SENATE
STATE OF MINNESOTA
NINETIETH SESSION

S.F. No. 4014

(SENATE AUTHORS: LOUREY)

DATE	D-PG	OFFICIAL STATUS
04/19/2018	7738	Introduction and first reading Referred to Health and Human Services Finance and Policy

A bill for an act

relating to state government; modifying provisions governing health care, children and family services, chemical and mental health services, continuing care, community supports, opioids, and health department; establishing MinnesotaCare Buy-In Option; making changes to statutory provisions affecting older and vulnerable adults; prohibiting retaliation for acting on behalf of a patient or resident; prohibiting deceptive marketing and business practices; creating an Assisted Living and Dementia Care Task Force; requiring rulemaking for assisted living licensure and dementia care unit certification; establishing opioid product stewardship fee; requiring reports; making forecast adjustments; modifying fines; appropriating money; amending Minnesota Statutes 2016, sections 16A.724, subdivision 2; 119B.011, subdivisions 6, 19, by adding subdivisions; 119B.03, subdivision 9; 119B.125, subdivision 1b, by adding subdivisions; 119B.16, subdivisions 1, 1a, 1b, by adding subdivisions; 144.291, subdivision 2; 144.3831, subdivision 1; 144.6501, subdivision 3; 144.651, subdivisions 1, 2, 4, 6, 14, 16, 17, 20, 21, by adding subdivisions; 144A.10, subdivisions 1, 6; 144A.44; 144A.441; 144A.45, subdivisions 1, 2; 144A.474, subdivisions 1, 8, 9; 144A.53, subdivisions 1, 4; 144D.01, subdivision 1; 144D.02; 144D.09; 151.252, subdivision 1; 152.126, subdivision 6, by adding a subdivision; 245.4889, by adding a subdivision; 245C.02, by adding a subdivision; 245C.12; 245E.03, subdivisions 2, 4; 245E.06, subdivision 3; 254B.02, subdivision 1; 254B.06, subdivision 1; 256B.0625, by adding subdivisions; 256B.0659, by adding a subdivision; 256B.439, by adding a subdivision; 325F.71; 518A.51; 573.02, subdivision 2; 609.2231, subdivision 8; 626.557, subdivisions 3, 4, 9, 9a, 9b, 9c, 9d, 10b, 12b, 14, 17; 626.5572, by adding a subdivision; Minnesota Statutes 2017 Supplement, sections 119B.011, subdivision 20; 119B.025, subdivision 1; 119B.09, subdivision 1; 119B.095, subdivision 2; 119B.13, subdivision 6; 144A.474, subdivision 11; 144D.04, subdivision 2; 245.4889, subdivision 1; 254A.03, subdivision 3; 256.045, subdivisions 3, 3b, 4; 256B.0625, subdivision 17; 256B.4914, subdivision 5; Laws 2014, chapter 312, article 27, section 76; Laws 2017, chapter 2, article 1, section 7, as amended; proposing coding for new law in Minnesota Statutes, chapters 119B; 144; 144D; 151; 245C; 256L; 256M; repealing Minnesota Statutes 2016, sections 119B.125, subdivision 5; 119B.16, subdivision 2; 144G.01; 144G.02; 144G.03; 144G.04; 144G.05; 144G.06; 245E.03, subdivision 3; 245E.06, subdivisions 2, 4, 5; Minnesota Rules, part 3400.0185, subpart 5.

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

ARTICLE 1

HEALTH CARE

Section 1. Minnesota Statutes 2016, section 16A.724, subdivision 2, is amended to read:

Subd. 2. **Transfers.** (a) Notwithstanding section 295.581, to the extent available resources in the health care access fund exceed expenditures in that fund, effective for the biennium beginning July 1, 2007, the commissioner of management and budget shall transfer the excess funds from the health care access fund to the general fund on June 30 of each year, provided that the amount transferred in fiscal year ~~2016~~ 2020 shall not exceed ~~$48,000,000~~ $134,073,000, the amount in fiscal year ~~2017~~ 2021 shall not exceed ~~$122,000,000~~ $151,002,000, and the amount in any fiscal biennium thereafter shall not exceed ~~$244,000,000~~ $302,004,000. The purpose of this transfer is to meet the rate increase required under Laws 2003, First Special Session chapter 14, article 13C, section 2, subdivision 6.

(b) For fiscal years 2006 to 2011, MinnesotaCare shall be a forecasted program, and, if necessary, the commissioner shall reduce these transfers from the health care access fund to the general fund to meet annual MinnesotaCare expenditures or, if necessary, transfer sufficient funds from the general fund to the health care access fund to meet annual MinnesotaCare expenditures.

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

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

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

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

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

(i) prescribing or considering prescribing any controlled substance;

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

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

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

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

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

(4) an individual who is the recipient of a controlled substance prescription for which data was submitted under subdivision 4, or a guardian of the individual, parent or guardian of a minor, or health care agent of the individual acting under a health care directive under chapter 145C;

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

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

(7) authorized personnel of a vendor under contract with the state of Minnesota who are engaged in the design, implementation, operation, and maintenance of the prescription monitoring program as part of the assigned duties and responsibilities of their employment, provided that access to data is limited to the minimum amount necessary to carry out such

duties and responsibilities, and subject to the requirement of de-identification and time limit on retention of data specified in subdivision 5, paragraphs (d) and (e);

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

(9) personnel of the Minnesota health care programs assigned to use the data collected under this section to:

(i) identify and manage recipients whose usage of controlled substances may warrant restriction to a single primary care provider, a single outpatient pharmacy, and a single hospital; and

(ii) identify and manage recipients paying cash for controlled substances and identify, investigate, and sanction providers dispensing controlled substances in violation of section 256B.0625, subdivision 55, paragraph (b), clause (6);

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

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

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

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

(c) By July 1, 2017, every prescriber licensed by a health-related licensing board listed in section 214.01, subdivision 2, practicing within this state who is authorized to prescribe controlled substances for humans and who holds a current registration issued by the federal Drug Enforcement Administration, and every pharmacist licensed by the board and practicing within the state, shall register and maintain a user account with the prescription monitoring program. Data submitted by a prescriber, pharmacist, or their delegate during the registration

application process, other than their name, license number, and license type, is classified as private pursuant to section 13.02, subdivision 12.

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

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

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

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

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

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

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

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

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

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

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

Sec. 3. Minnesota Statutes 2017 Supplement, section 256B.0625, subdivision 17, is amended to read:

Subd. 17. **Transportation costs.** (a) "Nonemergency medical transportation service" means motor vehicle transportation provided by a public or private person that serves Minnesota health care program beneficiaries who do not require emergency ambulance service, as defined in section 144E.001, subdivision 3, to obtain covered medical services.

(b) Medical assistance covers medical transportation costs incurred solely for obtaining emergency medical care or transportation costs incurred by eligible persons in obtaining emergency or nonemergency medical care when paid directly to an ambulance company, nonemergency medical transportation company, or other recognized providers of transportation services. Medical transportation must be provided by:

(1) nonemergency medical transportation providers who meet the requirements of this subdivision;

(2) ambulances, as defined in section 144E.001, subdivision 2;

(3) taxicabs that meet the requirements of this subdivision;

(4) public transit, as defined in section 174.22, subdivision 7; or

(5) not-for-hire vehicles, including volunteer drivers.

(c) Medical assistance covers nonemergency medical transportation provided by nonemergency medical transportation providers enrolled in the Minnesota health care programs. All nonemergency medical transportation providers must comply with the operating standards for special transportation service as defined in sections 174.29 to 174.30 and Minnesota Rules, chapter 8840, and ~~in consultation with the Minnesota Department of Transportation~~ all drivers must be individually enrolled with the commissioner and reported on the claim as the individual who provided the service. All nonemergency medical transportation providers shall bill for nonemergency medical transportation services in accordance with Minnesota health care programs criteria. Publicly operated transit systems, volunteers, and not-for-hire vehicles are exempt from the requirements outlined in this paragraph.

(d) An organization may be terminated, denied, or suspended from enrollment if:

(1) the provider has not initiated background studies on the individuals specified in section 174.30, subdivision 10, paragraph (a), clauses (1) to (3); or

(2) the provider has initiated background studies on the individuals specified in section 174.30, subdivision 10, paragraph (a), clauses (1) to (3), and:

(i) the commissioner has sent the provider a notice that the individual has been disqualified under section 245C.14; and

(ii) the individual has not received a disqualification set-aside specific to the special transportation services provider under sections 245C.22 and 245C.23.

(e) The administrative agency of nonemergency medical transportation must:

(1) adhere to the policies defined by the commissioner in consultation with the Nonemergency Medical Transportation Advisory Committee;

(2) pay nonemergency medical transportation providers for services provided to Minnesota health care programs beneficiaries to obtain covered medical services;

(3) provide data monthly to the commissioner on appeals, complaints, no-shows, canceled trips, and number of trips by mode; and

(4) by July 1, 2016, in accordance with subdivision 18e, utilize a Web-based single administrative structure assessment tool that meets the technical requirements established by the commissioner, reconciles trip information with claims being submitted by providers, and ensures prompt payment for nonemergency medical transportation services.

(f) Until the commissioner implements the single administrative structure and delivery system under subdivision 18e, clients shall obtain their level-of-service certificate from the commissioner or an entity approved by the commissioner that does not dispatch rides for clients using modes of transportation under paragraph (i), clauses (4), (5), (6), and (7).

(g) The commissioner may use an order by the recipient's attending physician or a medical or mental health professional to certify that the recipient requires nonemergency medical transportation services. Nonemergency medical transportation providers shall perform driver-assisted services for eligible individuals, when appropriate. Driver-assisted service includes passenger pickup at and return to the individual's residence or place of business, assistance with admittance of the individual to the medical facility, and assistance in passenger securement or in securing of wheelchairs, child seats, or stretchers in the vehicle.

Nonemergency medical transportation providers must take clients to the health care provider using the most direct route, and must not exceed 30 miles for a trip to a primary care provider or 60 miles for a trip to a specialty care provider, unless the client receives authorization from the local agency.

Nonemergency medical transportation providers may not bill for separate base rates for the continuation of a trip beyond the original destination. Nonemergency medical transportation providers must maintain trip logs, which include pickup and drop-off times, signed by the medical provider or client, whichever is deemed most appropriate, attesting to mileage traveled to obtain covered medical services. Clients requesting client mileage reimbursement must sign the trip log attesting mileage traveled to obtain covered medical services.

(h) The administrative agency shall use the level of service process established by the commissioner in consultation with the Nonemergency Medical Transportation Advisory Committee to determine the client's most appropriate mode of transportation. If public transit or a certified transportation provider is not available to provide the appropriate service mode for the client, the client may receive a onetime service upgrade.

(i) The covered modes of transportation are:

(1) client reimbursement, which includes client mileage reimbursement provided to clients who have their own transportation, or to family or an acquaintance who provides transportation to the client;

(2) volunteer transport, which includes transportation by volunteers using their own vehicle;

(3) unassisted transport, which includes transportation provided to a client by a taxicab or public transit. If a taxicab or public transit is not available, the client can receive transportation from another nonemergency medical transportation provider;

(4) assisted transport, which includes transport provided to clients who require assistance by a nonemergency medical transportation provider;

(5) lift-equipped/ramp transport, which includes transport provided to a client who is dependent on a device and requires a nonemergency medical transportation provider with a vehicle containing a lift or ramp;

(6) protected transport, which includes transport provided to a client who has received a prescreening that has deemed other forms of transportation inappropriate and who requires a provider: (i) with a protected vehicle that is not an ambulance or police car and has safety locks, a video recorder, and a transparent thermoplastic partition between the passenger and the vehicle driver; and (ii) who is certified as a protected transport provider; and

(7) stretcher transport, which includes transport for a client in a prone or supine position and requires a nonemergency medical transportation provider with a vehicle that can transport a client in a prone or supine position.

(j) The local agency shall be the single administrative agency and shall administer and reimburse for modes defined in paragraph (i) according to paragraphs (m) and (n) when the commissioner has developed, made available, and funded the Web-based single administrative structure, assessment tool, and level of need assessment under subdivision 18e. The local agency's financial obligation is limited to funds provided by the state or federal government.

(k) The commissioner shall:

(1) in consultation with the Nonemergency Medical Transportation Advisory Committee, verify that the mode and use of nonemergency medical transportation is appropriate;

(2) verify that the client is going to an approved medical appointment; and

(3) investigate all complaints and appeals.

(l) The administrative agency shall pay for the services provided in this subdivision and seek reimbursement from the commissioner, if appropriate. As vendors of medical care, local agencies are subject to the provisions in section 256B.041, the sanctions and monetary recovery actions in section 256B.064, and Minnesota Rules, parts 9505.2160 to 9505.2245.

(m) Payments for nonemergency medical transportation must be paid based on the client's assessed mode under paragraph (h), not the type of vehicle used to provide the service. The medical assistance reimbursement rates for nonemergency medical transportation services that are payable by or on behalf of the commissioner for nonemergency medical transportation services are:

(1) $0.22 per mile for client reimbursement;

(2) up to 100 percent of the Internal Revenue Service business deduction rate for volunteer transport;

(3) equivalent to the standard fare for unassisted transport when provided by public transit, and $11 for the base rate and $1.30 per mile when provided by a nonemergency medical transportation provider;

(4) $13 for the base rate and $1.30 per mile for assisted transport;

(5) $18 for the base rate and $1.55 per mile for lift-equipped/ramp transport;

(6) $75 for the base rate and $2.40 per mile for protected transport; and

(7) $60 for the base rate and $2.40 per mile for stretcher transport, and $9 per trip for an additional attendant if deemed medically necessary.

(n) The base rate for nonemergency medical transportation services in areas defined under RUCA to be super rural is equal to 111.3 percent of the respective base rate in paragraph (m), clauses (1) to (7). The mileage rate for nonemergency medical transportation services in areas defined under RUCA to be rural or super rural areas is:

(1) for a trip equal to 17 miles or less, equal to 125 percent of the respective mileage rate in paragraph (m), clauses (1) to (7); and

(2) for a trip between 18 and 50 miles, equal to 112.5 percent of the respective mileage rate in paragraph (m), clauses (1) to (7).

(o) For purposes of reimbursement rates for nonemergency medical transportation services under paragraphs (m) and (n), the zip code of the recipient's place of residence shall determine whether the urban, rural, or super rural reimbursement rate applies.

(p) For purposes of this subdivision, "rural urban commuting area" or "RUCA" means a census-tract based classification system under which a geographical area is determined to be urban, rural, or super rural.

(q) The commissioner, when determining reimbursement rates for nonemergency medical transportation under paragraphs (m) and (n), shall exempt all modes of transportation listed under paragraph (i) from Minnesota Rules, part 9505.0445, item R, subitem (2).

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

Sec. 4. Minnesota Statutes 2016, section 256B.0625, is amended by adding a subdivision to read:

Subd. 17d. **Transportation services oversight.** The commissioner shall contract with a vendor or dedicate staff for oversight of providers of nonemergency medical transportation services pursuant to the commissioner's authority in section 256B.04 and Minnesota Rules, parts 9505.2160 to 9505.2245.

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

Sec. 5. Minnesota Statutes 2016, section 256B.0625, is amended by adding a subdivision to read:

Subd. 17e. **Transportation provider termination.** (a) A terminated nonemergency medical transportation provider, including all named individuals on the current enrollment disclosure form and known or discovered affiliates of the nonemergency medical transportation provider, is not eligible to enroll as a nonemergency medical transportation provider for five years following the termination.

(b) After the five-year period in paragraph (a), if a provider seeks to reenroll as a nonemergency medical transportation provider, the nonemergency medical transportation provider must be placed on a one-year probation period. During a provider's probation period the commissioner shall complete unannounced site visits and request documentation to review compliance with program requirements.

