

**SENATE**  
**STATE OF MINNESOTA**  
**NINETIETH SESSION**

**S.F. No. 2505**

(SENATE AUTHORS: BENSON, Rosen and Kiffmeyer)

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
		See SF3656, Art. 34, Sec. 1, 3, 6, 8, 15; Art. 35, Sec. 1-5, 7-10; Art. 36, Sec. 1-2; Art. 37-38

1.1 A bill for an act

1.2 relating to state government; modifying provisions relating to health care; modifying

1.3 Department of Human Services administrative funds transfer; establishing a

1.4 Minnesota Health Policy Commission; repealing preferred incontinence program

1.5 in medical assistance; increasing reimbursement rates for doula services; modifying

1.6 telemedicine service limits; modifying EPSDT screening payments; modifying

1.7 capitation payment delay; modifying provisions relating to wells and borings;

1.8 adding security screening systems to ionizing radiation-producing equipment

1.9 regulation; authorizing statewide tobacco cessation services; establishing an opioid

1.10 reduction pilot program; establishing a low-value health services study; requiring

1.11 coverage of 3D mammograms; requiring disclosure of facility fees; establishing

1.12 a step therapy override process; requiring the synchronization of prescription

1.13 refills; prohibiting a health plan company from preventing a pharmacist from

1.14 informing a patient of a price differential; converting allied health professionals

1.15 to a birth month renewal cycle; modifying temporary license suspensions and

1.16 background checks for health-related professions; requiring a prescriber to access

1.17 the prescription monitoring program before prescribing certain controlled

1.18 substances; authorizing the Board of Pharmacy to impose a fee from a prescriber

1.19 or pharmacist accessing prescription monitoring data through a service offered by

1.20 the board's vendor; requiring administrative changes at the Office of Health Facility

1.21 Complaints; providing access to information and data sharing; making technical

1.22 changes; requiring reports; making forecasted adjustments; appropriating money;

1.23 amending Minnesota Statutes 2016, sections 3.3005, subdivision 8; 62A.30, by

1.24 adding a subdivision; 103I.301, subdivision 6; 144.121, subdivision 1a, by adding

1.25 a subdivision; 144A.53, subdivision 2; 147.012; 147.02, by adding a subdivision;

1.26 147A.06; 147A.07; 147B.02, subdivision 9, by adding a subdivision; 147C.15,

1.27 subdivision 7, by adding a subdivision; 147D.17, subdivision 6, by adding a

1.28 subdivision; 147D.27, by adding a subdivision; 147E.15, subdivision 5, by adding

1.29 a subdivision; 147E.40, subdivision 1; 147F.07, subdivision 5, by adding

1.30 subdivisions; 147F.17, subdivision 1; 148.7815, subdivision 1; 151.065, by adding

1.31 a subdivision; 151.214; 151.71, by adding a subdivision; 152.126, subdivisions 6,

1.32 10; 214.075, subdivisions 1, 4, 5, 6; 214.077; 214.10, subdivision 8; 256.01, by

1.33 adding a subdivision; 256B.04, subdivision 14; 256B.0625, subdivision 58;

1.34 Minnesota Statutes 2017 Supplement, sections 103I.005, subdivisions 2, 8a, 17a;

1.35 103I.205, subdivisions 1, 4; 103I.208, subdivision 1; 103I.235, subdivision 3;

1.36 103I.601, subdivision 4; 147.01, subdivision 7; 147A.28; 147B.08; 147C.40;

1.37 152.105, subdivision 2; 256B.0625, subdivision 3b; 364.09; Laws 2017, First

1.38 Special Session chapter 6, article 4, section 61; article 10, section 144; proposing

1.39 coding for new law in Minnesota Statutes, chapters 62J; 62Q; 144; 147A; 147B;

2.1 147C; 147D; 147E; 147F; 256B; repealing Minnesota Statutes 2016, section  
 2.2 214.075, subdivision 8; Minnesota Statutes 2017 Supplement, section 256B.0625,  
 2.3 subdivision 31c; Minnesota Rules, part 5600.0605, subparts 5, 8.

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

2.5 **ARTICLE 1**

2.6 **HEALTH CARE**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3.24 (ii) improved health of all populations; and

3.25 (iii) reduced per capita cost of health care;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4.29 (d) Public members may receive compensation and expenses as provided in section  
4.30 15.059, subdivision 3.

