and licensing boards, the requirements in this subdivision apply to all health-related licensing boards, except the Board of Veterinary Medicine.

(a) If the executive director or consulted board member determines that a communication received alleges a violation of statute or rule that involves sexual contact with a patient or

client, the communication shall be forwarded to the designee of the attorney general for an investigation of the facts alleged in the communication. If, after an investigation it is the opinion of the executive director or consulted board member that there is sufficient evidence to justify disciplinary action, the board shall conduct a disciplinary conference or hearing. If, after a hearing or disciplinary conference the board determines that misconduct involving sexual contact with a patient or client occurred, the board shall take disciplinary action. Notwithstanding subdivision 2, a board may not attempt to correct improper activities or redress grievances through education, conciliation, and persuasion, unless in the opinion of the executive director or consulted board member there is insufficient evidence to justify disciplinary action. The board may settle a case by stipulation prior to, or during, a hearing if the stipulation provides for disciplinary action.

(b) A board member who has a direct current or former financial connection or professional relationship to a person who is the subject of board disciplinary activities must not participate in board activities relating to that case.

(c) Each health-related licensing board shall establish procedures for exchanging information with other Minnesota state boards, agencies, and departments responsible for regulating health-related occupations, facilities, and programs, and for coordinating investigations involving matters within the jurisdiction of more than one regulatory body. The procedures must provide for the forwarding to other regulatory bodies of all information and evidence, including the results of investigations, that are relevant to matters within that licensing body's regulatory jurisdiction. Each health-related licensing board shall have access to any data of the Department of Human Services relating to a person subject to the jurisdiction of the licensing board. The data shall have the same classification under chapter 13, the Minnesota Government Data Practices Act, in the hands of the agency receiving the data as it had in the hands of the Department of Human Services.

(d) Each health-related licensing board shall establish procedures for exchanging information with other states regarding disciplinary actions against licensees. The procedures must provide for the collection of information from other states about disciplinary actions taken against persons who are licensed to practice in Minnesota or who have applied to be licensed in this state and the dissemination of information to other states regarding disciplinary actions taken in Minnesota. In addition to any authority in chapter 13 permitting the dissemination of data, the board may, in its discretion, disseminate data to other states regardless of its classification under chapter 13. Criminal history record information shall not be exchanged. Before transferring any data that is not public, the board shall obtain reasonable assurances from the receiving state that the data will not be made public.

Sec. 36. Minnesota Statutes 2017 Supplement, section 364.09, is amended to read:

364.09 EXCEPTIONS.

(a) This chapter does not apply to the licensing process for peace officers; to law enforcement agencies as defined in section 626.84, subdivision 1, paragraph (f); to fire protection agencies; to eligibility for a private detective or protective agent license; to the licensing and background study process under chapters 245A and 245C; to the licensing and background investigation process under chapter 240; to eligibility for school bus driver endorsements; to eligibility for special transportation service endorsements; to eligibility for a commercial driver training instructor license, which is governed by section 171.35 and rules adopted under that section; to emergency medical services personnel, or to the licensing by political subdivisions of taxicab drivers, if the applicant for the license has been discharged from sentence for a conviction within the ten years immediately preceding application of a violation of any of the following:

(1) sections 609.185 to 609.2114, 609.221 to 609.223, 609.342 to 609.3451, or 617.23, subdivision 2 or 3; or Minnesota Statutes 2012, section 609.21;

(2) any provision of chapter 152 that is punishable by a maximum sentence of 15 years or more; or

(3) a violation of chapter 169 or 169A involving driving under the influence, leaving the scene of an accident, or reckless or careless driving.

This chapter also shall not apply to eligibility for juvenile corrections employment, where the offense involved child physical or sexual abuse or criminal sexual conduct.

(b) This chapter does not apply to a school district or to eligibility for a license issued or renewed by the Professional Educator Licensing and Standards Board or the commissioner of education.

(c) Nothing in this section precludes the Minnesota Police and Peace Officers Training Board or the state fire marshal from recommending policies set forth in this chapter to the attorney general for adoption in the attorney general's discretion to apply to law enforcement or fire protection agencies.