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

Sec. 6. **[256L.29] MINNESOTACARE BUY-IN OPTION.**

Subdivision 1. **Request for federal authority.** (a) The commissioner of human services shall seek all necessary federal waivers to establish the MinnesotaCare Buy-In Option under this section.

(b) The commissioner shall also seek all necessary federal waivers to:

(1) allow eligible persons to use advance premium tax credits and cost-sharing reductions to purchase the MinnesotaCare Buy-In Option;

(2) offer the MinnesotaCare Buy-In Option through the MNsure Web site as a coverage option and to be compared with qualified health plans offered through the MNsure Web site;

(3) allow the commissioner to use surplus funds in the Minnesota premium security plan account under section 62E.25 or the premium subsidy program under Laws 2017, chapter 2, to establish an account as a reserve for the payment of claims and liabilities and other financial needs for the MinnesotaCare Buy-In Option; and

(4) maintain MinnesotaCare program requirements and funding mechanisms that provide coverage to persons eligible under section 256L.04.

(c) The commissioner is exempt from the requirements in chapter 16C to contract for actuarial services that satisfy the waiver submission requirements under this subdivision. The commissioner may utilize existing contracts to satisfy the waiver submission requirements of this subdivision.

Subd. 2. **Administration.** (a) The commissioner shall:

(1) coordinate administration of the MinnesotaCare Buy-In Option with the MinnesotaCare program, as described in section 256L.04, to maximize efficiency and improve continuity of care for enrollees;

(2) implement mechanisms to ensure the long-term financial sustainability of MinnesotaCare and mitigate any adverse financial impacts to the state and MNsure. These mechanisms must minimize adverse selection, state financial risk and contribution, and negative impacts to premiums in the individual and group health insurance markets;

(3) establish a cost allocation methodology to reimburse MNsure operations in lieu of the premium withhold for qualified health plans under section 62V.05; and

(4) establish provider reimbursement rates paid at the Medicare reimbursement rate or at the MinnesotaCare payment rate, whichever is greater.

(b) A person who is determined eligible for enrollment in a qualified health plan with or without advance payments of the premium tax credit and with or without cost-sharing reductions according to Code of Federal Regulations, title 45, section 155.305, paragraphs (a), (f), and (g), is eligible to purchase and enroll in a MinnesotaCare Buy-In Option health plan instead of purchasing a qualified health plan as defined under section 62V.02.

(c) The MinnesotaCare Buy-In Option shall be considered the MinnesotaCare program for purposes of the requirements for health maintenance organizations under section 62D.04, subdivision 5, and providers under section 256B.0644.

(d) The commissioner has the authority to accept and expend all enrollee premiums and federal funds made available under this section upon federal approval.

Subd. 3. **Establishment of health plans.** (a) The commissioner shall establish two MinnesotaCare Buy-In Option health plans: one health plan shall provide benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the health plan, and one health plan shall provide benefits that are actuarially equivalent to 80 percent of the full actuarial value of the benefits provided under the health plan. The benefits of the health plans shall be based on the benefits provided in section 256L.03.

(b) A person is limited to apply for the MinnesotaCare Buy-In Option during the annual open and special enrollment periods established for MNsure as defined in Code of Federal Regulations, title 45, sections 155.410 and 155.420. The MinnesotaCare Buy-In Option shall be available through the MNsure Web site as defined in section 62V.02, subdivision 13.

(c) The commissioner shall contract with vendors to provide services consistent with sections 256L.12 and 256L.121.

Subd. 4. **Premium administration and payment.** The commissioner shall establish an annual per-enrollee premium rate sufficient to cover state administrative costs and payments by the state to subcontractors under sections 256L.12 and 256L.121.

Subd. 5. **Premium tax credits, cost-sharing reductions, and subsidies.** (a) A person who is eligible under this section, and whose income is less than or equal to 400 percent of the federal poverty guidelines, may qualify for advance premium tax credits and cost-sharing reductions to purchase a health plan established under this section.

(b) There shall be no state subsidy to a person eligible for the MinnesotaCare Buy-In Option.

EFFECTIVE DATE. This section is effective January 1, 2020, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 7. **[256L.30] MINNESOTACARE BUY-IN OPTION RESERVE ACCOUNT.**

The MinnesotaCare Buy-In Option reserve account is created in the state treasury. Money in the MinnesotaCare Buy-In Option reserve account, including accrued interest or profit from investment, is appropriated to the commissioner of human services to meet cash flow, coverage, claims, and liabilities for the MinnesotaCare Buy-In Option program established under section 256L.29. Premium revenue from the MinnesotaCare Buy-In Option program

not used to pay claims or administrative expenses must be deposited into the MinnesotaCare Buy-In Option reserve account.

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

ARTICLE 2

CHILDREN AND FAMILY SERVICES

Section 1. Minnesota Statutes 2016, section 119B.011, subdivision 6, is amended to read:

Subd. 6. **Child care fund.** "Child care fund" means a program under this chapter providing:

(1) financial assistance for child care to support:

(i) parents engaged in employment, job search, or education and training leading to employment, or an at-home infant child care subsidy; and

(ii) the development and school readiness of children; and

(2) grants to develop, expand, and improve the access and availability of child care services statewide.

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

Sec. 2. Minnesota Statutes 2016, section 119B.011, is amended by adding a subdivision to read:

Subd. 13b. **Homeless.** "Homeless" means a self-declared housing status as defined in the McKinney-Vento Homeless Assistance Act and United States Code, title 42, section 11302, paragraph (a).

EFFECTIVE DATE. This section is effective August 12, 2019.

Sec. 3. Minnesota Statutes 2016, section 119B.011, is amended by adding a subdivision to read:

Subd. 16a. **Legal nonlicensed related provider.** "Legal nonlicensed related provider" means a legal nonlicensed child care provider under subdivision 16 who cares for children related to the provider and does not care for any child receiving assistance under this chapter who is not related to the provider. For purposes of this subdivision, "related" means the provider is, by marriage, blood relationship, or court decree, a sibling, grandparent, aunt, or uncle of the child.

EFFECTIVE DATE. This section is effective September 24, 2018.

Sec. 4. Minnesota Statutes 2016, section 119B.011, is amended by adding a subdivision to read:

Subd. 16b. **Legal nonlicensed unrelated provider.** "Legal nonlicensed unrelated provider" means a legal nonlicensed child care provider under subdivision 16 who provides care in Minnesota for at least one child receiving assistance under this chapter who is not related to the provider. For purposes of this subdivision, "related" means the provider is, by marriage, blood relationship, or court decree, a sibling, grandparent, aunt, or uncle of the child.

EFFECTIVE DATE. This section is effective September 24, 2018.

Sec. 5. Minnesota Statutes 2016, section 119B.011, subdivision 19, is amended to read:

Subd. 19. **Provider.** "Provider" means:

(1) an individual or child care center or facility~~, either licensed or unlicensed,~~ providing licensed legal child care services as defined under section 245A.03; ~~or~~

(2) a license exempt center required to be certified under chapter 245G;

(3) an individual or child care center or facility ~~holding~~ that:

(i) holds a valid child care license issued by another state or a tribe ~~and providing~~;

(ii) provides child care services in the licensing state or in the area under the licensing tribe's jurisdiction~~.~~; and

(iii) is in compliance with federal health and safety requirements as certified by the licensing state or tribe, or as determined by receipt of Child Care Development Block Grant funds in the licensing state; or

(4) a legal nonlicensed child care provider as defined under section 119B.011, subdivision 16, providing legal child care services. A ~~legally unlicensed family~~ legal nonlicensed child care provider must be at least 18 years of age, and not a member of the MFIP assistance unit or a member of the family receiving child care assistance to be authorized under this chapter.

EFFECTIVE DATE. This section is effective September 24, 2018.

Sec. 6. Minnesota Statutes 2017 Supplement, section 119B.011, subdivision 20, is amended to read:

Subd. 20. **Transition year families.** "Transition year families" means families who have received MFIP assistance, or who were eligible to receive MFIP assistance after choosing to discontinue receipt of the cash portion of MFIP assistance under section 256J.31, subdivision 12, or families who have received DWP assistance under section 256J.95 for at least ~~three~~ one of the last six months before losing eligibility for MFIP or DWP. Notwithstanding Minnesota Rules, parts 3400.0040, subpart 10, and 3400.0090, subpart 2, transition year child care may be used to support employment, approved education or training programs, or job search that meets the requirements of section 119B.10. Transition year child care is not available to families who have been disqualified from MFIP or DWP due to fraud.

EFFECTIVE DATE. This section is effective October 8, 2018.

Sec. 7. Minnesota Statutes 2017 Supplement, section 119B.025, subdivision 1, is amended to read:

Subdivision 1. **Applications.** (a) Except as provided in paragraph (c), clause (4), the county shall verify the following at all initial child care applications using the universal application:

(1) identity of adults;

(2) presence of the minor child in the home, if questionable;

(3) relationship of minor child to the parent, stepparent, legal guardian, eligible relative caretaker, or the spouses of any of the foregoing;

(4) age;

(5) immigration status, if related to eligibility;

(6) Social Security number, if given;

(7) counted income;

(8) spousal support and child support payments made to persons outside the household;

(9) residence; and

(10) inconsistent information, if related to eligibility.

(b) The county must mail a notice of approval or denial of assistance to the applicant within 30 calendar days after receiving the application. The county may extend the response time by 15 calendar days if the applicant is informed of the extension.

(c) For an applicant who declares that the applicant is homeless and who meets the definition of homeless in section 119B.011, subdivision 13b, the county must:

(1) if additional information is needed to determine eligibility, send a request for information to the applicant within five working days after receiving the application;

(2) if the applicant is eligible, send a notice of approval of assistance within five working days after receiving the application;

(3) if the applicant is ineligible, send a notice of denial of assistance within 30 days after receiving the application. The county may extend the response time by 15 calendar days if the applicant is informed of the extension;

(4) not require verifications required by paragraph (a) before issuing the notice of approval or denial; and

(5) follow limits set by the commissioner for how frequently expedited application processing may be used for an applicant who declares that the applicant is homeless.

(d) An applicant who declares that the applicant is homeless must submit proof of eligibility within three months of the date the application was received. If proof of eligibility is not submitted within three months, eligibility ends. A 15-day adverse action notice is required to end eligibility.

EFFECTIVE DATE. This section is effective August 12, 2019.

Sec. 8. Minnesota Statutes 2016, section 119B.03, subdivision 9, is amended to read:

Subd. 9. **Portability pool.** (a) The commissioner shall establish a pool of up to five percent of the annual appropriation for the basic sliding fee program to provide continuous child care assistance for eligible families who move between Minnesota counties. At the end of each allocation period, any unspent funds in the portability pool must be used for assistance under the basic sliding fee program. If expenditures from the portability pool exceed the amount of money available, the reallocation pool must be reduced to cover these shortages.

(b) ~~To be eligible for portable basic sliding fee assistance,~~ A family that has moved from a county in which it was receiving basic sliding fee assistance to a county with a waiting list for the basic sliding fee program must:

(1) meet the income and eligibility guidelines for the basic sliding fee program; and

(2) notify the ~~new county of residence within 60 days of moving and submit information to the new county of residence to verify eligibility for the basic sliding fee program~~ family's previous county of residence of the family's move to a new county of residence.

(c) The receiving county must:

(1) accept administrative responsibility for applicants for portable basic sliding fee assistance at the end of the two months of assistance under the Unitary Residency Act;

(2) continue portability pool basic sliding fee assistance ~~for the lesser of six months or~~ until the family is able to receive assistance under the county's regular basic sliding program; and

(3) notify the commissioner through the quarterly reporting process of any family that meets the criteria of the portable basic sliding fee assistance pool.

EFFECTIVE DATE. This section is effective October 8, 2018.

Sec. 9. Minnesota Statutes 2017 Supplement, section 119B.09, subdivision 1, is amended to read:

Subdivision 1. **General eligibility requirements.** (a) Child care services must be available to families who need child care to find or keep employment or to obtain the training or education necessary to find employment and who:

(1) have household income less than or equal to 67 percent of the state median income, adjusted for family size, at application and redetermination, and meet the requirements of section 119B.05; receive MFIP assistance; and are participating in employment and training services under chapter 256J; or

(2) have household income less than or equal to 47 percent of the state median income, adjusted for family size, at application and less than or equal to 67 percent of the state median income, adjusted for family size, at redetermination.

(b) Child care services must be made available as in-kind services.

(c) All applicants for child care assistance and families currently receiving child care assistance must be assisted and required to cooperate in establishment of paternity and enforcement of child support obligations for all children in the family at application and redetermination as a condition of program eligibility. For purposes of this section, a family is considered to meet the requirement for cooperation when the family complies with the requirements of section 256.741.

(d) All applicants for child care assistance and families currently receiving child care assistance must pay the co-payment fee under section 119B.12, subdivision 2, as a condition of eligibility. The co-payment fee may include additional recoupment fees due to a child care assistance program overpayment.

(e) If a family has one child with a child care authorization and that child reaches 13 years of age or that child has a disability and reaches 15 years of age, the family remains eligible until redetermination.

EFFECTIVE DATE. This section is effective October 8, 2018.

Sec. 10. Minnesota Statutes 2017 Supplement, section 119B.095, subdivision 2, is amended to read:

Subd. 2. **Maintain steady child care authorizations.** (a) Notwithstanding Minnesota Rules, chapter 3400, the amount of child care authorized under section 119B.10 for employment, education, or an MFIP or DWP employment plan shall continue at the same number of hours or more hours until redetermination, including:

(1) when the other parent moves in and is employed or has an education plan under section 119B.10, subdivision 3, or has an MFIP or DWP employment plan; or

(2) when the participant's work hours are reduced or a participant temporarily stops working or attending an approved education program. Temporary changes include, but are not limited to, a medical leave, seasonal employment fluctuations, or a school break between semesters.

(b) The county may increase the amount of child care authorized at any time if the participant verifies the need for increased hours for authorized activities.

(c) The county may reduce the amount of child care authorized if a parent requests a reduction or because of a change in:

(1) the child's school schedule;

(2) the custody schedule; or

(3) the provider's availability.

(d) When a child reaches 13 years of age or a child with a disability reaches 15 years of age, the amount of child care authorized shall continue at the same number of hours or more hours until redetermination.

~~(d)~~ (e) The amount of child care authorized for a family subject to subdivision 1, paragraph (b), must change when the participant's activity schedule changes. Paragraph (a) does not apply to a family subject to subdivision 1, paragraph (b).

EFFECTIVE DATE. This section is effective October 8, 2018.

Sec. 11. Minnesota Statutes 2016, section 119B.125, subdivision 1b, is amended to read:

Subd. 1b. **Training required.** (a) ~~Effective November 1, 2011, prior to~~ Before initial authorization as required in subdivision 1, a legal nonlicensed ~~family~~ child care provider must complete pediatric first aid and CPR training and provide the verification of the pediatric first aid and CPR training to the county. The training documentation must have valid effective dates as of the date the registration request is submitted to the county~~.~~ and the training must have been provided by an individual approved to provide pediatric first aid and CPR instruction and have included CPR techniques for infants and children.

(b) A legal nonlicensed ~~family child care providers with an authorization effective before November 1, 2011, must be notified of the requirements before October 1, 2011, or at authorization, and must meet the requirements upon renewal of an authorization that occurs on or after January 1, 2012.~~ related provider must:

(1) complete training on abusive head trauma before being authorized for a child through four years of age; and

(2) complete training on reducing the risk of sudden unexpected infant death before being authorized for a child younger than 12 months old.