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

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

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

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

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

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

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

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

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

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

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

6.19 (1) eyeglasses;

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

6.23 (3) hearing aids and supplies; and

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

6.25 (i) hospital beds;

6.26 (ii) commodes;

6.27 (iii) glide-about chairs;

6.28 (iv) patient lift apparatus;

6.29 (v) wheelchairs and accessories;

6.30 (vi) oxygen administration equipment;

6.31 (vii) respiratory therapy equipment;

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

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

7.5 (6) drugs.

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

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

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

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

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

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

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

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

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

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

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

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

8.3 (1) the type of service provided by telemedicine;

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

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

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

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

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

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

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

8.26 (e) For purposes of this section, "licensed health care provider" means a licensed health  
8.27 care provider under section 62A.671, subdivision 6, ~~and~~ a community paramedic as defined  
8.28 under section 144E.001, subdivision 5f; or a mental health practitioner defined under section  
8.29 245.462, subdivision 17, or 245.4871, subdivision 26, working under the general supervision  
8.30 of a mental health professional; "health care provider" is defined under section 62A.671,  
8.31 subdivision 3; and "originating site" is defined under section 62A.671, subdivision 7.

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

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

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

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

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

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

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

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

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

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

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

9.26 (a) The commissioner of human services shall delay the medical assistance capitation  
9.27 payment to managed care plans and county-based purchasing plans due in May 2019 until  
9.28 July 1, 2019. The payment shall be made no earlier than July 1, 2019, and no later than July  
9.29 31, 2019.

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

10.1 July 1, 2021. The payment shall be made no earlier than July 1, 2021, and no later than July  
10.2 31, 2021. This paragraph does not apply to the capitation payment for adults without  
10.3 dependent children.

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

10.6 The Health Policy Commission Advisory Council shall make its recommendations under  
10.7 Minnesota Statutes, section 62J.90, subdivision 9, for candidates to serve on the Minnesota  
10.8 Health Policy Commission to the Legislative Coordinating Commission by September 30,  
10.9 2018. The Legislative Coordinating Commission shall make the first appointments of public  
10.10 members to the Minnesota Health Policy Commission under Minnesota Statutes, section  
10.11 62J.90, by January 15, 2019. The Legislative Coordinating Commission shall designate five  
10.12 members to serve terms that are coterminous with the governor and six members to serve  
10.13 terms that end on the first Monday in January one year after the terms of the other members  
10.14 conclude. The director of the Legislative Coordinating Commission shall convene the first  
10.15 meeting of the Minnesota Health Policy Commission by June 15, 2019, and shall act as the  
10.16 chair until the commission elects a chair at its first meeting.

10.17 **Sec. 10. PAIN MANAGEMENT.**

10.18 (a) The Health Services Policy Committee established under Minnesota Statutes, section  
10.19 256B.0625, subdivision 3c, shall evaluate and make recommendations on the integration  
10.20 of nonpharmacologic pain management that are clinically viable and sustainable; reduce or  
10.21 eliminate chronic pain conditions; improve functional status; and prevent addiction and  
10.22 reduce dependence on opiates or other pain medications. The recommendations must be  
10.23 based on best practices for the effective treatment of musculoskeletal pain provided by  
10.24 health practitioners identified in paragraph (b), and covered under medical assistance. Each  
10.25 health practitioner represented under paragraph (b) shall present the minimum best integrated  
10.26 practice recommendations, policies, and scientific evidence for nonpharmacologic treatment  
10.27 options for eliminating pain and improving functional status within their full professional  
10.28 scope. Recommendations for integration of services may include guidance regarding  
10.29 screening for co-occurring behavioral health diagnosis; protocols for communication between  
10.30 all providers treating a unique individual, including protocols for follow-up; and universal  
10.31 mechanisms to assess improvements in functional status.

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

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

11.9 (c) The commissioner shall submit a progress report to the chairs and ranking minority  
 11.10 members of the legislative committees with jurisdiction over health and human services  
 11.11 policy and finance by January 15, 2019, and shall report final recommendations by August  
 11.12 1, 2019. The final report may also contain recommendations for developing and implementing  
 11.13 a pilot program to assess the clinical viability, sustainability, and effectiveness of integrated  
 11.14 nonpharmacologic, multidisciplinary treatments for managing musculoskeletal pain and  
 11.15 improving functional status.