~~(d) This chapter does not apply to a license to practice medicine that has been denied or revoked by the Board of Medical Practice pursuant to section 147.091, subdivision 1a.~~

~~(e) This chapter does not apply to any person who has been denied a license to practice chiropractic or whose license to practice chiropractic has been revoked by the board in accordance with section 148.10, subdivision 7.~~

~~(f) This chapter does not apply to any license, registration, or permit that has been denied or revoked by the Board of Nursing in accordance with section 148.261, subdivision 1a.~~

~~(g)~~ (d) This chapter does not apply to any license, registration, permit, or certificate that has been denied or revoked by the commissioner of health according to section 148.5195, subdivision 5; or 153A.15, subdivision 2.

~~(h)~~ (e) This chapter does not supersede a requirement under law to conduct a criminal history background investigation or consider criminal history records in hiring for particular types of employment.

(f) This chapter does not apply to the licensing or registration process for, or to any license, registration, or permit that has been denied or revoked by, a health-related licensing board listed in section 214.01, subdivision 2.

Sec. 37. **REPEALER.**

(a) Minnesota Statutes 2016, section 214.075, subdivision 8, is repealed.

(b) Minnesota Rules, part 5600.0605, subparts 5 and 8, are repealed.

ARTICLE 5

PRESCRIPTION MONITORING PROGRAM

Section 1. Minnesota Statutes 2016, section 151.065, is amended by adding a subdivision to read:

Subd. 7. **Deposit.** Fees collected by the board under this section shall be deposited in the state government special revenue fund.

Sec. 2. Minnesota Statutes 2016, section 152.126, subdivision 6, is amended to read:

Subd. 6. **Access to reporting system data.** (a) Except as indicated in this subdivision, the data submitted to the board under subdivision 4 is private data on individuals as defined in section 13.02, subdivision 12, and not subject to public disclosure.

(b) Except as specified in subdivision 5, the following persons shall be considered permissible users and may access the data submitted under subdivision 4 in the same or similar manner, and for the same or similar purposes, as those persons who are authorized to access similar private data on individuals under federal and state law:

(1) a prescriber or an agent or employee of the prescriber to whom the prescriber has delegated the task of accessing the data, to the extent the information relates specifically to a current patient, to whom the prescriber is:

(i) prescribing or considering prescribing any controlled substance;

(ii) providing emergency medical treatment for which access to the data may be necessary;

(iii) providing care, and the prescriber has reason to believe, based on clinically valid indications, that the patient is potentially abusing a controlled substance; or

(iv) providing other medical treatment for which access to the data may be necessary for a clinically valid purpose and the patient has consented to access to the submitted data, and with the provision that the prescriber remains responsible for the use or misuse of data accessed by a delegated agent or employee;

(2) a dispenser or an agent or employee of the dispenser to whom the dispenser has delegated the task of accessing the data, to the extent the information relates specifically to a current patient to whom that dispenser is dispensing or considering dispensing any controlled substance and with the provision that the dispenser remains responsible for the use or misuse of data accessed by a delegated agent or employee;

(3) a licensed pharmacist who is providing pharmaceutical care for which access to the data may be necessary to the extent that the information relates specifically to a current patient for whom the pharmacist is providing pharmaceutical care: (i) if the patient has consented to access to the submitted data; or (ii) if the pharmacist is consulted by a prescriber who is requesting data in accordance with clause (1);

(4) an individual who is the recipient of a controlled substance prescription for which data was submitted under subdivision 4, or a guardian of the individual, parent or guardian of a minor, or health care agent of the individual acting under a health care directive under chapter 145C. For purposes of this clause, access by individuals includes persons in the definition of an individual under section 13.02;

(5) personnel or designees of a health-related licensing board listed in section 214.01, subdivision 2, or of the Emergency Medical Services Regulatory Board, assigned to conduct a bona fide investigation of a complaint received by that board that alleges that a specific licensee is impaired by use of a drug for which data is collected under subdivision 4, has engaged in activity that would constitute a crime as defined in section 152.025, or has engaged in the behavior specified in subdivision 5, paragraph (a);