(c) A legal nonlicensed unrelated provider must:

(1) complete training on abusive head trauma before being authorized for a child through four years of age;

(2) complete training on reducing the risk of sudden unexpected infant death before being authorized for a child younger than 12 months old; and

(3) complete a child care provider orientation class, or equivalent training approved by the commissioner, within 90 days after initial authorization. The commissioner must develop the child care provider orientation class, which must include training on maintaining health, safety, and fire standards.

~~(c)~~ (d) Upon each reauthorization ~~after the authorization period when the initial first aid and CPR training requirements are met~~, a legal nonlicensed ~~family child care~~ unrelated provider must ~~provide verification of at least eight hours of additional training listed in the~~

~~Minnesota Center for Professional Development Registry.~~ complete training on the topics in paragraph (c), clause (3).

~~(d) This subdivision only applies to legal nonlicensed family child care providers.~~

EFFECTIVE DATE. This section is effective September 24, 2018.

Sec. 12. Minnesota Statutes 2016, section 119B.125, is amended by adding a subdivision to read:

Subd. 10. **Reporting required for child safety.** A legal nonlicensed provider must report to the county agency a death, serious injury, or instance of substantiated child abuse that occurred while a child was in the legal nonlicensed provider's care. A county agency shall report to the commissioner, in a manner prescribed by the commissioner, the number of deaths, serious injuries, and instances of substantiated child abuse that occurred in all legal nonlicensed child care providers care in the county.

EFFECTIVE DATE. This section is effective September 24, 2018.

Sec. 13. Minnesota Statutes 2016, section 119B.125, is amended by adding a subdivision to read:

Subd. 11. **Emergency preparedness plan.** A legal nonlicensed provider must have a written emergency preparedness plan for an emergency. The commissioner shall develop a form for a provider to create a written emergency preparedness plan.

EFFECTIVE DATE. This section is effective September 24, 2018.

Sec. 14. Minnesota Statutes 2016, section 119B.125, is amended by adding a subdivision to read:

Subd. 12. **Compliance with health and safety requirements.** (a) The commissioner must establish health, safety, and fire standards specific to a legal nonlicensed unrelated provider. The commissioner must develop a: (1) tool for a county agency to conduct an annual inspection of a legal nonlicensed unrelated provider; (2) process for a legal nonlicensed unrelated provider to correct violations of the health, safety, and fire standards; and (3) process to revoke authorization of a legal nonlicensed unrelated provider if the provider fails to correct violations of the health, safety, and fire standards.

(b) A county agency must conduct at least one inspection annually of each legal nonlicensed unrelated provider. The county agency must be given access to the physical facility and grounds where care is provided and to children cared for by the legal nonlicensed

unrelated provider. The county agency must be given access without prior notice and as often as the county agency considers necessary if the county agency is investigating alleged maltreatment, conducting an inspection, or investigating an alleged violation of applicable laws or rules. A provider's failure to give access to the county agency may result in termination of the legal nonlicensed unrelated provider's authorization to care for a child receiving child care assistance under this section.

EFFECTIVE DATE. This section is effective September 24, 2018.

Sec. 15. Minnesota Statutes 2017 Supplement, section 119B.13, subdivision 6, is amended to read:

Subd. 6. **Provider payments.** (a) The provider shall bill for services provided within ten days of the end of the service period. Payments under the child care fund shall be made within 21 days of receiving a complete bill from the provider. Counties or the state may establish policies that make payments on a more frequent basis.

(b) If a provider has received an authorization of care and been issued a billing form for an eligible family, the bill must be submitted within 60 days of the last date of service on the bill. A bill submitted more than 60 days after the last date of service must be paid if the county determines that the provider has shown good cause why the bill was not submitted within 60 days. Good cause must be defined in the county's child care fund plan under section 119B.08, subdivision 3, and the definition of good cause must include county error. Any bill submitted more than a year after the last date of service on the bill must not be paid.

(c) If a provider provided care for a time period without receiving an authorization of care and a billing form for an eligible family, payment of child care assistance may only be made retroactively for a maximum of six months from the date the provider is issued an authorization of care and billing form.

(d) A county or the commissioner may refuse to issue a child care authorization to a licensed or legal nonlicensed provider, revoke an existing child care authorization to a licensed or legal nonlicensed provider, stop payment issued to a licensed or legal nonlicensed provider, or refuse to pay a bill submitted by a licensed or legal nonlicensed provider if:

(1) the provider admits to intentionally giving the county materially false information on the provider's billing forms;

(2) a county or the commissioner finds by a preponderance of the evidence that the provider intentionally gave the county materially false information on the provider's billing forms, or provided false attendance records to a county or the commissioner;

(3) the provider is in violation of child care assistance program rules, until the agency determines those violations have been corrected;

(4) the provider is operating after:

(i) an order of suspension of the provider's license issued by the commissioner; or

(ii) an order of revocation of the provider's license; ~~or~~

~~(iii) a final order of conditional license issued by the commissioner for as long as the conditional license is in effect;~~

(5) the provider submits false attendance reports or refuses to provide documentation of the child's attendance upon request; ~~or~~

(6) the provider gives false child care price information~~.~~; or

(7) the provider fails to grant access to a county or the commissioner during regular business hours to examine all records necessary to determine the extent of services provided to a child care assistance recipient and the appropriateness of a claim for payment.

(e) If a county or the commissioner finds that a provider violated paragraph (d), clause (1) or (2), a county or the commissioner must deny or revoke the provider's authorization and either pursue a fraud disqualification under section 256.98, subdivision 8, paragraph (c), or refer the case to a law enforcement authority. A provider's rights related to an authorization denial or revocation under this paragraph are established in section 119B.161. If a provider's authorization is denied or revoked under this paragraph, the denial or revocation lasts until either:

(1) all criminal, civil, and administrative proceedings related to the provider's alleged misconduct conclude and any appeal rights are exhausted; or

(2) the commissioner decides, based on written evidence or argument submitted under section 119B.161, to authorize the provider.

(f) If a county or the commissioner denies or revokes a provider's authorization under paragraph (d), clause (4), the provider shall not be authorized until the order of suspension or order of revocation against the provider is lifted.

~~(e) For purposes of~~ (g) If a county or the commissioner finds that a provider violated paragraph (d), ~~clauses~~ clause (3), (5), ~~and~~ or (6), the county or the commissioner may

~~withhold~~ deny or revoke the provider's authorization ~~or payment for a period of time not to exceed three months beyond the time the condition has been corrected~~. If a provider's authorization is denied or revoked under this paragraph, the denial or revocation may last up to 90 days from the date a county or the commissioner denies or revokes the provider's authorization.

(h) If a county or the commissioner finds that a provider violated paragraph (d), clause (7), a county or the commissioner must deny or revoke the provider's authorization until a county or the commissioner determines whether the records sought comply with this chapter and chapter 245E. The provider's rights related to an authorization denial or revocation under this paragraph are established in section 119B.161.

~~(f)~~ (i) A county's payment policies must be included in the county's child care plan under section 119B.08, subdivision 3. If payments are made by the state, in addition to being in compliance with this subdivision, the payments must be made in compliance with section 16A.124.

EFFECTIVE DATE. This section is effective August 12, 2019.

Sec. 16. Minnesota Statutes 2016, section 119B.16, subdivision 1, is amended to read:

Subdivision 1. **Fair hearing allowed for applicants and recipients.** (a) An applicant or recipient adversely affected by an action of a county agency ~~action~~ or the commissioner may request and shall receive a fair hearing in accordance with this subdivision and section 256.045.

(b) A county agency must offer an informal conference to an applicant or recipient who is entitled to a fair hearing under this section. A county agency shall advise an adversely affected applicant or recipient that a request for a conference is optional and does not delay or replace the right to a fair hearing.

(c) An applicant or recipient does not have a right to a fair hearing if a county agency or the commissioner takes action against a provider.

(d) If a provider's authorization is suspended, denied, or revoked, a county agency or the commissioner must mail notice to a child care assistance program recipient receiving care from the provider.

EFFECTIVE DATE. This section is effective August 12, 2019.

Sec. 17. Minnesota Statutes 2016, section 119B.16, subdivision 1a, is amended to read:

Subd. 1a. **Fair hearing allowed for providers.** (a) This subdivision applies to providers caring for children receiving child care assistance.

~~(b) A provider to whom a county agency has assigned responsibility for an overpayment may request a fair hearing in accordance with section 256.045 for the limited purpose of challenging the assignment of responsibility for the overpayment and the amount of the overpayment. The scope of the fair hearing does not include the issues of whether the provider wrongfully obtained public assistance in violation of section 256.98 or was properly disqualified under section 256.98, subdivision 8, paragraph (c), unless the fair hearing has been combined with an administrative disqualification hearing brought against the provider under section 256.046.~~

(b) A provider may request a fair hearing only as specified in this subdivision.

(c) A provider may request a fair hearing according to sections 256.045 and 256.046 if a county agency or the commissioner:

(1) denies or revokes a provider's authorization, unless the action entitles the provider to a consolidated contested case hearing under section 119B.16, subdivision 3, or an administrative review under section 119B.161;

(2) assigns responsibility for an overpayment to a provider under section 119B.11, subdivision 2a;

(3) establishes an overpayment for failure to comply with section 119B.125, subdivision 6;

(4) seeks monetary recovery or recoupment under section 245E.02, subdivision 4, paragraph (c), item (2);

(5) initiates an administrative fraud disqualification hearing; or

(6) issues a payment and the provider disagrees with the amount of the payment.

(d) A provider may request a fair hearing by submitting a written request to the Department of Human Services, Appeals Division. A provider's request must be received by the Appeals Division no later than 30 days after the date a county or the commissioner mails the notice. The provider's appeal request must contain the following:

(1) each disputed item, the reason for the dispute, and, if appropriate, an estimate of the dollar amount involved for each disputed item;

(2) the computation the provider believes to be correct, if appropriate;

(3) the statute or rule relied on for each disputed item; and

(4) the name, address, and telephone number of the person at the provider's place of business with whom contact may be made regarding the appeal.

EFFECTIVE DATE. This section is effective August 12, 2019.

Sec. 18. Minnesota Statutes 2016, section 119B.16, subdivision 1b, is amended to read:

Subd. 1b. **Joint fair hearings.** ~~When a provider requests a fair hearing under subdivision 1a, the family in whose case the overpayment was created must be made a party to the fair hearing. All other issues raised by the family must be resolved in the same proceeding. When a family requests a fair hearing and claims that the county should have assigned responsibility for an overpayment to a provider, the provider must be made a party to the fair hearing.~~ The human services judge assigned to a fair hearing may join a family or a provider as a party to the fair hearing whenever joinder of that party is necessary to fully and fairly resolve ~~overpayment~~ issues raised in the appeal.

EFFECTIVE DATE. This section is effective August 12, 2019.

Sec. 19. Minnesota Statutes 2016, section 119B.16, is amended by adding a subdivision to read:

Subd. 1c. **Notice to providers.** (a) Before taking an action appealable under subdivision 1a, paragraph (c), a county agency or the commissioner must mail written notice to the provider against whom the action is being taken.

(b) The notice must state:

(1) the factual basis for the department's determination;

(2) the action the department intends to take;

(3) the dollar amount of the monetary recovery or recoupment, if known; and

(4) the provider's right to appeal the department's proposed action.

(c) Unless otherwise specified under chapter 119B or 245E or Minnesota Rules, chapter 3400, a county agency or the commissioner must mail the written notice at least 15 calendar days before the adverse action's effective date.

EFFECTIVE DATE. This section is effective August 12, 2019.

Sec. 20. Minnesota Statutes 2016, section 119B.16, is amended by adding a subdivision to read:

Subd. 3. **Consolidated contested case hearing.** If a county agency or the commissioner denies or revokes a provider's authorization based on a licensing action, the provider may only appeal the denial or revocation in the same contested case proceeding that the provider appeals the licensing action.

EFFECTIVE DATE. This section is effective August 12, 2019.

Sec. 21. Minnesota Statutes 2016, section 119B.16, is amended by adding a subdivision to read:

Subd. 4. **Final department action.** Unless the commissioner receives a timely and proper request for an appeal, a county agency's or the commissioner's action shall be considered a final department action.

EFFECTIVE DATE. This section is effective August 12, 2019.

Sec. 22. **[119B.161] ADMINISTRATIVE REVIEW.**

Subdivision 1. **Temporary suspension of payment or denial or revocation of authorization.** A provider has the rights listed under this section if: (1) a payment is suspended under chapter 245E; or (2) the provider's authorization is denied or revoked under section 119B.13, subdivision 6, paragraph (d), clause (1), (2), or (7). Unless the commissioner receives a timely and proper request for an appeal, a county's or the commissioner's action is a final department action.

Subd. 2. **Notice.** (a) A county or the commissioner must mail a provider notice within five days of denial or revocation of a provider's authorization or suspension of the provider's payment under subdivision 1.

(b) The notice must:

(1) state the provision under which a county or the commissioner denied or revoked a provider's authorization or suspended payment to the provider;

(2) set forth the general allegations leading to the denial or revocation of a provider's authorization or suspension of the provider's payment. The notice need not disclose any specific information concerning an ongoing investigation;

(3) state that the denial or revocation of a provider's authorization or suspension of the provider's payment is for a temporary period and explain the circumstances under which the action expires; and

(4) inform the provider of the right to submit written evidence and argument for consideration by the commissioner.

(c) Notwithstanding Minnesota Rules, part 3400.0185, if a county or the commissioner suspended payment to a provider under chapter 245E or denied or revoked a provider's authorization under section 119B.13, subdivision 6, paragraph (d), clause (1), (2), or (7), a county or the commissioner must send notice of service authorization closure to an affected family. The notice sent to an affected family is effective on the date the notice is created.

Subd. 3. **Duration.** If a provider's payment is suspended under chapter 245E or a provider's authorization is denied or revoked under section 119B.13, subdivision 6, paragraph (d), clause (1), (2), or (7), the provider's suspension, denial, or revocation remains in effect until:

(1) the commissioner or a law enforcement authority determines that there is insufficient evidence warranting the action and a county or the commissioner does not pursue an additional administrative remedy under chapter 245E or section 256.98; or

(2) all criminal, civil, and administrative proceedings related to the provider's alleged misconduct conclude and any appeal rights are exhausted.

Subd. 4. **Good cause exception.** The commissioner may find that good cause exists not to suspend payment to a provider or deny or revoke a provider's authorization, or not to continue a suspension of payment or denial or revocation of a provider's authorization if any of the following are applicable:

(1) a law enforcement authority specifically requested that payment to a provider not be suspended or a provider's authorization not be denied or revoked because the action may compromise an ongoing investigation;

(2) the commissioner determines that the suspension of the provider's payment or the denial or revocation of the provider's authorization should be removed based on the provider's written submission; or

(3) the commissioner determines that the suspension of payment or the denial or revocation of a provider's authorization is not in the best interests of the program.

EFFECTIVE DATE. This section is effective August 12, 2019.

Sec. 23. Minnesota Statutes 2016, section 245C.02, is amended by adding a subdivision to read:

Subd. 13c. **National criminal history record check.** (a) "National criminal history record check" means a check of records maintained by the Federal Bureau of Investigation through submission of fingerprints through the Minnesota Bureau of Criminal Apprehension to the Federal Bureau of Investigation when specifically required by law.

(b) For purposes of this chapter, "national crime information database," "national criminal records repository," "criminal history with the Federal Bureau of Investigation," and "national criminal record check" mean a national criminal history record check defined in paragraph (a).

Sec. 24. Minnesota Statutes 2016, section 245C.12, is amended to read:

245C.12 BACKGROUND STUDY; TRIBAL ORGANIZATIONS.

(a) For the purposes of background studies completed by tribal organizations performing licensing activities otherwise required of the commissioner under this chapter, after obtaining consent from the background study subject, tribal licensing agencies shall have access to criminal history data in the same manner as county licensing agencies and private licensing agencies under this chapter.