11.16 Sec. 11. **REPEALER.**

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

## 11.18 **ARTICLE 2**

### 11.19 **HEALTH DEPARTMENT**

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

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

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

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

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

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

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

12.6 (i) measure groundwater levels, including a piezometer;

12.7 (ii) determine groundwater flow direction or velocity;

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

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

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

12.13 An environmental well does not include an exploratory boring.

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

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

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

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

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

12.27 (4) determine groundwater flow direction or velocity; or

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

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

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

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

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

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

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

13.29 (1) the location of the well;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14.26 (2) sealing wells and borings;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16.31 (1) medical or veterinary equipment \$ 100

17.1	(2) dental x-ray equipment	\$ 40
17.2	(3) x-ray equipment not used on	\$ 100
17.3	humans or animals	
17.4	(4) devices with sources of ionizing	\$ 100
17.5	radiation not used on humans or	
17.6	animals	
17.7	(5) <u>security screening system</u>	<u>\$ 100</u>

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

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

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

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

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

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

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

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

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

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

18.9 (1) telephone-based coaching and counseling;

18.10 (2) referrals;

18.11 (3) written materials mailed upon request;

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

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

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

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

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

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

18.27 (b) Each pilot project must:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

20.18 (d) The commissioner shall submit a preliminary report to the chairs and ranking minority  
20.19 members of the legislative committees with jurisdiction over health care by February 1,  
20.20 2019, outlining the work group's recommendations and any early findings from the analysis.  
20.21 The commissioner shall submit a final report containing the completed analysis by January  
20.22 15, 2020. The commissioner may release select research findings as a result of this study  
20.23 throughout the study and analytic process and shall provide the public an opportunity to  
20.24 comment on any research findings before the release of any finding.

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

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

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

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

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

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

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

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

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

21.20 Subd. 3. **Evaluation.** An ambulance service that receives a grant under this section shall  
 21.21 evaluate the extent to which the project was successful in reducing the number of opioid  
 21.22 overdoses and opioid overdose deaths among patients who received services and in reducing  
 21.23 the inappropriate use of opioids by patients who received services. The commissioner of  
 21.24 health shall develop specific evaluation measures and reporting timelines for ambulance  
 21.25 services receiving grants. Ambulance services shall submit the information required by the  
 21.26 commissioner to the commissioner and the commissioner shall submit a summary of the  
 21.27 information reported by the ambulance services to the chairs and ranking minority members  
 21.28 of the legislative committees with jurisdiction over health and human services by December  
 21.29 1, 2019.

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

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

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

### 22.4 **ARTICLE 3**

### 22.5 **HEALTH COVERAGE**

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

22.8 Subd. 4. **Mammograms.** (a) For purposes of subdivision 2, coverage for a preventive  
22.9 mammogram screening shall include digital breast tomosynthesis for enrollees at risk for  
22.10 breast cancer, and shall be covered as a preventive item or service, as described under section  
22.11 62Q.46.

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

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

22.18 (2) testing positive for BRCA1 or BRCA2 mutations;

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

22.21 (4) having a previous diagnosis of breast cancer.

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

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

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

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

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

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

23.8 (d) For purposes of this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

24.27 (i) cause an adverse reaction in the enrollee;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

26.15 **151.214 PAYMENT DISCLOSURE.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

28.8 (b) For purposes of this subdivision:

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

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

#### 28.14 ARTICLE 4

#### 28.15 HEALTH-RELATED LICENSING BOARDS

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

28.18 Subd. 7. **Physician application and license fees.** (a) The board may charge the following  
 28.19 nonrefundable application and license fees processed pursuant to sections 147.02, 147.03,  
 28.20 147.037, 147.0375, and 147.38:

28.21 (1) physician application fee, \$200;

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

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

28.24 (4) physician emeritus license, \$50;

28.25 (5) physician temporary license, \$60;

28.26 (6) physician late fee, \$60;

28.27 (7) duplicate license fee, \$20;

28.28 (8) certification letter fee, \$25;

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

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

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

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

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

29.6 (14) verification fee, \$25; and

29.7 (15) criminal background check fee, \$32.

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

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

29.12 **147.012 OVERSIGHT OF ALLIED HEALTH PROFESSIONS.**

29.13 The board has responsibility for the oversight of the following allied health professions:  
29.14 physician assistants under chapter 147A<sup>5,2</sup>, acupuncture practitioners under chapter 147B<sup>5,2</sup>,  
29.15 respiratory care practitioners under chapter 147C<sup>5,2</sup>, traditional midwives under chapter 147D<sup>5,2</sup>,  
29.16 registered naturopathic doctors under chapter 147E<sup>5</sup>, genetic counselors under chapter 147F,  
29.17 and athletic trainers under sections 148.7801 to 148.7815.

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

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

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

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

30.2 **147A.06 CANCELLATION OF LICENSE FOR NONRENEWAL.**

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

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

30.13 (b) This subdivision expires July 1, 2021.