(6) personnel of the board engaged in the collection, review, and analysis of controlled substance prescription information as part of the assigned duties and responsibilities under this section;

(7) authorized personnel of a vendor under contract with the state of Minnesota who are engaged in the design, implementation, operation, and maintenance of the prescription monitoring program as part of the assigned duties and responsibilities of their employment, provided that access to data is limited to the minimum amount necessary to carry out such duties and responsibilities, and subject to the requirement of de-identification and time limit on retention of data specified in subdivision 5, paragraphs (d) and (e);

(8) federal, state, and local law enforcement authorities acting pursuant to a valid search warrant;

(9) personnel of the Minnesota health care programs assigned to use the data collected under this section to identify and manage recipients whose usage of controlled substances may warrant restriction to a single primary care provider, a single outpatient pharmacy, and a single hospital;

(10) personnel of the Department of Human Services assigned to access the data pursuant to paragraph (i);

(11) personnel of the health professionals services program established under section 214.31, to the extent that the information relates specifically to an individual who is currently enrolled in and being monitored by the program, and the individual consents to access to that information. The health professionals services program personnel shall not provide this data to a health-related licensing board or the Emergency Medical Services Regulatory Board, except as permitted under section 214.33, subdivision 3~~.~~; and

~~For purposes of clause (4), access by an individual includes persons in the definition of an individual under section 13.02; and~~

(12) personnel or designees of a health-related licensing board listed in section 214.01, subdivision 2, assigned to conduct a bona fide investigation of a complaint received by that board that alleges that a specific licensee is inappropriately prescribing controlled substances as defined in this section.

(c) By July 1, 2017, every prescriber licensed by a health-related licensing board listed in section 214.01, subdivision 2, practicing within this state who is authorized to prescribe controlled substances ~~for humans~~ and who holds a current registration issued by the federal Drug Enforcement Administration, and every pharmacist licensed by the board and practicing

within the state, shall register and maintain a user account with the prescription monitoring program. Data submitted by a prescriber, pharmacist, or their delegate during the registration application process, other than their name, license number, and license type, is classified as private pursuant to section 13.02, subdivision 12.

(d) Notwithstanding paragraph (b), beginning January 1, 2020, a prescriber or an agent or employee of the prescriber to whom the prescriber has delegated the task of accessing the data, must access the data submitted under subdivision 4 to the extent the information relates specifically to the patient before the prescriber issues a prescription order for a Schedule II or Schedule III controlled substance to the patient. This paragraph does not apply if:

(1) the patient is receiving hospice care;

(2) the prescription order is for a number of doses that is intended to last the patient five days or less and is not subject to a refill;

(3) the controlled substance is lawfully administered by injection, ingestion, or any other means to the patient by the prescriber, a pharmacist, or by the patient at the direction of a prescriber and in the presence of the prescriber or pharmacist;

(4) due to an emergency, it is not possible for the prescriber to review the data before the prescriber issues the prescription order for the patient; or

(5) the prescriber is unable to access the data due to operational or other technological failure of the program so long as the prescriber reports the failure to the board.

(e) Only permissible users identified in paragraph (b), clauses (1), (2), (3), (6), (7), (9), and (10), may directly access the data electronically. No other permissible users may directly access the data electronically. If the data is directly accessed electronically, the permissible user shall implement and maintain a comprehensive information security program that contains administrative, technical, and physical safeguards that are appropriate to the user's size and complexity, and the sensitivity of the personal information obtained. The permissible user shall identify reasonably foreseeable internal and external risks to the security, confidentiality, and integrity of personal information that could result in the unauthorized disclosure, misuse, or other compromise of the information and assess the sufficiency of any safeguards in place to control the risks.

~~(e)~~ (f) The board shall not release data submitted under subdivision 4 unless it is provided with evidence, satisfactory to the board, that the person requesting the information is entitled to receive the data.

~~(f)~~ (g) The board shall maintain a log of all persons who access the data for a period of at least three years and shall ensure that any permissible user complies with paragraph (c) prior to attaining direct access to the data.