(b) Tribal organizations may contract with the commissioner to obtain background study data on individuals under tribal jurisdiction related to adoptions according to section 245C.34. Tribal organizations may also contract with the commissioner to obtain background study data on individuals under tribal jurisdiction related to child foster care according to section 245C.34.

(c) For the purposes of background studies completed to comply with a tribal organization's licensing requirements for individuals affiliated with a tribally licensed nursing facility, the commissioner shall obtain criminal history data from the National Criminal Records Repository in accordance with section 245C.32.

(d) Tribal organizations may contract with the commissioner to conduct background studies or obtain background study data on individuals affiliated with a child care program sponsored, managed, or licensed by a tribal organization. Studies conducted under this paragraph require the commissioner to conduct a national criminal history record check as defined in section 245C.02, subdivision 13c. Any tribally affiliated child care program that does not contract with the commissioner to conduct background studies is exempt from the relevant requirements in this chapter. A study conducted under this paragraph must include

all components of studies for certified license-exempt child care centers under this chapter to be transferable to other child care entities.

Sec. 25. **[245C.121] BACKGROUND STUDY; HEAD START PROGRAMS.**

Head Start programs that receive funding disbursed under section 119A.52 may contract with the commissioner to conduct background studies and obtain background study data on individuals affiliated with a Head Start program. Studies conducted under this paragraph require the commissioner to conduct a national criminal history record check as defined in section 245C.02, subdivision 13c. Any Head Start program site that does not contract with the commissioner, is not licensed, and is not registered to receive funding under chapter 119B is exempt from the relevant requirements in this chapter. Nothing in this paragraph supersedes requirements for background studies in this chapter, chapter 119B, or child care centers under chapter 245H that are related to licensed child care programs or programs registered to receive funding under chapter 119B. A study conducted under this paragraph must include all components of studies for certified license-exempt child care centers under this chapter to be transferable to other child care entities.

Sec. 26. Minnesota Statutes 2016, section 245E.03, subdivision 2, is amended to read:

Subd. 2. **Failure to provide access.** ~~Failure to provide access may result in denial or termination of authorizations for or payments to a recipient, provider, license holder, or controlling individual in the child care assistance program.~~ A provider, license holder, controlling individual, employee, or staff member must grant the department access during any hours that the program is open to examine the provider's program or the records listed in section 245E.05. A provider shall make records immediately available at the provider's place of business at the time the department requests access, unless the provider and the department both agree otherwise.

EFFECTIVE DATE. This section is effective August 12, 2019.

Sec. 27. Minnesota Statutes 2016, section 245E.03, subdivision 4, is amended to read:

Subd. 4. **Continued or repeated failure to provide access.** If the provider continues to fail to provide access at the expiration of the 15-day notice period, child care assistance program payments to the provider must ~~be denied beginning~~ end on the 16th day following notice of the initial failure or refusal to provide access. ~~The department may rescind the denial based upon good cause if the provider submits in writing a good cause basis for having failed or refused to provide access. The writing must be postmarked no later than~~

~~the 15th day following the provider's notice of initial failure to provide access.~~ A provider's, license holder's, controlling individual's, employee's, staff member's, or recipient's duty to provide access in this section continues after the provider's authorization is suspended, denied, or revoked. Additionally, the provider, license holder, or controlling individual must immediately provide complete, ongoing access to the department. Repeated failures to provide access must, after the initial failure or for any subsequent failure, result in termination from participation in the child care assistance program.

EFFECTIVE DATE. This section is effective August 12, 2019.

Sec. 28. Minnesota Statutes 2016, section 245E.06, subdivision 3, is amended to read:

Subd. 3. **Appeal of department ~~sanction~~ action.** ~~(a) If the department does not pursue a criminal action against a provider, license holder, controlling individual, or recipient for financial misconduct, but the department imposes an administrative sanction under section 245E.02, subdivision 4, paragraph (c), any individual or entity against whom the sanction was imposed may appeal the department's administrative sanction under this section pursuant to section 119B.16 or 256.045 with the additional requirements in clauses (1) to (4). An appeal must specify:~~

~~(1) each disputed item, the reason for the dispute, and an estimate of the dollar amount involved for each disputed item, if appropriate;~~

~~(2) the computation that is believed to be correct, if appropriate;~~

~~(3) the authority in the statute or rule relied upon for each disputed item; and~~

~~(4) the name, address, and phone number of the person at the provider's place of business with whom contact may be made regarding the appeal.~~

~~(b) Notwithstanding section 245E.03, subdivision 4, an appeal is considered timely only if postmarked or received by the department's Appeals Division within 30 days after receiving a notice of department sanction.~~

~~(c) Before the appeal hearing, the department may deny or terminate authorizations or payment to the entity or individual if the department determines that the action is necessary to protect the public welfare or the interests of the child care assistance program.~~

A provider's rights related to an action taken under this chapter are established in sections 119B.16 and 119B.161.

EFFECTIVE DATE. This section is effective August 12, 2019.

Sec. 29. Minnesota Statutes 2016, section 518A.51, is amended to read:

518A.51 FEES FOR IV-D SERVICES.

(a) When a recipient of IV-D services is no longer receiving assistance under the state's title IV-A, IV-E foster care, or medical assistance programs, the public authority responsible for child support enforcement must notify the recipient, within five working days of the notification of ineligibility, that IV-D services will be continued unless the public authority is notified to the contrary by the recipient. The notice must include the implications of continuing to receive IV-D services, including the available services and fees, cost recovery fees, and distribution policies relating to fees.

(b) In the case of an individual who has never received assistance under a state program funded under title IV-A of the Social Security Act and for whom the public authority has collected at least ~~$500~~ $550 of support, the public authority must impose an annual federal collections fee of $25 for each case in which services are furnished. This fee must be retained by the public authority from support collected on behalf of the individual, but not from the first ~~$500~~ $550 collected.

(c) When the public authority provides full IV-D services to an obligee who has applied for those services, upon written notice to the obligee, the public authority must charge a cost recovery fee of two percent of the amount collected. This fee must be deducted from the amount of the child support and maintenance collected and not assigned under section 256.741 before disbursement to the obligee. This fee does not apply to an obligee who:

(1) is currently receiving assistance under the state's title IV-A, IV-E foster care, or medical assistance programs; or

(2) has received assistance under the state's title IV-A or IV-E foster care programs, until the person has not received this assistance for 24 consecutive months.

(d) When the public authority provides full IV-D services to an obligor who has applied for such services, upon written notice to the obligor, the public authority must charge a cost recovery fee of two percent of the monthly court-ordered child support and maintenance obligation. The fee may be collected through income withholding, as well as by any other enforcement remedy available to the public authority responsible for child support enforcement.

(e) Fees assessed by state and federal tax agencies for collection of overdue support owed to or on behalf of a person not receiving public assistance must be imposed on the person for whom these services are provided. The public authority upon written notice to

the obligee shall assess a fee of $25 to the person not receiving public assistance for each successful federal tax interception. The fee must be withheld prior to the release of the funds received from each interception and deposited in the general fund.

(f) Federal collections fees collected under paragraph (b) and cost recovery fees collected under paragraphs (c) and (d) retained by the commissioner of human services shall be considered child support program income according to Code of Federal Regulations, title 45, section 304.50, and shall be deposited in the special revenue fund account established under paragraph (h). The commissioner of human services must elect to recover costs based on either actual or standardized costs.

(g) The limitations of this section on the assessment of fees shall not apply to the extent inconsistent with the requirements of federal law for receiving funds for the programs under title IV-A and title IV-D of the Social Security Act, United States Code, title 42, sections 601 to 613 and United States Code, title 42, sections 651 to 662.

(h) The commissioner of human services is authorized to establish a special revenue fund account to receive the federal collections fees collected under paragraph (b) and cost recovery fees collected under paragraphs (c) and (d).

(i) The nonfederal share of the cost recovery fee revenue must be retained by the commissioner and distributed as follows:

(1) one-half of the revenue must be transferred to the child support system special revenue account to support the state's administration of the child support enforcement program and its federally mandated automated system;

(2) an additional portion of the revenue must be transferred to the child support system special revenue account for expenditures necessary to administer the fees; and

(3) the remaining portion of the revenue must be distributed to the counties to aid the counties in funding their child support enforcement programs.

(j) The nonfederal share of the federal collections fees must be distributed to the counties to aid them in funding their child support enforcement programs.

(k) The commissioner of human services shall distribute quarterly any of the funds dedicated to the counties under paragraphs (i) and (j) using the methodology specified in section 256.979, subdivision 11. The funds received by the counties must be reinvested in the child support enforcement program and the counties must not reduce the funding of their child support programs by the amount of the funding distributed.

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

Sec. 30. **REPEALER.**

(a) Minnesota Statutes 2016, section 119B.125, subdivision 5, is repealed the day following final enactment.

(b) Minnesota Statutes 2016, sections 119B.16, subdivision 2; 245E.03, subdivision 3; and 245E.06, subdivisions 2, 4, and 5, and Minnesota Rules, part 3400.0185, subpart 5, are repealed effective August 12, 2019.

ARTICLE 3

CHEMICAL AND MENTAL HEALTH SERVICES

Section 1. Minnesota Statutes 2017 Supplement, section 245.4889, subdivision 1, is amended to read:

Subdivision 1. **Establishment and authority.** (a) The commissioner is authorized to make grants from available appropriations to assist:

(1) counties;

(2) Indian tribes;

(3) children's collaboratives under section 124D.23 or 245.493; or

(4) mental health service providers.

(b) The following services are eligible for grants under this section:

(1) services to children with emotional disturbances as defined in section 245.4871, subdivision 15, and their families;

(2) transition services under section 245.4875, subdivision 8, for young adults under age 21 and their families;

(3) respite care services for children with severe emotional disturbances who are at risk of out-of-home placement;

(4) children's mental health crisis services;

(5) mental health services for people from cultural and ethnic minorities;

(6) children's mental health screening and follow-up diagnostic assessment and treatment;

(7) services to promote and develop the capacity of providers to use evidence-based practices in providing children's mental health services;

(8) school-linked mental health services, including transportation for children receiving school-linked mental health services when school is not in session;

(9) building evidence-based mental health intervention capacity for children birth to age five;

(10) suicide prevention and counseling services that use text messaging statewide;

(11) mental health first aid training;

(12) training for parents, collaborative partners, and mental health providers on the impact of adverse childhood experiences and trauma and development of an interactive Web site to share information and strategies to promote resilience and prevent trauma;

(13) transition age services to develop or expand mental health treatment and supports for adolescents and young adults 26 years of age or younger;

(14) early childhood mental health consultation;

(15) evidence-based interventions for youth at risk of developing or experiencing a first episode of psychosis, and a public awareness campaign on the signs and symptoms of psychosis;

(16) psychiatric consultation for primary care practitioners; and

(17) providers to begin operations and meet program requirements when establishing a new children's mental health program. These may be start-up grants.

(c) Services under paragraph (b) must be designed to help each child to function and remain with the child's family in the community and delivered consistent with the child's treatment plan. Transition services to eligible young adults under this paragraph must be designed to foster independent living in the community.

(d) As a condition of receiving grant funds a grantee must obtain all available third-party reimbursement sources, if applicable.

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

Sec. 2. Minnesota Statutes 2016, section 245.4889, is amended by adding a subdivision to read:

Subd. 1a. **School-linked mental health grants.** (a) An eligible applicant for school-linked mental health services grants under subdivision 1, paragraph (b), clause (8), is an entity that is:

(1) certified under Minnesota Rules, parts 9520.0750 to 9520.0870;

(2) a community mental health center under section 256B.0625, subdivision 5;

(3) an Indian health service facility or facility owned and operated by a tribe or tribal organization operating under United States Code, title 25, section 5321;

(4) a provider of children's therapeutic services and supports as defined in section 256B.0943; or

(5) enrolled in medical assistance as a mental health or substance use disorder provider agency and employs at least two full-time equivalent mental health professionals as defined in section 245.4871, subdivision 27, clauses (1) to (6), or two alcohol and drug counselors licensed or exempt from licensure under chapter 148F who are qualified to provide clinical services to children and families.

(b) The commissioner shall consult with school districts when selecting school-linked mental health services grantees and shall ensure access to school-linked mental health services in both urban and rural areas.

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

Sec. 3. Minnesota Statutes 2017 Supplement, section 254A.03, subdivision 3, is amended to read:

Subd. 3. **Rules for substance use disorder care.** (a) The commissioner of human services shall establish by rule criteria to be used in determining the appropriate level of chemical dependency care for each recipient of public assistance seeking treatment for substance misuse or substance use disorder. Upon federal approval of a comprehensive assessment as a Medicaid benefit, or on July 1, 2018, whichever is later, and notwithstanding the criteria in Minnesota Rules, parts 9530.6600 to 9530.6655, an eligible vendor of comprehensive assessments under section 254B.05 may determine and approve the appropriate level of substance use disorder treatment for a recipient of public assistance. The process for determining an individual's financial eligibility for the consolidated chemical dependency treatment fund or determining an individual's enrollment in or eligibility for a publicly subsidized health plan is not affected by the individual's choice to access a comprehensive assessment for placement.

(b) The commissioner shall develop and implement a utilization review process for publicly funded treatment placements to monitor and review the clinical appropriateness and timeliness of all publicly funded placements in treatment.

(c) A structured assessment for alcohol or substance use disorder that is provided to a recipient of public assistance by a primary care clinic, hospital, or other medical setting

establishes medical necessity and approval for an initial set of substance use disorder services identified in section 254B.05, subdivision 5, when the screen result is positive for alcohol or substance misuse. The initial set of services approved for a recipient whose screen result is positive shall include four hours of individual or group substance use disorder treatment, two hours of substance use disorder care coordination, and two hours of substance use disorder peer support services. A recipient must obtain an assessment pursuant to paragraph (a) to be approved for additional treatment services.

EFFECTIVE DATE. This section is effective July 1, 2018, contingent on federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained or denied.

Sec. 4. Minnesota Statutes 2016, section 254B.02, subdivision 1, is amended to read:

Subdivision 1. **Chemical dependency treatment allocation.** The chemical dependency treatment appropriation shall be placed in a special revenue account. ~~The commissioner shall annually transfer funds from the chemical dependency fund to pay for operation of the drug and alcohol abuse normative evaluation system and to pay for all costs incurred by adding two positions for licensing of chemical dependency treatment and rehabilitation programs located in hospitals for which funds are not otherwise appropriated.~~ The ~~remainder of the~~ money in the special revenue account must be used according to the requirements in this chapter.

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

Sec. 5. Minnesota Statutes 2016, section 254B.06, subdivision 1, is amended to read:

Subdivision 1. **State collections.** The commissioner is responsible for all collections from persons determined to be partially responsible for the cost of care of an eligible person receiving services under Laws 1986, chapter 394, sections 8 to 20. The commissioner may initiate, or request the attorney general to initiate, necessary civil action to recover the unpaid cost of care. The commissioner may collect all third-party payments for chemical dependency services provided under Laws 1986, chapter 394, sections 8 to 20, including private insurance and federal Medicaid and Medicare financial participation. ~~The commissioner shall deposit in a dedicated account a percentage of collections to pay for the cost of operating the chemical dependency consolidated treatment fund invoice processing and vendor payment system, billing, and collections.~~ The ~~remaining~~ receipts must be deposited in the chemical dependency fund.

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

Sec. 6. **INTEGRATED LOCAL RESPONSE TO THE OPIOID CRISIS GRANT PROGRAM.**

Subdivision 1. **Definitions.** For purposes of this section, the following terms have the meanings given them.

(a) "Commissioner" means the commissioner of human services.