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

30.15 **147A.07 RENEWAL.**

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

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

30.19 (2) completing the appropriate forms; and

30.20 (3) meeting any other requirements of the board.

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

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

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

31.2 **147A.28 PHYSICIAN ASSISTANT APPLICATION AND LICENSE FEES.**

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

31.4 (1) physician assistant application fee, \$120;

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

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

31.7 (4) physician assistant temporary registration, \$115;

31.8 (5) physician assistant temporary permit, \$60;

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

31.10 (7) physician assistant late fee, \$50;

31.11 (8) duplicate license fee, \$20;

31.12 (9) certification letter fee, \$25;

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

31.14 (11) report creation and generation fee, \$60- per hour;

31.15 (12) verification fee, \$25; and

31.16 (13) criminal background check fee, \$32.

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

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

31.21 Subdivision 1. **Generally.** The license renewal cycle for physician assistant licensees  
31.22 is converted to an annual cycle where renewal is due on the last day of the licensee's month  
31.23 of birth. Conversion pursuant to this section begins January 1, 2019. This section governs  
31.24 license renewal procedures for licensees who were licensed before December 31, 2018. The  
31.25 conversion renewal cycle is the renewal cycle following the first license renewal after  
31.26 January 1, 2019. The conversion license period is the license period for the conversion  
31.27 renewal cycle. The conversion license period is between six and 17 months and ends on the  
31.28 last day of the licensee's month of birth in either 2019 or 2020, as described in subdivision  
31.29 2.

32.1 Subd. 2. Conversion of license renewal cycle for current licensees. For a licensee  
32.2 whose license is current as of December 31, 2018, the licensee's conversion license period  
32.3 begins on January 1, 2019, and ends on the last day of the licensee's month of birth in 2019,  
32.4 except that for licensees whose month of birth is January, February, March, April, May, or  
32.5 June, the licensee's renewal cycle ends on the last day of the licensee's month of birth in  
32.6 2020.

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

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

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

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

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

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

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

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

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

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

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

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

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

33.10 (2) submit the renewal fee;

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

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

33.14 (b) An applicant shall submit any additional information requested by the board to clarify  
 33.15 information presented in the renewal application. The information must be submitted within  
 33.16 30 days after the board's request, or the renewal request is nullified.

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

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

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

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

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

34.3 (b) This subdivision expires July 1, 2021.

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

34.5 **147B.08 FEES.**

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

34.8 (1) acupuncturist application fee, \$150;

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

34.10 (3) acupuncturist temporary registration fee, \$60;

34.11 (4) acupuncturist inactive status fee, \$50;

34.12 (5) acupuncturist late fee, \$50;

34.13 (6) duplicate license fee, \$20;

34.14 (7) certification letter fee, \$25;

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

34.16 (9) report creation and generation fee, \$60- per hour;

34.17 (10) verification fee, \$25; and

34.18 (11) criminal background check fee, \$32.

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

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

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

35.1 last day of the licensee's month of birth in either 2019 or 2020, as described in subdivision  
35.2 2.

35.3 Subd. 2. **Conversion of license renewal cycle for current licensees.** For a licensee  
35.4 whose license is current as of December 31, 2018, the licensee's conversion license period  
35.5 begins on January 1, 2019, and ends on the last day of the licensee's month of birth in 2019,  
35.6 except that for licensees whose month of birth is January, February, March, April, May, or  
35.7 June, the licensee's renewal cycle ends on the last day of the licensee's month of birth in  
35.8 2020.

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

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

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

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

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

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

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

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

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

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

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

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

36.14 (2) submit the renewal fee;

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

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

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

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

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

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

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

37.8 (b) This subdivision expires July 1, 2021.

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

37.10 **147C.40 FEES.**

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

37.13 (1) respiratory therapist application fee, \$100;

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

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

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

37.17 (5) respiratory therapist temporary permit, \$60;

37.18 (6) respiratory therapist late fee, \$50;

37.19 (7) duplicate license fee, \$20;

37.20 (8) certification letter fee, \$25;

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

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

37.23 (11) verification fee, \$25; and

37.24 (12) criminal background check fee, \$32.