~~(g)~~ (h) Section 13.05, subdivision 6, shall apply to any contract the board enters into pursuant to subdivision 2. A vendor shall not use data collected under this section for any purpose not specified in this section.

~~(h)~~ (i) The board may participate in an interstate prescription monitoring program data exchange system provided that permissible users in other states have access to the data only as allowed under this section, and that section 13.05, subdivision 6, applies to any contract or memorandum of understanding that the board enters into under this paragraph.

~~(i)~~ (j) With available appropriations, the commissioner of human services shall establish and implement a system through which the Department of Human Services shall routinely access the data for the purpose of determining whether any client enrolled in an opioid treatment program licensed according to chapter 245A has been prescribed or dispensed a controlled substance in addition to that administered or dispensed by the opioid treatment program. When the commissioner determines there have been multiple prescribers or multiple prescriptions of controlled substances, the commissioner shall:

(1) inform the medical director of the opioid treatment program only that the commissioner determined the existence of multiple prescribers or multiple prescriptions of controlled substances; and

(2) direct the medical director of the opioid treatment program to access the data directly, review the effect of the multiple prescribers or multiple prescriptions, and document the review.

If determined necessary, the commissioner of human services shall seek a federal waiver of, or exception to, any applicable provision of Code of Federal Regulations, title 42, section 2.34, paragraph (c), prior to implementing this paragraph.

~~(j)~~ (k) The board shall review the data submitted under subdivision 4 on at least a quarterly basis and shall establish criteria, in consultation with the advisory task force, for referring information about a patient to prescribers and dispensers who prescribed or dispensed the prescriptions in question if the criteria are met.

Sec. 3. Minnesota Statutes 2016, section 152.126, subdivision 10, is amended to read:

Subd. 10. **Funding.** (a) The board may seek grants and private funds from nonprofit charitable foundations, the federal government, and other sources to fund the enhancement

and ongoing operations of the prescription monitoring program established under this section. Any funds received shall be appropriated to the board for this purpose. The board may not expend funds to enhance the program in a way that conflicts with this section without seeking approval from the legislature.

(b) Notwithstanding any other section, the administrative services unit for the health-related licensing boards shall apportion between the Board of Medical Practice, the Board of Nursing, the Board of Dentistry, the Board of Podiatric Medicine, the Board of Optometry, the Board of Veterinary Medicine, and the Board of Pharmacy an amount to be paid through fees by each respective board. The amount apportioned to each board shall equal each board's share of the annual appropriation to the Board of Pharmacy from the state government special revenue fund for operating the prescription monitoring program under this section. Each board's apportioned share shall be based on the number of prescribers or dispensers that each board identified in this paragraph licenses as a percentage of the total number of prescribers and dispensers licensed collectively by these boards. Each respective board may adjust the fees that the boards are required to collect to compensate for the amount apportioned to each board by the administrative services unit.

(c) The board shall have the authority to modify its contract with its vendor as provided in subdivision 2, to authorize that vendor to provide a service to prescribers and pharmacies that allows them to access prescription monitoring program data from within the electronic health record system or pharmacy software used by those prescribers and pharmacists. Beginning July 1, 2018, the board has the authority to collect an annual fee from each prescriber or pharmacist who accesses prescription monitoring program data through the service offered by the vendor. The annual fee collected must not exceed $50 per user. The fees collected by the board under this paragraph shall be deposited in the state government special revenue fund and are appropriated to the board for the purposes of this paragraph.

ARTICLE 6

PROTECTION OF VULNERABLE ADULTS

Section 1. Minnesota Statutes 2016, section 144A.53, subdivision 2, is amended to read:

Subd. 2. **Complaints.** (a) The director may receive a complaint from any source concerning an action of an administrative agency, a health care provider, a home care provider, a residential care home, or a health facility. The director may require a complainant to pursue other remedies or channels of complaint open to the complainant before accepting or investigating the complaint. Investigators are required to interview at least one family member of the vulnerable adult identified in the complaint. If the vulnerable adult is directing

his or her own care and does not want the investigator to contact the family, this information must be documented in the investigative file.