(b) "Sectors" refers to the various health care providers, mental health and substance use disorder treatment providers, public health-related entities, child protection groups, law enforcement agencies, courts, community groups, schools, and others that have a role in a local response to the opioid crisis.

(c) "Integrated local response" means an activity that requires coordination between two or more sectors to serve specific groups of individuals with chronic opioid analgesia use or opioid use disorder to improve outcomes in a community.

Subd. 2. **Establishment.** (a) The commissioner shall implement a grant program to support an integrated local response to the opioid crisis.

(b) A grantee must match state funding received under this program with local in-kind or fiscal resources and must collaborate with at least one local partner from a different sector.

(c) At the outset of the program, a grantee must identify where the grantee and the grantee's local partner are on a local integration continuum as defined by the commissioner and tailor the program as needed to meet the needs of individual communities. A grantee must increase the extent of the integrated local response during the course of the grant.

Subd. 3. **Grant awards.** (a) The commissioner shall award four-year grants to eligible applicants to support integrated local responses to the opioid crisis with priority given to applicants serving communities that are suffering disparities in health outcomes related to the opioid crisis. In determining grant awards, the commissioner shall consider health disparities and inequities attributed to individuals living in the community who are served by a local partner. The commissioner may award up to 20 percent of the appropriation to fund one or more contractors to provide technical assistance and other support to grantees.

(b) Grant awards must support integration of services and supports to address the opioid crisis. Grantees may use funding to hire project staff.

Subd. 4. **Eligibility.** Grantees may be tribal and local governments, health care providers, mental health and substance use disorder treatment providers, or nonprofit social service

and cultural agencies. A grantee must serve as a fiscal agent for the grantee's local partner from a different sector.

Subd. 5. **Domains.** A grantee must address one or more domains of the opioid crisis that are most relevant to the grantee's community. The domains are optimizing integrated local response:

(1) for pregnant women and newborns and support for their recovery from opioid use disorder and other substance use disorders including implementation of plans of safe care for the mother and newborn;

(2) for reducing chronic opioid analgesia for individuals at high risk of opioid dependence or who are identified as having opioid use disorder;

(3) for opioid use disorder and other substance use disorders for individuals involved with the criminal justice system before, during, and after confinement in a correctional facility, as defined in Minnesota Statutes, section 241.33, subdivision 3, including individuals convicted of drug-related offenses who are diverted to treatment and individuals previously incarcerated; or

(4) for opioid use disorder and other substance use disorders for other populations.

Subd. 6. **Reports.** The commissioner shall issue an interim report and a final report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance on the progress of this grant program. The reports must include data on grantees' progress toward optimizing integrated local response capacity and outcomes relevant to each of the domains. Outcomes must relate to the domains chosen by the grantees and may include the number or rate of out-of-home placements for newborns, changes in chronic opioid analgesia use, and treatment outcomes of opioid use disorder in previously incarcerated populations. The interim report is due September 15, 2020, and the final report is due six months following the expenditure of all appropriated funds.

Subd. 7. **Expiration.** This section expires June 30, 2022, or six months after appropriated funds are expended, whichever is later.

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

ARTICLE 4

CONTINUING CARE

Section 1. **[256M.42] ADULT PROTECTION GRANT ALLOCATION.**

Subdivision 1. **Formula.** The commissioner shall allocate state funds appropriated under this section each calendar year to each county board or tribal government in an amount determined according to the following formula:

(1) 25 percent must be distributed on the basis of the number of reports of suspected vulnerable adult maltreatment under sections 626.557 and 626.5572, when the county or tribe is the lead investigative agency responsible, as determined by the most recent data of the commissioner; and

(2) 75 percent must be distributed on the basis of the number of screened-in reports for adult protective services or vulnerable adult maltreatment investigation under sections 626.557 and 626.5572 by the county or tribe, as determined by the most recent data of the commissioner.

Subd. 2. **Payment.** The commissioner shall make allocations under subdivision 1 to each county board or tribal government on or before July 10 of each calendar year.

Subd. 3. **Prohibition on supplanting existing funds.** Funds received under this section must be used for staffing for protection of vulnerable adults or to expand adult protective services. Funds must not be used to supplant current county or tribe expenditures for these purposes.

ARTICLE 5

COMMUNITY SUPPORTS

Section 1. Minnesota Statutes 2016, section 256B.0659, is amended by adding a subdivision to read:

Subd. 32. **Rate increase for personal care assistance services, community first services and supports, consumer-directed community supports, and consumer support grant program.** The commissioner of human services shall increase reimbursement rates, individual budgets, grants, and allocations by 1.69 percent for services provided on or after July 1, 2018, in personal care assistance services under this section; community first services and supports under section 256B.85; consumer-directed community supports under sections 256B.0913, subdivision 5, 256B.0915, subdivision 1, 256B.092, subdivision 5, and 256B.49, subdivision 11; and the consumer support grant program under section 256.476.

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

Sec. 2. Minnesota Statutes 2016, section 256B.439, is amended by adding a subdivision to read:

Subd. 8. **Calculation of disability waiver rates system services quality add-on.** (a) For services with rates determined under the disability waiver rates system in section 256B.4914, the quality add-on required under subdivision 7 shall be applied to the rate calculations in section 256B.4914, subdivisions 6 to 9, until the first application of the inflationary adjustments required under section 256B.4914, subdivision 5, paragraphs (h) and (i).

(b) For services with rates determined under the disability waiver rates system in section 256B.4914 and subject to rate stabilization under section 256B.4913, the quality add-on required under subdivision 7 shall be applied to the historical rates calculated in section 256B.4913, subdivision 4a, paragraph (b), until the end of the rate stabilization period.

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

Sec. 3. Minnesota Statutes 2017 Supplement, section 256B.4914, subdivision 5, is amended to read:

Subd. 5. **Base wage index and standard component values.** (a) The base wage index is established to determine staffing costs associated with providing services to individuals receiving home and community-based services. For purposes of developing and calculating the proposed base wage, Minnesota-specific wages taken from job descriptions and standard occupational classification (SOC) codes from the Bureau of Labor Statistics as defined in the most recent edition of the Occupational Handbook must be used. The base wage index must be calculated as follows:

(1) for residential direct care staff, the sum of:

(i) 15 percent of the subtotal of 50 percent of the median wage for personal and home health aide (SOC code 39-9021); 30 percent of the median wage for nursing assistant (SOC code 31-1014); and 20 percent of the median wage for social and human services aide (SOC code 21-1093); and

(ii) 85 percent of the subtotal of 20 percent of the median wage for home health aide (SOC code 31-1011); 20 percent of the median wage for personal and home health aide (SOC code 39-9021); 20 percent of the median wage for nursing assistant (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

(2) for day services, 20 percent of the median wage for nursing assistant (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

(3) for residential asleep-overnight staff, the wage is the minimum wage in Minnesota for large employers, except in a family foster care setting, the wage is 36 percent of the minimum wage in Minnesota for large employers;

(4) for behavior program analyst staff, 100 percent of the median wage for mental health counselors (SOC code 21-1014);

(5) for behavior program professional staff, 100 percent of the median wage for clinical counseling and school psychologist (SOC code 19-3031);

(6) for behavior program specialist staff, 100 percent of the median wage for psychiatric technicians (SOC code 29-2053);

(7) for supportive living services staff, 20 percent of the median wage for nursing assistant (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

(8) for housing access coordination staff, 100 percent of the median wage for community and social services specialist (SOC code 21-1099);

(9) for in-home family support staff, 20 percent of the median wage for nursing aide (SOC code 31-1012); 30 percent of the median wage for community social service specialist (SOC code 21-1099); 40 percent of the median wage for social and human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric technician (SOC code 29-2053);

(10) for individualized home supports services staff, 40 percent of the median wage for community social service specialist (SOC code 21-1099); 50 percent of the median wage for social and human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric technician (SOC code 29-2053);

(11) for independent living skills staff, 40 percent of the median wage for community social service specialist (SOC code 21-1099); 50 percent of the median wage for social and human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric technician (SOC code 29-2053);

(12) for independent living skills specialist staff, 100 percent of mental health and substance abuse social worker (SOC code 21-1023);

(13) for supported employment staff, 20 percent of the median wage for nursing assistant (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

(14) for employment support services staff, 50 percent of the median wage for rehabilitation counselor (SOC code 21-1015); and 50 percent of the median wage for community and social services specialist (SOC code 21-1099);

(15) for employment exploration services staff, 50 percent of the median wage for rehabilitation counselor (SOC code 21-1015); and 50 percent of the median wage for community and social services specialist (SOC code 21-1099);

(16) for employment development services staff, 50 percent of the median wage for education, guidance, school, and vocational counselors (SOC code 21-1012); and 50 percent of the median wage for community and social services specialist (SOC code 21-1099);

(17) for adult companion staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing assistant (SOC code 31-1014);

(18) for night supervision staff, 20 percent of the median wage for home health aide (SOC code 31-1011); 20 percent of the median wage for personal and home health aide (SOC code 39-9021); 20 percent of the median wage for nursing assistant (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

(19) for respite staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing assistant (SOC code 31-1014);

(20) for personal support staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing assistant (SOC code 31-1014);

(21) for supervisory staff, 100 percent of the median wage for community and social services specialist (SOC code 21-1099), with the exception of the supervisor of behavior professional, behavior analyst, and behavior specialists, which is 100 percent of the median wage for clinical counseling and school psychologist (SOC code 19-3031);

(22) for registered nurse staff, 100 percent of the median wage for registered nurses (SOC code 29-1141); and

(23) for licensed practical nurse staff, 100 percent of the median wage for licensed practical nurses (SOC code 29-2061).

(b) Component values for residential support services are:

(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

(3) employee-related cost ratio: 23.6 percent;

(4) general administrative support ratio: 13.25 percent;

(5) program-related expense ratio: 1.3 percent; and

(6) absence and utilization factor ratio: 3.9 percent.

(c) Component values for family foster care are:

(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

(3) employee-related cost ratio: 23.6 percent;

(4) general administrative support ratio: 3.3 percent;

(5) program-related expense ratio: 1.3 percent; and

(6) absence factor: 1.7 percent.

(d) Component values for day services for all services are:

(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

(3) employee-related cost ratio: 23.6 percent;

(4) program plan support ratio: 5.6 percent;

(5) client programming and support ratio: ten percent;

(6) general administrative support ratio: 13.25 percent;

(7) program-related expense ratio: 1.8 percent; and

(8) absence and utilization factor ratio: 9.4 percent.

(e) Component values for unit-based services with programming are:

(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

(3) employee-related cost ratio: 23.6 percent;

(4) program plan supports ratio: 15.5 percent;

(5) client programming and supports ratio: 4.7 percent;

(6) general administrative support ratio: 13.25 percent;

(7) program-related expense ratio: 6.1 percent; and

(8) absence and utilization factor ratio: 3.9 percent.

(f) Component values for unit-based services without programming except respite are:

(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

(3) employee-related cost ratio: 23.6 percent;

(4) program plan support ratio: 7.0 percent;

(5) client programming and support ratio: 2.3 percent;

(6) general administrative support ratio: 13.25 percent;

(7) program-related expense ratio: 2.9 percent; and

(8) absence and utilization factor ratio: 3.9 percent.

(g) Component values for unit-based services without programming for respite are:

(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

(3) employee-related cost ratio: 23.6 percent;

(4) general administrative support ratio: 13.25 percent;

(5) program-related expense ratio: 2.9 percent; and

(6) absence and utilization factor ratio: 3.9 percent.

(h) On July 1, 2017, the commissioner shall update the base wage index in paragraph (a) based on the wage data by standard occupational code (SOC) from the Bureau of Labor Statistics available on December 31, 2016. The commissioner shall publish these updated values and load them into the rate management system. On July 1, 2022, and every five years thereafter, the commissioner shall update the base wage index in paragraph (a) based

on the most recently available wage data by SOC from the Bureau of Labor Statistics. The commissioner shall publish these updated values and load them into the rate management system.

(i) On July 1, 2017, the commissioner shall update the framework components in paragraph (d), clause (5); paragraph (e), clause (5); and paragraph (f), clause (5); subdivision 6, clauses (8) and (9); and subdivision 7, clauses (10), (16), and (17), for changes in the Consumer Price Index. The commissioner will adjust these values higher or lower by the percentage change in the Consumer Price Index-All Items, United States city average (CPI-U) from January 1, 2014, to January 1, 2017. The commissioner shall publish these updated values and load them into the rate management system. On July 1, 2022, and every five years thereafter, the commissioner shall update the framework components in paragraph (d), clause (5); paragraph (e), clause (5); and paragraph (f), clause (5); subdivision 6, clauses (8) and (9); and subdivision 7, clauses (10), (16), and (17), for changes in the Consumer Price Index. The commissioner shall adjust these values higher or lower by the percentage change in the CPI-U from the date of the previous update to the date of the data most recently available prior to the scheduled update. The commissioner shall publish these updated values and load them into the rate management system.

(j) Upon the implementation of the automatic inflation adjustment in paragraphs (h) and (i), rate adjustments applied to the service rates calculated under this section that are not included in the cost components or rate methodology specified in this section must not be included in the rate calculation.

~~(j)~~ (k) In this subdivision, if Bureau of Labor Statistics occupational codes or Consumer Price Index items are unavailable in the future, the commissioner shall recommend to the legislature codes or items to update and replace missing component values.

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

Sec. 4. Laws 2014, chapter 312, article 27, section 76, is amended to read:

Sec. 76. **DISABILITY WAIVER REIMBURSEMENT RATE ADJUSTMENTS.**

~~Subdivision 1. **Historical rate.**~~ The commissioner of human services shall adjust the historical rates calculated in Minnesota Statutes, section 256B.4913, subdivision 4a, paragraph (b), in effect during the banding period under Minnesota Statutes, section 256B.4913, subdivision 4a, paragraph (a), for the reimbursement rate increases effective April 1, 2014, and any rate modification enacted during the 2014 legislative session.

~~Subd. 2. **Residential support services.** The commissioner of human services shall adjust the rates calculated in Minnesota Statutes, section 256B.4914, subdivision 6, paragraphs (b), clause (4), and (c), for the reimbursement rate increases effective April 1, 2014, and any rate modification enacted during the 2014 legislative session.~~

~~Subd. 3. **Day programs.** The commissioner of human services shall adjust the rates calculated in Minnesota Statutes, section 256B.4914, subdivision 7, paragraph (a), clauses (15) to (17), for the reimbursement rate increases effective April 1, 2014, and any rate modification enacted during the 2014 legislative session.~~

~~Subd. 4. **Unit-based services with programming.** The commissioner of human services shall adjust the rate calculated in Minnesota Statutes, section 256B.4914, subdivision 8, paragraph (a), clause (14), for the reimbursement rate increases effective April 1, 2014, and any rate modification enacted during the 2014 legislative session.~~

~~Subd. 5. **Unit-based services without programming.** The commissioner of human services shall adjust the rate calculated in Minnesota Statutes, section 256B.4914, subdivision 9, paragraph (a), clause (23), for the reimbursement rate increases effective April 1, 2014, and any rate modification enacted during the 2014 legislative session.~~

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

ARTICLE 6

OPIOIDS

Section 1. Minnesota Statutes 2016, section 151.252, subdivision 1, is amended to read:

Subdivision 1. **Requirements.** (a) No person shall act as a drug manufacturer without first obtaining a license from the board and paying any applicable fee specified in section 151.065.

(b) Application for a drug manufacturer license under this section shall be made in a manner specified by the board.

(c) No license shall be issued or renewed for a drug manufacturer unless the applicant agrees to operate in a manner prescribed by federal and state law and according to Minnesota Rules.