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

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

38.2 **Subdivision 1. Generally.** The license renewal cycle for respiratory care practitioner  
38.3 licensees is converted to an annual cycle where renewal is due on the last day of the licensee's  
38.4 month of birth. Conversion pursuant to this section begins January 1, 2019. This section  
38.5 governs license renewal procedures for licensees who were licensed before December 31,  
38.6 2018. The conversion renewal cycle is the renewal cycle following the first license renewal  
38.7 after January 1, 2019. The conversion license period is the license period for the conversion  
38.8 renewal cycle. The conversion license period is between six and 17 months and ends on the  
38.9 last day of the licensee's month of birth in either 2019 or 2020, as described in subdivision  
38.10 2.

38.11 **Subd. 2. Conversion of license renewal cycle for current licensees.** For a licensee  
38.12 whose license is current as of December 31, 2018, the licensee's conversion license period  
38.13 begins on January 1, 2019, and ends on the last day of the licensee's month of birth in 2019,  
38.14 except that for licensees whose month of birth is January, February, March, April, May, or  
38.15 June, the licensee's renewal cycle ends on the last day of the licensee's month of birth in  
38.16 2020.

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

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

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

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

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

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

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

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

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

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

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

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

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

39.20 (2) submit the renewal fee;

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

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

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

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

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

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

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

40.13 (b) This subdivision expires July 1, 2021.

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

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

40.17 (1) verification fee, \$25;

40.18 (2) certification letter fee, \$25;

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

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

40.21 (5) duplicate license fee, \$20; and

40.22 (6) criminal background check fee, \$32.

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

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

41.1 last day of the licensee's month of birth in either 2019 or 2020, as described in subdivision  
41.2 2.

41.3 Subd. 2. **Conversion of license renewal cycle for current licensees.** For a licensee  
41.4 whose license is current as of December 31, 2018, the licensee's conversion license period  
41.5 begins on January 1, 2019, and ends on the last day of the licensee's month of birth in 2019,  
41.6 except that for licensees whose month of birth is January, February, March, April, May, or  
41.7 June, the licensee's renewal cycle ends on the last day of the licensee's month of birth in  
41.8 2020.

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

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

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

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

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

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

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

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

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

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

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

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

42.14 (2) submit the renewal fee;

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

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

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

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

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

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

43.8 (b) This subdivision expires July 1, 2021.

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

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

43.11 (1) registration application fee, \$200;

43.12 (2) renewal fee, \$150;

43.13 (3) late fee, \$75;

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

43.15 (5) temporary permit fee, \$25<sup>-2</sup>;

43.16 (6) emeritus registration fee, \$50;

43.17 (7) duplicate license fee, \$20;

43.18 (8) certification letter fee, \$25;

43.19 (9) verification fee, \$25;

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

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

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

43.23 Subdivision 1. **Generally.** The registration renewal cycle for registered naturopathic  
43.24 doctors is converted to an annual cycle where renewal is due on the last day of the registrant's  
43.25 month of birth. Conversion pursuant to this section begins January 1, 2019. This section  
43.26 governs registration renewal procedures for registrants who were registered before December  
43.27 31, 2018. The conversion renewal cycle is the renewal cycle following the first registration  
43.28 renewal after January 1, 2019. The conversion registration period is the registration period  
43.29 for the conversion renewal cycle. The conversion registration period is between six and 17

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

45.16 (3) evidence of compliance with the continuing education requirements in section  
45.17 147F.11; and

45.18 (4) any additional information requested by the board.

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

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

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

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

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

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

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

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

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

46.18 (b) This subdivision expires July 1, 2021.

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

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

46.21 (1) license application fee, \$200;

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

46.23 (3) late fee, \$75;<sub>2</sub>

46.24 (4) temporary license fee, \$60;

46.25 (5) duplicate license fee, \$20;

46.26 (6) certification letter fee, \$25;

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

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

46.29 (9) criminal background check fee, \$32.

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

47.2 **Subdivision 1. Generally.** The license renewal cycle for genetic counselor licensees is  
47.3 converted to an annual cycle where renewal is due on the last day of the licensee's month  
47.4 of birth. Conversion pursuant to this section begins January 1, 2019. This section governs  
47.5 license renewal procedures for licensees who were licensed before December 31, 2018. The  
47.6 conversion renewal cycle is the renewal cycle following the first license renewal after  
47.7 January 1, 2019. The conversion license period is the license period for the conversion  
47.8 renewal cycle. The conversion license period is between six and 17 months and ends on the  
47.9 last day of the licensee's month of birth in either 2019 or 2020, as described in subdivision  
47.10 2.

47.11 **Subd. 2. Conversion of license renewal cycle for current licensees.** For a licensee  
47.12 whose license is current as of December 31, 2018, the licensee's conversion license period  
47.13 begins on January 1, 2019, and ends on the last day of the licensee's month of birth in 2019,  
47.14 except that for licensees whose month of birth is January, February, March, April, May, or  
47.15 June, the licensee's renewal cycle ends on the last day of the licensee's month of birth in  
47.16 2020.