(b) The director shall keep written records of all complaints and any action upon them. After completing an investigation of a complaint, the director shall inform the complainant, the administrative agency having jurisdiction over the subject matter, the health care provider, the home care provider, the residential care home, and the health facility of the action taken. Complainants must be provided a copy of the public report upon completion of the investigation.

(c) Notwithstanding section 626.557, subdivision 5 or 9c, upon request of a vulnerable adult or an interested person acting on behalf of the vulnerable adult, the director shall:

(1) disclose whether a health care provider or other person has made a report or submitted a complaint that involves maltreatment of the vulnerable adult; and

(2) provide a redacted version of the initial report or complaint that does not disclose data on individuals, as defined in section 13.02, subdivision 5.

For purposes of this paragraph, "interested person acting on behalf of the vulnerable adult" has the meaning given in section 626.557, subdivision 9d, paragraph (d).

Sec. 2. **DIRECTION TO COMMISSIONER.**

Subdivision 1. **Policies and procedures for the Office of Health Facility Complaints.** The commissioner of health shall develop comprehensive, written policies and procedures for the Office of Health Facility Complaints for conducting timely reviews and investigation of allegations that are available for all investigators in a centralized location, including policies, procedures, guidelines, and criteria for:

(1) data collection that will allow for rigorous trend analysis of maltreatment and licensing violations;

(2) data entry in the case management system, including an up-to-date description of each data entry point to be used consistently by all staff;

(3) intake of allegation reports, including the gathering of all data from the reporter and verification of jurisdiction;

(4) selection of allegation reports for further investigation within the time frames required by federal and state law;

(5) the investigative process, including guidelines for interviews and documentation;

(6) cross-referencing of data, including when and under what circumstances to combine data collection or maltreatment investigations regarding the same vulnerable adult, allegations, facility, or alleged perpetrator;

(7) final determinations, including having supporting documentation for the determinations;

(8) enforcement actions, including the imposition of immediate fines and any distinctions in process for licensing violations versus maltreatment determinations;

(9) communication with interested parties and the public regarding the status of investigations, final determinations, enforcement actions, and appeal rights, including when communication must be made if the timelines established in law are not able to be met and sufficient information in written communication for understanding the process; and

(10) quality control measures, including audits and random samplings, to discover gaps in understanding and to ensure accuracy.

Subd. 2. **Training of staff at the Office of Health Facility Complaints.** The commissioner of health shall revise the training program at the Office of Health Facility Complaints to ensure that all staff are trained adequately and consistently to perform their duties. The revised training program must provide for timely and consistent training whenever policies, procedures, guidelines, or criteria are changed due to legislative changes, decisions by management, or interpretations of state or federal law. The revised training program shall include a mentor-based training program that assigns a mentor to all new investigators and ensures new investigators work with an experienced investigator during every aspect of the investigation process.

Subd. 3. **Quality controls at the Office of Health Facility Complaints.** The commissioner of health shall implement quality control measures to ensure that intake, triage, investigations, final determinations, enforcement actions, and communication are conducted and documented in a consistent, thorough, and accurate manner. The quality control measures must include regular internal audits of staff work, including when a decision is made to not investigate a report, reporting to staff of patterns and trends discovered through the audits, training of staff to address patterns and trends discovered through the audits, and electronic safeguards in the case management system to prevent backdating of data, incomplete or missing data fields, missed deadlines, and missed communications, including communications concerning the status of investigations, delays in investigations, final determinations, and appeal rights following final determinations.

Subd. 4. **Provider education.** (a) The commissioner of health shall develop decision-making tools, including decision trees, regarding provider self-reported maltreatment allegations and share these tools with providers. As soon as practicable, the commissioner shall update the decision-making tools as necessary, including whenever federal or state requirements change, and inform providers that the updated tools are available. The commissioner shall develop decision-making tools that clarify and encourage reporting whether the provider is licensed or registered under federal or state law, while also educating on any distinctions in reporting under federal versus state law.