(d) No license shall be issued or renewed for a drug manufacturer that is required to be registered pursuant to United States Code, title 21, section 360, unless the applicant supplies the board with proof of registration. The board may establish by rule the standards for

licensure of drug manufacturers that are not required to be registered under United States Code, title 21, section 360.

(e) No license shall be issued or renewed for a drug manufacturer that is required to be licensed or registered by the state in which it is physically located unless the applicant supplies the board with proof of licensure or registration. The board may establish, by rule, standards for the licensure of a drug manufacturer that is not required to be licensed or registered by the state in which it is physically located.

(f) The board shall require a separate license for each facility located within the state at which drug manufacturing occurs and for each facility located outside of the state at which drugs that are shipped into the state are manufactured.

(g) The board shall not issue an initial or renewed license for a drug manufacturing facility unless the facility passes an inspection conducted by an authorized representative of the board. In the case of a drug manufacturing facility located outside of the state, the board may require the applicant to pay the cost of the inspection, in addition to the license fee in section 151.065, unless the applicant furnishes the board with a report, issued by the appropriate regulatory agency of the state in which the facility is located or by the United States Food and Drug Administration, of an inspection that has occurred within the 24 months immediately preceding receipt of the license application by the board. The board may deny licensure unless the applicant submits documentation satisfactory to the board that any deficiencies noted in an inspection report have been corrected.

(h) The board shall not issue a renewed license for a drug manufacturer unless the manufacturer pays any stewardship fee it is required to pay under section 151.2521.

Sec. 2. **[151.2521] OPIOID PRODUCT STEWARDSHIP FEE.**

Subdivision 1. **Opioid product stewardship fee established.** (a) A manufacturer licensed under section 151.252 that sells any products containing opium or opiates listed in section 152.02, subdivision 3, paragraphs (b) and (c), any products containing narcotics listed in section 152.02, subdivision 4, paragraph (e), or any products containing narcotic drugs listed in section 152.02, subdivision 5, paragraph (b) shall pay to the Board of Pharmacy a stewardship fee as specified in this section.

(b) Drugs approved by the United States Food and Drug Administration for the treatment of opioid dependence are not subject to the annual stewardship fee, but only when used for that purpose.

Subd. 2. **Reporting requirements.** (a) Effective March 1, 2019, a manufacturer licensed under section 151.252 shall provide the board with data about each of its prescription products that contain controlled substances listed in section 152.02, subdivisions 3 to 6, that are sold within this state. The data shall include, for each product, the trade and generic names, strength, package size, and national drug code. A manufacturer required to report this data shall also report a billing address to which the board can send invoices and inquiries related to the product stewardship fee. A manufacturer shall notify the board of any change to this data no later than 30 days after the change is made. The board may require a manufacturer to confirm the accuracy of the data on a quarterly basis. If a manufacturer fails to provide information required under this paragraph on a timely basis, the board may assess an administrative penalty of $100 per day. This penalty shall not be considered a form of disciplinary action.

(b) Effective May 1, 2019, a manufacturer licensed under section 151.252 or a wholesaler licensed under section 151.47 shall report to the board every sale, delivery, or other distribution within or into this state of any prescription controlled substance listed in section 152.02, subdivisions 3 to 6, that is made to any practitioner, pharmacy, hospital, veterinary hospital, or other person who is permitted by section 151.37 to possess controlled substances for administration or dispensing to patients. Reporting shall be in the manner and format specified by the board, and shall occur by the 15th day of each calendar month, for sales, deliveries, and other distributions that occurred during the previous calendar month. If a manufacturer or wholesaler fails to provide information required under this paragraph on a timely basis, the board may assess an administrative penalty of $100 per day. This penalty shall not be considered a form of disciplinary action.

(c) Effective May 1, 2019, any pharmacy licensed under section 151.19 and located outside of this state, including but not limited to community, long-term care, mail order, and compounding and central service pharmacies, must report the dispensing of controlled substances to patients located within this state. Reporting shall be in the manner and format specified by the board, and shall occur by the 15th day of each month for dispensing that occurred during the previous calendar month. If a pharmacy fails to provide information required under this paragraph on a timely basis, the board may assess an administrative penalty of $100 per day. This penalty shall not be considered a form of disciplinary action.

(d) Effective May 1, 2019, the owners of pharmacies that are located within this state must report the intracompany delivery or distribution, into this state, of the drugs listed in subdivision 1, to the extent that those deliveries and distributions are not reported to the board by a licensed wholesaler owned by, under contract to, or otherwise operating on behalf

of the owner of the pharmacies. Reporting shall be in the manner and format specified by the board, and shall occur by the 15th day of each month for deliveries and distributions that occurred during the previous calendar month. If a pharmacy fails to provide information required under this paragraph on a timely basis, the board may assess an administrative penalty of $100 per day. This penalty shall not be considered a form of disciplinary action.

Subd. 3. **Invoicing and payment.** (a) The board, beginning July 1, 2019, and at least quarterly thereafter, shall use the data submitted under subdivision 2 to prepare invoices for each manufacturer that is required to pay the opioid stewardship fee required by this section. The invoices for each quarter shall be prepared and sent to manufacturers no later than 60 days after the end of each quarter. Manufacturers shall remit payment to the board by no later than 30 days after the date of the invoice. If a manufacturer fails to remit payment by that date, the board shall charge interest at the rate that manufacturers are charged interest for making late Medicaid rebate payments.

(b) A manufacturer may dispute the amount invoiced by the board no later than 30 days after the date of the invoice. However, the manufacturer must still remit payment for the amount invoiced as required by this section. The dispute shall be filed with the board in the manner and using the forms specified by the board. A manufacturer must submit, with the required forms, data satisfactory to the board that demonstrates that the original amount invoiced was incorrect. The board shall make a decision concerning a dispute no later than 60 days after receiving the required forms. If the board determines that the manufacturer has satisfactorily demonstrated that the original fee invoiced by the board was incorrect, the board shall reimburse the manufacturer for any amount that is in excess of the correct amount that should have been invoiced. The board shall make this reimbursement when it notifies the manufacturer of its decision.

Subd. 4. **Calculation of fees.** (a) The board shall calculate the fee that is to be paid by using a base rate for all drugs and multipliers of the base rate for certain drugs and dosage forms as specified in this subdivision.

(b) The base rate shall be $0.01 per unit distributed or dispensed. A unit is each capsule, tablet, milliliter, gram, patch, or other commonly accepted unit.

(c) An active ingredient multiplier of 10 shall be applied to the base for Schedule II opium derivatives and opiates, as defined in section 152.02, subdivision 3, except as further defined below:

(1) oxycodone: 15;

(2) oxymorphone: 15;

(3) hydromorphone: 15;

(4) methadone: 20; and

(5) fentanyl: 20.

(d) In addition to the active ingredient multiplier, a dosage form multiplier shall be applied to the base as follows:

(1) liquid: 0.2; and

(2) patch: 20.

Sec. 3. **[151.2522] OPIOID STEWARDSHIP FUND.**

The opioid stewardship fund is established in the state treasury. The fees collected by the Board of Pharmacy under section 151.2521 shall be deposited into the opioid stewardship fund unless otherwise specifically designated by law. Any interest or profit accruing from investment of these sums is deposited in the opioid stewardship fund.

Sec. 4. Minnesota Statutes 2016, section 152.126, is amended by adding a subdivision to read:

Subd. 11. **Integration of access to the prescription monitoring program into electronic health records.** The board may enter into a contract with a vendor who provides a product or service that allows health care providers to integrate access to the prescription monitoring program into the provider's electronic health record or pharmacy software system. The value of the contract shall be limited to funds appropriated for this purpose. Such integration shall not modify any requirements of this section regarding the information that must be reported to the database, who can access the database and for what purpose, and the data classification of information in the database.

ARTICLE 7

HEALTH DEPARTMENT

Section 1. **CITATION.**

Sections 1 to 57 may be cited as the "Older and Vulnerable Adults Rights and Protection Act of 2018."

Sec. 2. Minnesota Statutes 2016, section 144.291, subdivision 2, is amended to read:

Subd. 2. **Definitions.** For the purposes of sections 144.291 to 144.298, the following terms have the meanings given.

(a) "Group purchaser" has the meaning given in section 62J.03, subdivision 6.

(b) "Health information exchange" means a legal arrangement between health care providers and group purchasers to enable and oversee the business and legal issues involved in the electronic exchange of health records between the entities for the delivery of patient care.

(c) "Health record" means any information, whether oral or recorded in any form or medium, that relates to the past, present, or future physical or mental health or condition of a patient; the provision of health care to a patient; or the past, present, or future payment for the provision of health care to a patient.

(d) "Identifying information" means the patient's name, address, date of birth, gender, parent's or guardian's name regardless of the age of the patient, and other nonclinical data which can be used to uniquely identify a patient.

(e) "Individually identifiable form" means a form in which the patient is or can be identified as the subject of the health records.

(f) "Medical emergency" means medically necessary care which is immediately needed to preserve life, prevent serious impairment to bodily functions, organs, or parts, or prevent placing the physical or mental health of the patient in serious jeopardy.

(g) "Patient" means:

(1) a natural person who has received health care services from a provider for treatment or examination of a medical, psychiatric, or mental condition~~.~~;

(2) the surviving spouse, children, sibling, guardian, conservator, and parents of a deceased patient, ~~or~~ unless the authority of the surviving spouse, children, sibling, guardian, conservator, or parents has been restricted by either a court or the deceased person who received health care services;

(3) a person the patient appoints in writing as a representative, including a health care agent acting according to chapter 145C, unless the authority of the agent has been limited by the principal in the principal's health care directive~~.~~; and

(4) except for minors who have received health care services under sections 144.341 to 144.347, in the case of a minor, patient includes a parent or guardian, or a person acting as a parent or guardian in the absence of a parent or guardian.

(h) "Patient information service" means a service providing the following query options: a record locator service as defined in paragraph (j) or a master patient index or clinical data repository as defined in section 62J.498, subdivision 1.

(i) "Provider" means:

(1) any person who furnishes health care services and is regulated to furnish the services under chapter 147, 147A, 147B, 147C, 147D, 148, 148B, 148D, 148F, 150A, 151, 153, or 153A;

(2) a home care provider licensed under section 144A.471;

(3) a health care facility licensed under this chapter or chapter 144A; and

(4) a physician assistant registered under chapter 147A.

(j) "Record locator service" means an electronic index of patient identifying information that directs providers in a health information exchange to the location of patient health records held by providers and group purchasers.

(k) "Related health care entity" means an affiliate, as defined in section 144.6521, subdivision 3, paragraph (b), of the provider releasing the health records.

Sec. 3. Minnesota Statutes 2016, section 144.6501, subdivision 3, is amended to read:

Subd. 3. **Contracts of admission.** (a) A facility shall make complete unsigned copies of its admission contract available to potential applicants and to the state or local long-term care ombudsman immediately upon request.

(b) A facility shall post conspicuously within the facility, in a location accessible to public view, either a complete copy of its admission contract or notice of its availability from the facility.

(c) An admission contract must be printed in black type of at least ten-point type size. The facility shall give a complete copy of the admission contract to the resident or the resident's legal representative promptly after it has been signed by the resident or legal representative. The admission contract must contain the name, address, and contact information of the current owner, manager, and, if different from the owner, license holder, of the facility, and the name and physical mailing address, which may not be a public or private post office box, of at least one natural person who is authorized to accept service of

process. Upon admission, and whenever there is a change in the owner, manager, or license holder, the facility must provide written notice within five business days of the change to the resident or resident's legal representative of a new owner, manager, and, if different from the owner, license holder of the facility, and the name and physical mailing address, which may not be a public or private post office box, of any new or additional natural person not identified in the admission contract who is authorized to accept service of process.

(d) An admission contract is a consumer contract under sections 325G.29 to 325G.37.

(e) All admission contracts must state in bold capital letters the following notice to applicants for admission: "NOTICE TO APPLICANTS FOR ADMISSION. READ YOUR ADMISSION CONTRACT. ORAL STATEMENTS OR COMMENTS MADE BY THE FACILITY OR YOU OR YOUR REPRESENTATIVE ARE NOT PART OF YOUR ADMISSION CONTRACT UNLESS THEY ARE ALSO IN WRITING. DO NOT RELY ON ORAL STATEMENTS OR COMMENTS THAT ARE NOT INCLUDED IN THE WRITTEN ADMISSION CONTRACT."

Sec. 4. Minnesota Statutes 2016, section 144.651, subdivision 1, is amended to read:

Subdivision 1. **Legislative intent.** It is the intent of the legislature and the purpose of this section to promote the interests and well being of the patients and residents of health care facilities. It is the intent of this section that every patient's and resident's civil and religious liberties, including the right to independent personal decisions and knowledge of available choices, must not be infringed and that the facility must encourage and assist in the fullest possible exercise of these rights. The rights provided under this section are established for the benefit of patients and residents. No health care facility may require or request a patient or resident to waive any of these rights at any time or for any reason including as a condition of admission to the facility. ~~Any guardian or conservator of a patient or resident or, in the absence of a guardian or conservator,~~ An interested person~~,~~ may seek enforcement of these rights on behalf of a patient or resident, as provided under section 144.6512. ~~An interested person may also seek enforcement of these rights on behalf of a patient or resident who has a guardian or conservator through administrative agencies or in district court having jurisdiction over guardianships and conservatorships.~~ Pending the outcome of an enforcement proceeding the health care facility may, in good faith, comply with the instructions of a guardian or conservator. ~~It is the intent of this section that every patient's civil and religious liberties, including the right to independent personal decisions and knowledge of available choices, shall not be infringed and that the facility shall encourage and assist in the fullest possible exercise of these rights.~~

Sec. 5. Minnesota Statutes 2016, section 144.651, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) For the purposes of this section, the terms defined in this subdivision have the meanings given them.

(b) "Patient" means:

(1) a person who is admitted to an acute care inpatient facility for a continuous period longer than 24 hours, for the purpose of diagnosis or treatment bearing on the physical or mental health of that person.;

(2) a minor who is admitted to a residential program as defined in section 253C.01;

(3) for purposes of subdivisions 4 to 9, 12, 13, 15, 16, and 18 to 20, ~~"patient" also means~~ a person who receives health care services at an outpatient surgical center or at a birth center licensed under section 144.615~~. "Patient" also means a minor who is admitted to a residential program as defined in section 253C.01.~~; and

(4) for purposes of subdivisions 1, 3 to 16, 18, 20, and 30, ~~"patient" also means~~ any person who is receiving mental health treatment on an outpatient basis or in a community support program or other community-based program.

(c) "Resident" means a person who is admitted to, resides in, or receives services from:

(1) a nonacute care facility including extended care facilities~~, nursing homes, and~~;

(2) an establishment operating under an assisted living license;

(3) a licensed home care service provider in a unit registered as a housing with services establishment under chapter 144D;

(4) a nursing home;

(5) a boarding care ~~homes~~ home for care required because of prolonged mental or physical illness or disability, recovery from injury or disease, or advancing age.; and

(6) for purposes of all subdivisions except subdivisions 28 and 29, ~~"resident" also means a person who is admitted to~~ a facility licensed as a board and lodging facility under Minnesota Rules, ~~parts 4625.0100 to 4625.2355~~ chapter 4625, or a supervised living facility under Minnesota Rules, ~~parts 4665.0100 to 4665.9900~~ chapter 4665, and which operates a rehabilitation program licensed under Minnesota Rules, parts ~~9530.6405~~ 9530.6510 to 9530.6590.