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

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

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

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

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

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

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

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

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

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

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

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

48.18 (1) application fee, \$50;

48.19 (2) annual registration fee, \$100;

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

48.21 (4) temporary permit, \$50<sub>;</sub>

48.22 (5) late fee, \$15;

48.23 (6) duplicate license fee, \$20;

48.24 (7) certification letter fee, \$25;

48.25 (8) verification fee, \$25;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

50.15 **214.077 TEMPORARY LICENSE SUSPENSION; IMMINENT RISK OF SERIOUS**  
50.16 **HARM.**

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

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

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

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

51.20 (e) If the regulated person requests a delay in the contested case proceedings provided  
51.21 for in paragraphs (c) and (d) for any reason, the temporary suspension shall remain in effect  
51.22 until the health-related licensing board issues a final order pursuant to sections 14.61 and  
51.23 14.62.

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

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

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

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

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

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

52.15 (c) Each health-related licensing board shall establish procedures for exchanging  
52.16 information with other Minnesota state boards, agencies, and departments responsible for  
52.17 regulating health-related occupations, facilities, and programs, and for coordinating  
52.18 investigations involving matters within the jurisdiction of more than one regulatory body.  
52.19 The procedures must provide for the forwarding to other regulatory bodies of all information  
52.20 and evidence, including the results of investigations, that are relevant to matters within that  
52.21 licensing body's regulatory jurisdiction. Each health-related licensing board shall have access  
52.22 to any data of the Department of Human Services relating to a person subject to the  
52.23 jurisdiction of the licensing board. The data shall have the same classification under chapter  
52.24 13, the Minnesota Government Data Practices Act, in the hands of the agency receiving the  
52.25 data as it had in the hands of the Department of Human Services.

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

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

53.2 **364.09 EXCEPTIONS.**

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

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

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

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

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

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

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

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

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

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

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

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

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

54.12 Sec. 37. **REPEALER.**

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

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

## 54.15 ARTICLE 5

### 54.16 PRESCRIPTION MONITORING PROGRAM

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

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

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

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

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

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

55.4 (i) prescribing or considering prescribing any controlled substance;

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

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

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

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

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

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

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

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

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

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

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

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

56.18 (11) personnel of the health professionals services program established under section  
56.19 214.31, to the extent that the information relates specifically to an individual who is currently  
56.20 enrolled in and being monitored by the program, and the individual consents to access to  
56.21 that information. The health professionals services program personnel shall not provide this  
56.22 data to a health-related licensing board or the Emergency Medical Services Regulatory  
56.23 Board, except as permitted under section 214.33, subdivision 3; and

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

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

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

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

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

57.11 (1) the patient is receiving hospice care;

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

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

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

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

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

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

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

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

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

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

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

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

58.24 If determined necessary, the commissioner of human services shall seek a federal waiver  
58.25 of, or exception to, any applicable provision of Code of Federal Regulations, title 42, section  
58.26 2.34, paragraph (c), prior to implementing this paragraph.

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

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

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

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

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

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

## 59.26 ARTICLE 6

### 59.27 PROTECTION OF VULNERABLE ADULTS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



64.1 **Subd. 2. Forecasted Programs**64.2 **(a) MFIP/DWP**64.3 Appropriations by Fund64.4 General Fund (3,749,000) (11,267,000)64.5 Federal TANF (7,418,000) 4,565,00064.6 **(b) MFIP Child Care Assistance** (7,995,000) (521,000)64.7 **(c) General Assistance** (4,850,000) (3,770,000)64.8 **(d) Minnesota Supplemental Aid** (1,179,000) (821,000)64.9 **(e) Housing Support** (3,260,000) (3,038,000)64.10 **(f) Northstar Care for Children** (5,168,000) (6,458,000)64.11 **(g) MinnesotaCare** 7,620,000 9,258,00064.12 These appropriations are from the health care  
64.13 access fund.64.14 **(h) Medical Assistance**64.15 Appropriations by Fund64.16 General Fund (199,817,000) (106,124,000)64.17 Health Care Access64.18 Fund -0- -0-64.19 **(i) Alternative Care Program** -0- -0-64.20 **(j) CCDTF Entitlements** 15,935,000 28,464,00064.21 **Subd. 3. Technical Activities** 918,000 1,349,00064.22 These appropriations are from the federal  
64.23 TANF fund.64.24 **EFFECTIVE DATE.** This section is effective June 30, 2018.64.25 **ARTICLE 8**64.26 **APPROPRIATIONS**64.27 Section 1. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**64.28 The sums shown in the columns marked "Appropriations" are added to or, if shown in  
64.29 parentheses, subtracted from the appropriations in Laws 2017, First Special Session chapter  
64.30 6, article 18, to the agencies and for the purposes specified in this article. The appropriations  
64.31 are from the general fund, or another named fund, and are available for the fiscal years