(b) The commissioner of health shall conduct rigorous trend analysis of maltreatment reports, triage decisions, investigation determinations, enforcement actions, and appeals to identify trends and patterns in reporting of maltreatment, substantiated maltreatment, and licensing violations, and share these findings with providers and interested stakeholders.

Subd. 5. **Departmental oversight of the Office of Health Facility Complaints.** The commissioner of health shall ensure that the commissioner's office provides direct oversight of the Office of Health Facility Complaints.

Sec. 3. **DIRECTION TO COMMISSIONER.**

On a quarterly basis until January 2021, and annually thereafter, the commissioner of health must submit a report on the Office of Health Facility Complaints' response to allegations of maltreatment of vulnerable adults. The report must include:

(1) a description and assessment of the office's efforts to improve its internal processes and compliance with federal and state requirements concerning allegations of maltreatment of vulnerable adults, including any relevant timelines;

(2) the number of reports received by the type of reporter, the number of reports investigated, the percentage and number of reported cases awaiting triage, the number and percentage of open investigations, and the number and percentage of investigations that have failed to meet state or federal timelines by cause of delay;

(3) a trend analysis of internal audits conducted by the office; and

(4) trends and patterns in maltreatment of vulnerable adults, licensing violations by facilities or providers serving vulnerable adults, and other metrics as determined by the commissioner.

Sec. 4. **DIRECTION TO COMMISSIONERS.**

By February 1 of each year, the commissioners of health and human services must submit an annual joint report on each department's response to allegations of maltreatment of vulnerable adults. The annual report must include a description and assessment of the departments' efforts to improve their internal processes and compliance with federal and state requirements concerning allegations of maltreatment of vulnerable adults, including any relevant timelines. The report must also include trends and patterns in maltreatment of vulnerable adults, licensing violations by facilities or providers serving vulnerable adults, and other metrics as determined by the commissioner.

This section expires upon submission of the commissioners' 2024 report.

ARTICLE 7

HUMAN SERVICES FORECAST ADJUSTMENTS

Section 1. **HUMAN SERVICES APPROPRIATION.**

The dollar amounts shown in the columns marked "Appropriations" are added to or, if shown in parentheses, are subtracted from the appropriations in Laws 2017, First Special Session chapter 6, article 18, from the general fund or any fund named to the Department of Human Services for the purposes specified in this article, to be available for the fiscal year indicated for each purpose. The figures "2018" and "2019" used in this article mean that the appropriations listed under them are available for the fiscal years ending June 30, 2018, or June 30, 2019, respectively. "The first year" is fiscal year 2018. "The second year" is fiscal year 2019. "The biennium" is fiscal years 2018 and 2019.

	APPROPRIATIONS Available for the Year Ending June 30	
	2018	**2019**
Sec. 2. **COMMISSIONER OF HUMAN SERVICES**		
Subdivision 1. **Total Appropriation**	**$ (208,963,000)**	**$ (88,363,000)**
Appropriations by Fund		
General Fund	(210,083,000)	(103,535,000)
Health Care Access Fund	7,620,000	9,258,000
Federal TANF	(6,500,000)	5,914,000

Subd. 2. **Forecasted Programs**

(a) **MFIP/DWP**

	Appropriations by Fund	
General Fund	(3,749,000)	(11,267,000)
Federal TANF	(7,418,000)	4,565,000

(b) **MFIP Child Care Assistance**	(7,995,000)	(521,000)
(c) **General Assistance**	(4,850,000)	(3,770,000)
(d) **Minnesota Supplemental Aid**	(1,179,000)	(821,000)
(e) **Housing Support**	(3,260,000)	(3,038,000)
(f) **Northstar Care for Children**	(5,168,000)	(6,458,000)
(g) **MinnesotaCare**	7,620,000	9,258,000

These appropriations are from the health care access fund.

(h) **Medical Assistance**

	Appropriations by Fund	
General Fund	(199,817,000)	(106,124,000)
Health Care Access Fund	-0-	-0-

(i) **Alternative Care Program**	-0-	-0-
(j) **CCDTF Entitlements**	15,935,000	28,464,000
Subd. 3. **Technical Activities**	918,000	1,349,000

These appropriations are from the federal TANF fund.