(d) "Facility" means:

(1) an acute care inpatient facility;

(2) a residential program as defined in section 253C.01;

(3) an outpatient surgical center or a birth center licensed under section 144.615;

(4) a community support program or other community-based program providing mental health treatment;

(5) a nonacute care facility including extended care facilities;

(6) an establishment operating under assisted living title protection under chapter 144G;

(7) a licensed home care services in a unit registered as a housing with services establishment under chapter 144D;

(8) a nursing home;

(9) a boarding care home for care required because of prolonged mental or physical illness or disability, recovery from injury or disease, or advancing age; or

(10) a facility licensed as a board and lodging facility under Minnesota Rules, chapter 4625, or a supervised living facility under Minnesota Rules, chapter 4665, and which operates a rehabilitation program licensed under Minnesota Rules, parts 9530.6510 to 9530.6590.

(e) "Interested person" includes:

(1) the "resident representative" as defined in Code of Federal Regulations, title 42, section 483.5; and

(2) the vulnerable adult, resident, or patient.

(f) An interested person who is not a health care agent, guardian, or resident representative must obtain written verification from the ombudsman for long-term care that the ombudsman does not object to that interested person seeking enforcement, information, or action on behalf of the patient or resident. Written verification must include the signature of an ombudsman for long-term care designee. If a conflict arises between multiple interested persons seeking enforcement, the ombudsman for long-term care will be consulted.

Sec. 6. Minnesota Statutes 2016, section 144.651, subdivision 4, is amended to read:

Subd. 4. **Information about rights.** Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement in plain language and in terms patients and residents can understand of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written

statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs, and the name and address of the state or county agency. Reasonable accommodations shall be made for people who have communication disabilities and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults.

Sec. 7. Minnesota Statutes 2016, section 144.651, subdivision 6, is amended to read:

Subd. 6. **Appropriate health care.** Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning-, provided with continuity of staff assignment as far as facility policy allows by persons who are properly trained and competent to perform their duties. This right is limited where the service is not reimbursable by public or private resources.

Sec. 8. Minnesota Statutes 2016, section 144.651, subdivision 14, is amended to read:

Subd. 14. **Freedom from maltreatment.** (a) Patients and residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and nontherapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every patient and resident has the right to immediate notification by a facility of suspected maltreatment of a patient or resident, including the details of any report submitted to the common entry point, as defined in section 626.5572, subdivision 5, by the licensed care provider under section 626.557. The names and contact information of alleged perpetrators, employees, other residents, or members of the public in the report must be redacted along with personal identifying information before release by the facility. An interested person, as define in section 626.5572, subdivision 12a, also has the right to redacted information about suspected maltreatment. Consistent with federal laws, the facility and commissioner of health must protect the name and identity of a complainant.

(b) Every patient and resident shall also be free from nontherapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing

after examination by a patient's or resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others.

Sec. 9. Minnesota Statutes 2016, section 144.651, is amended by adding a subdivision to read:

Subd. 14a. **Placement of cameras in private space.** (a) For the purposes of this subdivision:

(1) "resident representative" has the meaning given in Code of Federal Regulations, title 42, section 483.5; and

(2) "camera" includes all electronic monitoring devices.

(b) Every resident has the right to place a camera in the resident's private space. A facility shall not interfere with the placement. The resident may define when, where, and under what circumstances the camera may be temporarily turned off and has the right to change these preferences at any time.

(c) If the resident resides in shared space, the resident must document a discussion regarding placement of a camera with any roommate or the roommate's guardian or health care agent and include a written verification that consent is given. If consent from the roommate or the roommate's guardian or health care agent cannot be obtained, the facility must make a reasonable accommodation to either provide a private room or another shared room in which the roommate consents to placement of a camera.

(d) Costs for placement of a camera are incurred by the resident, except that the resident may utilize the facility's Internet service if otherwise made available to the resident.

(e) A health care agent or guardian may place a camera in the resident's private space on behalf of the resident after documenting a discussion with the resident, which includes informing the resident of the resident's right to privacy and a right to be free from maltreatment, and obtaining written verification that the resident does not object to the placement of a camera in the resident's private space.

(f) A resident representative who is not the health care agent or guardian may place a camera in the resident's private space on behalf of the resident after documenting a discussion with any health care agent or guardian of the resident regarding the placement and obtaining written verification that the resident and any health care agent or guardian do not object to the placement.

(g) An interested person who is not the health care agent, guardian, or resident representative may place a camera in the resident's private space on behalf of the resident after documenting a discussion with any health care agent, guardian, or resident representative of the resident regarding the placement, and obtaining written verification that the health care agent, guardian, or resident representative does not object to the placement. Where there is no health care agent, guardian, or resident representative of the resident, an interested person must document a discussion with the ombudsman for long-term care regarding the placement and obtain written verification that the ombudsman does not object to the placement. If conflict arises between multiple interested parties, the ombudsman for long-term care must be consulted.

(h) The health care agent, guardian, resident representative, or interested person who has placed the camera after discussion with the resident, may define when, where, and under what circumstances the camera be temporarily turned off and has the right to change these preferences at any time.

(i) No one may seek placement of a camera in the resident's private space on behalf of a resident if the placement has been restricted or rescinded in writing by a resident or a court.

(j) The facility may not tamper with or remove any camera placed in the resident's private space or attempt to persuade, coerce, or influence the resident not to place a camera in the resident's private space. The facility shall not retaliate against the resident for placement of a camera. A facility does not violate Minnesota law or rules if a camera for which the facility was unaware is found during a survey or investigation by the Department of Health.

Sec. 10. Minnesota Statutes 2016, section 144.651, subdivision 16, is amended to read:

Subd. 16. **Confidentiality of records.** Patients and residents shall be assured confidential treatment of their personal, financial, and medical records, and may approve or refuse their release to any individual outside the facility. Residents shall be notified when personal records are requested by any individual outside the facility and may select someone to accompany them when the records or information are the subject of a personal interview. Patients and residents have a right to access their own records and written information from those records. Copies of records and written information from the records shall be made available in accordance with this subdivision and sections 144.291 to 144.298. This right does not apply to complaint investigations and inspections by the Department of Health, where required by third-party payment contracts, or where otherwise provided by law.

Sec. 11. Minnesota Statutes 2016, section 144.651, subdivision 17, is amended to read:

Subd. 17. **Disclosure of services available.** Patients and residents shall be informed, prior to or at the time of admission and during their stay, of services which are included in the facility's basic per diem or daily room rate and that other services are available at additional charges. Patients and residents have the right to 30 days' advance notice of changes in charges. As required under section 504B.178, a facility may not collect a nonrefundable security deposit unless it is applied to the first month's charges. Facilities and providers are prohibited from charging fees because a patient or resident exercises the right to refuse treatment or medication, when the patient or resident chooses pharmacies or other health professionals other than the ones selected or preferred by the facility or provider. Facilities shall make every effort to assist patients and residents in obtaining information regarding whether the Medicare or medical assistance program will pay for any or all of the aforementioned services.

Sec. 12. Minnesota Statutes 2016, section 144.651, subdivision 20, is amended to read:

Subd. 20. **Grievances.** (a) Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances, assert the rights granted under this section personally, or have these rights asserted by an interested person, and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, retaliation, or reprisal, including threat of discharge. ~~Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place.~~

(b) Patients, residents, and interested persons have the right to complain about services that are provided, services that are not being provided, and the lack of courtesy or respect to the patient or resident or the patient's or resident's property. The facility must investigate and attempt resolution of the complaint or grievance. The facility must inform the patient or resident of the name and contact information of the staff person who is responsible for handling grievances.

(c) Notice must be posted in a conspicuous place and available to any patient or resident upon request of the facility's or program's grievance procedure, as well as telephone numbers and, where applicable, addresses for the common entry point defined under section 626.5572,

subdivision 5, a protection and advocacy agency, and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12).

(d) Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure.

Sec. 13. Minnesota Statutes 2016, section 144.651, subdivision 21, is amended to read:

Subd. 21. **Communication privacy.** Patients and residents may associate and communicate privately with persons of their choice and enter and, except as provided by the Minnesota Commitment Act, leave the facility as they choose. Patients and residents shall have access, at their own expense unless provided by the facility, to writing instruments, stationery, ~~and~~ postage, Internet service, and placement of a video or Web camera, or other electronic monitoring devices in the patient's or resident's room. Personal mail shall be sent without interference and received unopened unless medically or programmatically contraindicated and documented by the physician in the medical record. There shall be access to a telephone where patients and residents can make and receive calls as well as speak privately. Facilities which are unable to provide a private area shall make reasonable arrangements to accommodate the privacy of patients' or residents' calls. Upon admission to a facility where federal law prohibits unauthorized disclosure of patient or resident identifying information to callers and visitors, the patient or resident, or the legal guardian or conservator of the patient or resident, shall be given the opportunity to authorize disclosure of the patient's or resident's presence in the facility to callers and visitors who may seek to communicate with the patient or resident. To the extent possible, the legal guardian or conservator of a patient or resident shall consider the opinions of the patient or resident regarding the disclosure of the patient's or resident's presence in the facility. This right is limited where medically inadvisable, as documented by the attending physician in a patient's or resident's care record. Where programmatically limited by a facility abuse prevention

plan pursuant to section 626.557, subdivision 14, paragraph (b), this right shall also be limited accordingly.

Sec. 14. Minnesota Statutes 2016, section 144.651, is amended by adding a subdivision to read:

Subd. 34. **Retaliation prohibited.** (a) A facility or person must not retaliate against a patient, resident, employee, or interested person who:

(1) files a complaint or grievance or asserts any rights on behalf of the patient or resident as provided under subdivision 20;

(2) submits a suspected maltreatment report, whether mandatory or voluntary, on behalf of the patient or resident under section 626.557, subdivision 3, 4, or 4a;

(3) advocates on behalf of the patient or resident for necessary or improved care and services or enforcement of rights under this section or other law;

(4) contracts to receive services from a service provider of the patient's or resident's choice; or

(5) places a camera or electronic monitoring device in the resident's private space pursuant to subdivision 14a.

(b) There is a rebuttable presumption that adverse action is retaliatory if taken against a patient, resident, employee, or interested person within 90 days of a patient, resident, employee, or interested person filing a grievance as provided in paragraph (a), submitting a suspected maltreatment report, or otherwise advocating on behalf of a patient or resident.

(c) For purposes of this section, "adverse action" means only action taken by a facility or person against the patient, resident, employee, or interested person that includes but is not limited to:

(1) discharge or transfer from the facility;

(2) discharge from or termination of employment;

(3) demotion or reduction in remuneration for services;

(4) restriction or prohibition of access either to the facility or to the patient or resident, including issuing a no trespass order pursuant to section 609.605;

(5) any restriction of any of the rights set forth in state or federal law;

(6) any restriction of access to or use of amenities or services;

(7) termination of services or lease agreement, or both;

(8) a sudden increase in costs for services not already contemplated at the time of the action taken;

(9) removal, tampering with, or deprivation of technology, communication, or electronic monitoring devices of the patient or resident;

(10) filing a maltreatment report in bad faith; or

(11) making any oral or written communication of false information about a person advocating on behalf of the patient or resident.

Sec. 15. **[144.6511] DECEPTIVE MARKETING AND BUSINESS PRACTICES.**

(a) Deceptive marketing and business practices are prohibited by home care providers, assisted living settings, and housing with services establishments.

(b) For the purposes of this section, it is a deceptive practice for a facility listed in section 144.651, subdivision 2, to:

(1) make any false, fraudulent, deceptive, or misleading statements in marketing, advertising, or any other oral or written description or representation of care or services, whether in oral, written, or electronic form;

(2) arrange for or provide health care or services that are inferior to, substantially different from, or substantially more expensive than those offered, promised, marketed, or advertised;

(3) fail to deliver any care or services the provider or facility promised or represented that the facility was able to provide;

(4) fail to inform the patient or resident in writing of any limitations to care services available prior to executing a contract for admission;

(5) discharge or terminate the lease or services of a patient or resident following a required period of private pay who then receives benefits under the medical assistance elderly waiver program after the facility has made an oral or written promise to continue the same services provided under private pay and accept medical assistance elderly waiver payments after the expiration of the private pay period;

(6) fail to disclose and clearly explain the purpose of a nonrefundable community fee or other fee prior to contracting for services with a patient or resident;

(7) advertise or represent, orally or in writing, that the facility is or has a special care unit, such as for dementia or memory care, without complying with training and disclosure requirements under sections 144D.065 and 325F.72, and any other applicable law; or

(8) misstate the statutory definitions of the terms "facility," "contract of admission," "admission contract," "admission agreement," "legal representative," or "responsible party" contrary to section 144.6501

Sec. 16. **[144.6512] ENFORCEMENT OF THE HEALTH CARE BILL OF RIGHTS.**

(a) In addition to the remedies otherwise provided by or available under law, a patient or resident, or an interested person on behalf of the patient or resident, may bring a civil action in state district court to recover the greater of actual, incidental, and consequential damages or $5,000, together with costs and disbursements, including costs of investigation and reasonable attorney fees, and receive other equitable relief including punitive damages as determined by the court for a violation of any provision of sections 144.651 to 144.6511 or section 144.6501, subdivision 2.

(b) For the purposes of this section:

(1) "patient" has the meaning given in section 144.651, subdivision 2, paragraph (b);

(2) "resident" has the meaning given in section 144.651, subdivision 2, paragraph (c); and

(3) "interested person" has the meaning given in section 524.5-102.

Sec. 17. Minnesota Statutes 2016, section 144A.10, subdivision 1, is amended to read:

Subdivision 1. **Enforcement authority.** The commissioner of health is the exclusive state agency charged with the responsibility and duty of inspecting all facilities required to be licensed under section 144A.02~~.~~, and issuing correction orders and imposing fines as provided in this section, section 144.651, or 626.557, Minnesota Rules, chapter 4658, or any other applicable law. The commissioner of health shall enforce the rules established pursuant to sections 144A.01 to 144A.155, subject only to the authority of the Department of Public Safety respecting the enforcement of fire and safety standards in nursing homes and the responsibility of the commissioner of human services under sections 245A.01 to 245A.16 or 252.28.

The commissioner may request and must be given access to relevant information, records, incident reports, or other documents in the possession of a licensed facility if the commissioner considers them necessary for the discharge of responsibilities. For the purposes

of inspections and securing information to determine compliance with the licensure laws and rules, the commissioner need not present a release, waiver, or consent of the individual. The identities of patients or residents must be kept private as defined by section 13.02, subdivision 12.

Sec. 18. Minnesota Statutes 2016, section 144A.10, subdivision 6, is amended to read:

Subd. 6. **Fines.** A nursing home which is issued a notice of noncompliance with a correction order shall be assessed a civil fine in accordance with a schedule of fines established by the commissioner of health before December 1, 1983. A nursing home's refusal to cooperate in providing lawfully requested information is grounds for a correction order and a fine of $1,000 per instance the correct information is not provided to the commissioner in the time requested. In establishing the schedule of fines, the commissioner shall consider the potential for harm presented to any resident as a result of noncompliance with each statute or rule. The fine shall be assessed for each day the facility remains in noncompliance and until a notice of correction is received by the commissioner of health in accordance with subdivision 7. ~~No fine for a specific violation may exceed $500 per day of noncompliance.~~

Sec. 19. Minnesota Statutes 2016, section 144A.44, is amended to read:

144A.44 HOME CARE BILL OF RIGHTS.

Subdivision 1. ~~**Statement of rights**~~ **Scope.** ~~A person who receives home care services has these rights:~~ All home care providers, including those exempt under section 144A.471, subdivision 8, must comply with this section.