65.1 indicated for each purpose. The figures "2018" and "2019" used in this article mean that  
 65.2 the addition to or subtraction from appropriations listed under them are available for the  
 65.3 fiscal year ending June 30, 2018, or June 30, 2019, respectively. Base level adjustments  
 65.4 mean the addition or subtraction from the base level adjustments in Laws 2017, First Special  
 65.5 Session chapter 6, article 18. "The first year" is fiscal year 2018. "The second year" is fiscal  
 65.6 year 2019. "The biennium" is fiscal years 2018 and 2019. Supplemental appropriations and  
 65.7 reductions to appropriations for the fiscal year ending June 30, 2018, are effective June 30,  
 65.8 2018, unless a different effective date is specified.

		<u>APPROPRIATIONS</u>	
		<u>Available for the Year</u>	
		<u>Ending June 30</u>	
		<u>2018</u>	<u>2019</u>
65.13	<b>Sec. 2. <u>COMMISSIONER OF HUMAN</u></b>		
65.14	<b><u>SERVICES</u></b>		
65.15	<b><u>Subdivision 1. Total Appropriation</u></b>	<b><u>\$</u></b>	<b><u>-0-</u></b> <b><u>\$</u></b> <b><u>2,022,000</u></b>
65.16	<u>The amounts that may be spent for each</u>		
65.17	<u>purpose are specified in the following</u>		
65.18	<u>subdivisions.</u>		
65.19	<b><u>Subd. 2. Forecasted Programs; Medical</u></b>		
65.20	<b><u>Assistance</u></b>		<b><u>-0-</u></b> <b><u>2,022,000</u></b>
65.21	<b>Sec. 3. <u>COMMISSIONER OF HEALTH</u></b>		
65.22	<b><u>Subdivision 1. Total Appropriation</u></b>	<b><u>\$</u></b>	<b><u>-0-</u></b> <b><u>\$</u></b> <b><u>6,516,000</u></b>
65.23	<u>Appropriations by Fund</u>		
65.24		<u>2018</u>	<u>2019</u>
65.25	<u>General</u>	<u>-0-</u>	<u>6,491,000</u>
65.26	<u>State Government</u>		
65.27	<u>Special Revenue</u>	<u>-0-</u>	<u>25,000</u>
65.28	<u>The amounts that may be spent for each</u>		
65.29	<u>purpose are specified in the following</u>		
65.30	<u>subdivisions.</u>		
65.31	<b><u>Subd. 2. Health Improvement</u></b>		<b><u>-0-</u></b> <b><u>3,451,000</u></b>

66.1 **(a) Opioid Overdose Reduction Pilot**

66.2 **Program.** \$1,062,000 in fiscal year 2019 is  
66.3 for the opioid overdose reduction pilot  
66.4 program in article 2, section 15. Of this  
66.5 appropriation, the commissioner may use up  
66.6 to \$112,000 to administer the program. This  
66.7 is a onetime appropriation and is available  
66.8 until June 30, 2021.

66.9 **(b) Low-Value Health Services Study.**

66.10 \$389,000 in fiscal year 2019 is for the  
66.11 low-value health services study in article 2,  
66.12 section 14. The base for this appropriation is  
66.13 \$106,000 in fiscal year 2020.

66.14 **(c) Statewide Tobacco Cessation Services.**

66.15 \$291,000 in fiscal year 2019 is appropriated  
66.16 from the health care access fund for statewide  
66.17 tobacco cessation services under Minnesota  
66.18 Statutes, section 144.397. The base for this  
66.19 appropriation is \$1,550,000 in fiscal year  
66.20 2020, and \$2,955,000 in fiscal year 2021.

66.21 **(d) Reduction of Statewide Health**

66.22 **Improvement Program Appropriation.** The  
66.23 appropriation in Laws 2017, First Special  
66.24 Session chapter 6, article 18, section 3,  
66.25 subdivision 2, from the health care access fund  
66.26 for the statewide health improvement program  
66.27 under Minnesota Statutes, section 145.986, is  
66.28 reduced by \$291,000 in fiscal year 2019. The  
66.29 base for this reduction is \$1,550,000 in fiscal  
66.30 year 2020, and \$2,955,000 in fiscal year 2021.