EFFECTIVE DATE. This section is effective June 30, 2018.

ARTICLE 8

APPROPRIATIONS

Section 1. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are added to or, if shown in parentheses, subtracted from the appropriations in Laws 2017, First Special Session chapter 6, article 18, to the agencies and for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years

indicated for each purpose. The figures "2018" and "2019" used in this article mean that the addition to or subtraction from appropriations listed under them are available for the fiscal year ending June 30, 2018, or June 30, 2019, respectively. Base level adjustments mean the addition or subtraction from the base level adjustments in Laws 2017, First Special Session chapter 6, article 18. "The first year" is fiscal year 2018. "The second year" is fiscal year 2019. "The biennium" is fiscal years 2018 and 2019. Supplemental appropriations and reductions to appropriations for the fiscal year ending June 30, 2018, are effective June 30, 2018, unless a different effective date is specified.

	APPROPRIATIONS	
	Available for the Year	
	Ending June 30	
	2018	**2019**

Sec. 2. **COMMISSIONER OF HUMAN SERVICES**

Subdivision 1. **Total Appropriation**	**$**	**-0-**	**$ 2,022,000**
The amounts that may be spent for each purpose are specified in the following subdivisions.			
Subd. 2. **Forecasted Programs; Medical Assistance**		-0-	2,022,000

Sec. 3. **COMMISSIONER OF HEALTH**

Subdivision 1. **Total Appropriation**	**$**	**-0-**	**$ 6,516,000**

Appropriations by Fund

	2018	2019
General	-0-	6,491,000
State Government Special Revenue	-0-	25,000

The amounts that may be spent for each purpose are specified in the following subdivisions.		
Subd. 2. **Health Improvement**	-0-	3,451,000

(a) **Opioid Overdose Reduction Pilot Program.** $1,062,000 in fiscal year 2019 is for the opioid overdose reduction pilot program in article 2, section 15. Of this appropriation, the commissioner may use up to $112,000 to administer the program. This is a onetime appropriation and is available until June 30, 2021.

(b) **Low-Value Health Services Study.** $389,000 in fiscal year 2019 is for the low-value health services study in article 2, section 14. The base for this appropriation is $106,000 in fiscal year 2020.

(c) **Statewide Tobacco Cessation Services.** $291,000 in fiscal year 2019 is appropriated from the health care access fund for statewide tobacco cessation services under Minnesota Statutes, section 144.397. The base for this appropriation is $1,550,000 in fiscal year 2020, and $2,955,000 in fiscal year 2021.

(d) **Reduction of Statewide Health Improvement Program Appropriation.** The appropriation in Laws 2017, First Special Session chapter 6, article 18, section 3, subdivision 2, from the health care access fund for the statewide health improvement program under Minnesota Statutes, section 145.986, is reduced by $291,000 in fiscal year 2019. The base for this reduction is $1,550,000 in fiscal year 2020, and $2,955,000 in fiscal year 2021.

(e) **Additional Funding for Opioid Prevention Pilot Projects.** $2,000,000 in fiscal year 2019 is appropriated for opioid abuse prevention pilot projects under Laws 2017, First Special Session chapter 6, article

10, section 144. Of this amount, $1,400,000 is for the opioid abuse prevention pilot project through CHI St. Gabriel's Health Family Medical Center, also known as Unity Family Health Care. $600,000 is for Project Echo through CHI St. Gabriel's Health Family Medical Center for e-learning sessions centered around opioid case management and best practices for opioid abuse prevention. This is a onetime appropriation.

(f) **Base Level Adjustments.** The general fund base is increased by $106,000 in fiscal year 2020.

Subd. 3. **Health Protection**

Appropriations by Fund		
General	-0-	3,040,000
State Government Special Revenue	-0-	25,000

(a) **Regulation of Low-Dose X-Ray Security Screening Systems.** $29,000 in fiscal year 2019 is from the state government special revenue fund for rulemaking under Minnesota Statutes, section 144.121. The base for this appropriation is $21,000 in fiscal year 2020 and $21,000 in fiscal year 2021.

(b) **Technology Upgrades.** $..... in fiscal year 2019 is from the general fund for technology upgrades of systems administered by the Office of Health Facility Complaints, related to provisions enacted in 2018. This is a onetime appropriation and is available until June 30, 2022. The commissioner may not transfer this appropriation or use this appropriation for any other purpose.

(c) **Base Level Adjustment.** The general fund base is increased by $3,923,000 in fiscal year 2020 and increased by $3,923,000 in fiscal year 2021. The state government special revenue fund base is increased by $17,000 in fiscal year 2020 and increased by $17,000 in fiscal year 2021.

Sec. 4. **HEALTH-RELATED BOARDS**

Subdivision 1. **Total Appropriation**	**$**	**-0-**	**$**	**278,000**

This appropriation is from the state government special revenue fund. The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **Board of Pharmacy**		-0-	278,000

This appropriation is for migration to a new information technology platform for the prescription monitoring program. This is a onetime appropriation.

Sec. 5. **LEGISLATIVE COORDINATING COMMISSION**

	$	**-0-**	**$**	**137,000**

(a) **Health Policy Commission.** $137,000 in fiscal year 2019 is for administration of the Health Policy Commission under Minnesota Statutes, section 62J.90. The base for this appropriation is $405,000 in fiscal year 2020 and $410,000 in fiscal year 2021.

(b) **Base Level Adjustment.** The base is increased by $405,000 in fiscal year 2020 and is increased by $410,000 in fiscal year 2021.

Sec. 6. **TRANSFERS.**

By June 30, 2018, the commissioner of management and budget shall transfer $14,000,000 from the systems operations account in the special revenue fund to the general fund. This is a onetime transfer.

EFFECTIVE DATE. This section is effective June 30, 2018.

Sec. 7. **EXPIRATION OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires on June 30, 2019, unless a different expiration date is explicit.

Sec. 8. **EFFECTIVE DATE.**

This article is effective July 1, 2018, unless a different effective date is specified.

APPENDIX
Article locations in SF2505-1

214.075 HEALTH-RELATED LICENSING BOARDS; CRIMINAL BACKGROUND CHECKS.

Subd. 8. **Instructions to the board; plans.** The health-related licensing boards, in collaboration with the commissioner of human services and the BCA, shall establish a plan for completing criminal background checks of all licensees who were licensed before the effective date requirement under subdivision 1. The plan must seek to minimize duplication of requirements for background checks of licensed health professionals. The plan for background checks of current licensees shall be developed no later than January 1, 2017, and may be contingent upon the implementation of a system by the BCA or FBI in which any new crimes that an applicant or licensee commits after an initial background check are flagged in the BCA's or FBI's database and reported back to the board. The plan shall include recommendations for any necessary statutory changes.

256B.0625 COVERED SERVICES.

Subd. 31c. **Preferred incontinence product program.** The commissioner shall implement a preferred incontinence product program by July 1, 2018. The program shall require the commissioner to volume purchase incontinence products and related supplies in accordance with section 256B.04, subdivision 14. Medical assistance coverage for incontinence products and related supplies shall conform to the limitations established under the program.

5600.0605 LICENSE RENEWAL PROCEDURES.

Subp. 5. **Service.** The licensee must maintain a correct mailing address with the board for receiving board communications, notices, and licensure renewal documents. Placing the license renewal application in first class United States mail, addressed to the licensee at the licensee's last known address with postage prepaid, constitutes valid service. Failure to receive the renewal documents does not relieve a license holder of the obligation to comply with this part.

5600.0605 LICENSE RENEWAL PROCEDURES.

Subp. 8. **Removal of name from list.** The names of licensees who do not return a complete license renewal application, the annual license fee, or the late application fee within the time period listed in subpart 7, shall be removed from the list of individuals authorized to practice medicine and surgery during the current renewal period. Upon reinstatement of licensure, the licensee's name will be placed on the list of individuals authorized to practice medicine and surgery.