66.31 **(e) Additional Funding for Opioid**

66.32 **Prevention Pilot Projects.** \$2,000,000 in  
66.33 fiscal year 2019 is appropriated for opioid  
66.34 abuse prevention pilot projects under Laws  
66.35 2017, First Special Session chapter 6, article

67.1 10, section 144. Of this amount, \$1,400,000  
 67.2 is for the opioid abuse prevention pilot project  
 67.3 through CHI St. Gabriel's Health Family  
 67.4 Medical Center, also known as Unity Family  
 67.5 Health Care. \$600,000 is for Project Echo  
 67.6 through CHI St. Gabriel's Health Family  
 67.7 Medical Center for e-learning sessions  
 67.8 centered around opioid case management and  
 67.9 best practices for opioid abuse prevention.  
 67.10 This is a onetime appropriation.

67.11 (f) **Base Level Adjustments.** The general fund  
 67.12 base is increased by \$106,000 in fiscal year  
 67.13 2020.

67.14 Subd. 3. **Health Protection**

	<u>Appropriations by Fund</u>	
67.15		
67.16	<u>General</u>	<u>-0-      3,040,000</u>
67.17	<u>State Government</u>	
67.18	<u>Special Revenue</u>	<u>-0-      25,000</u>

67.19 (a) **Regulation of Low-Dose X-Ray Security**  
 67.20 **Screening Systems.** \$29,000 in fiscal year  
 67.21 2019 is from the state government special  
 67.22 revenue fund for rulemaking under Minnesota  
 67.23 Statutes, section 144.121. The base for this  
 67.24 appropriation is \$21,000 in fiscal year 2020  
 67.25 and \$21,000 in fiscal year 2021.

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

68.1 (c) Base Level Adjustment. The general fund  
 68.2 base is increased by \$3,923,000 in fiscal year  
 68.3 2020 and increased by \$3,923,000 in fiscal  
 68.4 year 2021. The state government special  
 68.5 revenue fund base is increased by \$17,000 in  
 68.6 fiscal year 2020 and increased by \$17,000 in  
 68.7 fiscal year 2021.

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

68.9 <b><u>Subdivision 1. Total Appropriation</u></b>	<b><u>\$</u></b>	<b><u>-0-</u></b>	<b><u>\$</u></b>	<b><u>278,000</u></b>
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68.10 This appropriation is from the state  
 68.11 government special revenue fund. The  
 68.12 amounts that may be spent for each purpose  
 68.13 are specified in the following subdivisions.

68.14 <b><u>Subd. 2. Board of Pharmacy</u></b>		<b><u>-0-</u></b>		<b><u>278,000</u></b>
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68.15 This appropriation is for migration to a new  
 68.16 information technology platform for the  
 68.17 prescription monitoring program. This is a  
 68.18 onetime appropriation.

68.19 <b><u>Sec. 5. LEGISLATIVE COORDINATING</u></b>				
68.20 <b><u>COMMISSION</u></b>	<b><u>\$</u></b>	<b><u>-0-</u></b>	<b><u>\$</u></b>	<b><u>137,000</u></b>

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

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

69.1 Sec. 6. **TRANSFERS.**

69.2 By June 30, 2018, the commissioner of management and budget shall transfer  
69.3 \$14,000,000 from the systems operations account in the special revenue fund to the general  
69.4 fund. This is a onetime transfer.

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

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

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

69.9 Sec. 8. **EFFECTIVE DATE.**

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

APPENDIX  
Article locations in SF2505-1

ARTICLE 1	HEALTH CARE.....	Page.Ln 2.5
ARTICLE 2	HEALTH DEPARTMENT.....	Page.Ln 11.18
ARTICLE 3	HEALTH COVERAGE.....	Page.Ln 22.4
ARTICLE 4	HEALTH-RELATED LICENSING BOARDS.....	Page.Ln 28.14
ARTICLE 5	PRESCRIPTION MONITORING PROGRAM.....	Page.Ln 54.15
ARTICLE 6	PROTECTION OF VULNERABLE ADULTS .....	Page.Ln 59.26
ARTICLE 7	HUMAN SERVICES FORECAST ADJUSTMENTS.....	Page.Ln 63.11
ARTICLE 8	APPROPRIATIONS.....	Page.Ln 64.25

**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.

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.