Subd. 1a. **Statement of rights.** (a) A person who receives home care services has the right to:

(1) ~~the right to~~ receive written information about rights before receiving services, including what to do if rights are violated;

(2) ~~the right to~~ receive care and services according to a suitable and up-to-date plan, and subject to accepted health care, medical or nursing standards, to take an active part in developing, modifying, and evaluating the plan and services;

(3) ~~the right to~~ be told before receiving services the type and disciplines of staff who will be providing the services, the frequency of visits proposed to be furnished, other choices that are available for addressing home care needs, and the potential consequences of refusing these services;

(4) ~~the right to~~ be told in advance of any recommended changes by the provider in the service plan and to take an active part in any decisions about changes to the service plan;

(5) ~~the right to~~ refuse services or treatment;

(6) ~~the right to~~ know, before receiving services or during the initial visit, any limits to the services available from a home care provider;

(7) ~~the right to~~ be told before services are initiated what the provider charges for the services; to what extent payment may be expected from health insurance, public programs, or other sources, if known; and what charges the client may be responsible for paying;

(8) ~~the right to~~ know that there may be other services available in the community, including other home care services and providers, and to know where to find information about these services;

(9) ~~the right to~~ choose freely among available providers and to change providers after services have begun, within the limits of health insurance, long-term care insurance, medical assistance, or other health programs;

(10) ~~the right to~~ have personal, financial, and medical information kept private, and to be advised of the provider's policies and procedures regarding disclosure of such information;

(11) ~~the right to~~ access the client's own records and written information from those records in accordance with sections 144.291 to 144.298;

(12) ~~the right to~~ be served by people who are properly trained and competent to perform their duties;

(13) ~~the right to~~ be treated with courtesy and respect, and to have the client's property treated with respect;

(14) ~~the right to~~ be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act;

(15) ~~the right to~~ reasonable, advance notice of changes in services or charges;

(16) ~~the right to~~ know the provider's reason for termination of services;

(17) ~~the right to~~ at least ~~ten~~ 30 days' advance notice of the termination of a service by a provider, except in cases where:

(i) the client engages in conduct that significantly alters the terms of the service plan with the home care provider;

(ii) the client, person who lives with the client, or others create an abusive or unsafe work environment for the person providing home care services; or

(iii) an emergency or a significant change in the client's condition has resulted in service needs that exceed the current service plan and that cannot be safely met by the home care provider;

(18) ~~the right to~~ a coordinated transfer when there will be a change in the provider of services;

(19) ~~the right to~~ complain about services that are provided, or fail to be provided, and the lack of courtesy or respect to the client or the client's property;

(20) ~~the right to~~ know how to contact an individual associated with the home care provider who is responsible for handling problems and to have the home care provider investigate and attempt to resolve the grievance or complaint;

(21) ~~the right to~~ know the name and address of the state or county agency to contact for additional information or assistance; ~~and~~

(22) ~~the right to~~ assert these rights personally, or have them asserted by the client's representative or by anyone on behalf of the client, without retaliation~~.~~; and

(23) reasonable access at reasonable times to available rights protection or legal and advocacy services so that the client may receive assistance in understanding, exercising, and protecting the rights in this section and other law.

(b) A home care provider shall:

(1) encourage and assist in the fullest possible exercise of these rights;

(2) provide the names and telephone numbers of at least three individuals and organizations that provide advocacy and legal services for clients;

(3) make every effort to assist clients in obtaining information regarding whether the Medicare or medical assistance program will pay for services;

(4) make reasonable accommodations for people who have communication disabilities and those who speak a language other than English; and

(5) provide all information and notices in plain language and in terms the client can understand.

Subd. 2. **Interpretation and enforcement of rights.** ~~These rights are established for the benefit of clients who receive home care services. All home care providers, including~~

~~those exempted under section 144A.471, must comply with this section. The commissioner shall enforce this section and the home care bill of rights requirement against home care providers exempt from licensure in the same manner as for licensees. A home care provider may not request or require a client to surrender any of these rights as a condition of receiving services. This statement of rights does not replace or diminish other rights and liberties that may exist relative to clients receiving home care services, persons providing home care services, or providers licensed under sections 144A.43 to 144A.482.~~ The rights provided under this section are established for the benefit of clients who receive home care services whether in a licensed assisted living facility or not; do not replace or diminish other rights and liberties that may exist relative to clients receiving home care services, persons providing home care services, or providers licensed under sections 144A.43 to 144A.482; and may not be waived. Any oral or written waiver of the rights provided under this section is void and unenforceable.

Subd. 3. **Deceptive marketing and business practices.** (a) Deceptive marketing and business practices are prohibited.

(b) For purposes of this section, it is a deceptive marketing and business practice to:

(1) engage in any conduct listed in section 144.6511;

(2) seek or collect a nonrefundable deposit, unless the deposit is applied to the first month's charges;

(3) fail to disclose and clearly explain the purpose of a nonrefundable community fee or other fee prior to contracting for services with a client; or

(4) make any oral or written statement or representation, either directly or in marketing or advertising materials that contradict, conflict with, or otherwise are inconsistent with the provisions in the admissions agreement, service agreement, contract, lease, or Uniform Consumer Information Guide under section 144G.06.

Subd. 4. **Enforcement of rights.** The commissioner shall enforce this section and the requirements of the home care bill of rights against home care providers exempt from licensure in the same manner as for licensees.

Subd. 6. **Private enforcement of rights.** In addition to the remedies otherwise available under law, a person who receives home care services, an assisted living client, or an interested person on behalf of the person may bring a civil action in state district court and recover damages, together with costs and disbursements, including costs of investigation, and reasonable attorney fees, and receive other equitable relief including punitive damages as

determined by the court for a violation of this section and section 144A.441. For purposes of this section, an interested person has the meaning given in section 144.651, subdivision 2.

Sec. 20. Minnesota Statutes 2016, section 144A.441, is amended to read:

144A.441 ASSISTED LIVING BILL OF RIGHTS ADDENDUM.

Assisted living clients, as defined in section 144G.01, subdivision 3, shall be provided with the home care bill of rights required by section 144A.44, except that the home care bill of rights provided to these clients must include the following provision in place of the provision in section 144A.44, subdivision ~~1~~ 1a, clause (17):

"(17) the right to reasonable, advance notice of changes in services or charges, including at least 30 days' advance notice of the termination of a service by a provider, except in cases where:

(i) the recipient of services ~~engages in conduct that alters the conditions of employment as specified in the employment contract between the home care provider and the individual providing home care services, or~~ creates and the home care provider can document an abusive or unsafe work environment for the individual providing home care services;

(ii) a doctor or treating physician documents that an emergency ~~for the informal caregiver~~ or a significant change in the recipient's condition has resulted in service needs that exceed the current service provider agreement and that cannot be safely met by the home care provider; or

(iii) the provider has not received payment for services, for which at least ten days' advance notice of the termination of a service shall be provided."

Sec. 21. Minnesota Statutes 2016, section 144A.45, subdivision 1, is amended to read:

Subdivision 1. **Regulations.** The commissioner shall regulate home care providers pursuant to sections 144A.43 to 144A.482. The regulations shall include the following:

(1) provisions to assure, to the extent possible, the health, safety, well-being, and appropriate treatment of persons who receive home care services while respecting a client's autonomy and choice;

(2) requirements that home care providers furnish the commissioner with specified information necessary to implement sections 144A.43 to 144A.482;

(3) standards of training of home care provider personnel;

(4) standards for provision of home care services;

(5) standards for medication management;

(6) standards for supervision of home care services;

(7) standards for client evaluation or assessment;

(8) requirements for the involvement of a client's health care provider, the documentation of health care providers' orders, if required, and the client's service plan;

(9) the maintenance of accurate, current client records;

(10) the establishment of basic and comprehensive levels of licenses based on services provided; and

(11) provisions to enforce these regulations and the home care bill of rights, including provisions for issuing penalties and fines as allowed under law.

Sec. 22. Minnesota Statutes 2016, section 144A.45, subdivision 2, is amended to read:

Subd. 2. **Regulatory functions.** The commissioner shall:

(1) license, survey, and monitor without advance notice, home care providers in accordance with sections 144A.43 to 144A.482;

(2) survey every temporary licensee within one year of the temporary license issuance date subject to the temporary licensee providing home care services to a client or clients;

(3) survey all licensed home care providers on an interval that will promote the health and safety of clients;

(4) with the consent of the client, visit the home where services are being provided;

(5) issue correction orders and assess civil penalties in accordance with ~~section~~ sections 144.653, subdivisions 5 to 8, 144A.474, and 144A.475, for violations of sections 144A.43 to 144A.482;

(6) take action as authorized in section 144A.475; and

(7) take other action reasonably required to accomplish the purposes of sections 144A.43 to 144A.482.

Sec. 23. Minnesota Statutes 2016, section 144A.474, subdivision 1, is amended to read:

Subdivision 1. **Surveys.** The commissioner shall conduct surveys of each home care provider. ~~By June 30, 2016,~~ The commissioner shall conduct a survey of home care providers

on a frequency of at least once every three years. Survey frequency may be based on the license level, the provider's compliance history, the number of clients served, or other factors as determined by the department deemed necessary to ensure the health, safety, and welfare of clients and compliance with the law. The commissioner shall conduct an annual health environment and physical plant survey for assisted living licenses effective on February 1, 2020.

Sec. 24. Minnesota Statutes 2016, section 144A.474, subdivision 8, is amended to read:

Subd. 8. **Correction orders.** (a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a home care provider, a managerial official, or an employee of the provider is not in compliance with sections 144A.43 to 144A.482. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction.

(b) The commissioner shall mail copies of any correction order to the last known address of the home care provider, or electronically scan the correction order and e-mail it to the last known home care provider e-mail address, within 30 calendar days after the survey exit date. A copy of each correction order, the amount of any fine issued, and copies of any documentation supplied to the commissioner shall be kept on file by the home care provider, and ~~public~~ these documents shall be made available for viewing by any person upon request. Copies may be kept electronically.

(c) By the correction order date, the home care provider must document in the provider's records and submit in writing to the commissioner any action taken to comply with the correction order. ~~The commissioner may request a copy of this documentation and the home care provider's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed.~~

Sec. 25. Minnesota Statutes 2016, section 144A.474, subdivision 9, is amended to read:

Subd. 9. **Follow-up surveys.** For providers that have Level 3 or Level 4 violations under subdivision 11, or any violations determined to be widespread, the department shall conduct a follow-up survey within 90 calendar days of the survey. When conducting a follow-up survey, the surveyor will focus on whether the previous violations have been corrected and may also address any new violations that are observed while evaluating the corrections that have been made. If a new violation is identified on a follow-up survey, ~~no~~ a fine ~~will~~ may be immediately imposed ~~unless it is not corrected on the next follow-up survey~~.

Sec. 26. Minnesota Statutes 2017 Supplement, section 144A.474, subdivision 11, is amended to read:

Subd. 11. **Fines.** (a) Fines and enforcement actions under this subdivision may be assessed based on the level and scope of the violations described in paragraph (c) as follows:

(1) Level 1, no fines or enforcement;

(2) Level 2, fines ranging from $0 to ~~$500~~ $1,000, in addition to any of the enforcement mechanisms authorized in section 144A.475 for widespread violations;

(3) Level 3, fines ranging from ~~$500 to~~ $1,000 to $5,000, in addition to any of the enforcement mechanisms authorized in section 144A.475; and

(4) Level 4, fines ranging from ~~$1,000 to~~ $5,000 to $10,000, in addition to any of the enforcement mechanisms authorized in section 144A.475.

(b) Correction orders for violations are categorized by both level and scope and fines shall be assessed as follows:

(1) level of violation:

(i) Level 1 is a violation that has no potential to cause more than a minimal impact on the client and does not affect health or safety;

(ii) Level 2 is a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death;

(iii) Level 3 is a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death; and

(iv) Level 4 is a violation that results in serious injury, impairment, or death.

(2) scope of violation:

(i) isolated, when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally;

(ii) pattern, when more than a limited number of clients are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly but is not found to be pervasive; and

(iii) widespread, when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the clients.

(c) If the commissioner finds that the applicant or a home care provider required to be licensed under sections 144A.43 to 144A.482 has not corrected violations by the date specified in the correction order or conditional license resulting from a survey or complaint investigation, the commissioner may impose ~~a~~ an additional fine. A notice of noncompliance with a correction order must be mailed to the applicant's or provider's last known address. The noncompliance notice must list the violations not corrected.

(d) The license holder must pay the fines assessed on or before the payment date specified. If the license holder fails to fully comply with the order, the commissioner may issue a second fine or suspend the license until the license holder complies by paying the fine. A timely appeal shall stay payment of the fine until the commissioner issues a final order.

(e) A license holder shall promptly notify the commissioner in writing when a violation specified in the order is corrected. If upon reinspection the commissioner determines that a violation has not been corrected as indicated by the order, the commissioner may issue ~~a second~~ an additional fine. The commissioner shall notify the license holder by mail to the last known address in the licensing record that ~~a second~~ an additional fine has been assessed. The license holder may appeal the ~~second~~ additional fine as provided under this subdivision.

(f) A home care provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14.

(g) When a fine has been assessed, the license holder may not avoid payment by closing, selling, or otherwise transferring the licensed program to a third party. In such an event, the license holder shall be liable for payment of the fine.

(h) In addition to any fine imposed under this section, the commissioner may assess costs related to an investigation that results in a final order assessing a fine or other enforcement action authorized by this chapter.

(i) Fines collected under this subdivision shall be deposited in the state government special revenue fund and credited to an account separate from the revenue collected under section 144A.472. Subject to an appropriation by the legislature, the revenue from the fines collected must be used by the commissioner for special projects to improve home care in Minnesota as recommended by the advisory council established in section 144A.4799.

(j) For nursing homes licensed by the commissioner, this section may be used to calculate the fine amount on nursing homes violating the Vulnerable Adults Act in section 626.557 or other licensing violations.

Sec. 27. Minnesota Statutes 2016, section 144A.53, subdivision 1, is amended to read:

Subdivision 1. **Powers.** The director may:

(a) Promulgate by rule, pursuant to chapter 14, and within the limits set forth in subdivision 2, the methods by which complaints against health facilities, health care providers, home care providers, or residential care homes, or administrative agencies are to be made, reviewed, investigated, and acted upon; provided, however, that a fee may not be charged for filing a complaint.

(b) Recommend legislation and changes in rules to the state commissioner of health, governor, administrative agencies or the federal government.

(c) Investigate, upon a complaint or upon initiative of the director, any action or failure to act by a health care provider, home care provider, residential care home, or a health facility.

(d) Request and receive access to relevant information, records, incident reports, or documents in the possession of an administrative agency, a health care provider, a home care provider, a residential care home, or a health facility, and issue investigative subpoenas to individuals and facilities for oral information and written information, including privileged information which the director deems necessary for the discharge of responsibilities. For purposes of investigation and securing information to determine violations, the director need not present a release, waiver, or consent of an individual. The identities of patients or residents must be kept private as defined by section 13.02, subdivision 12.

(e) Enter and inspect, at any time, a health facility or residential care home and be permitted to interview staff; provided that the director shall not unduly interfere with or disturb the provision of care and services within the facility or home or the activities of a patient or resident unless the patient or resident consents.

(f) Issue correction orders and assess civil fines ~~pursuant to section~~ for violations of sections 144.651, 144.653, 144A.10, 144A.44, 144A.45, and 626.557, Minnesota Rules, chapters 4655, 4658, 4664, and 4665, or any other law ~~which~~ that provides for the issuance of correction orders to health facilities or home care provider, or under section 144A.45. The director may use the authority in section 144A.474, subdivision 11, to calculate the fine amount. A facility's or home's refusal to cooperate in providing lawfully requested information within the requested time period may also be grounds for a correction order or fine at a Level 2 fine pursuant to section 144A.474, subdivision 11.

(g) Recommend the certification or decertification of health facilities pursuant to Title XVIII or XIX of the United States Social Security Act.

(h) Assist patients or residents of health facilities or residential care homes in the enforcement of their rights under Minnesota law.

(i) Work with administrative agencies, health facilities, home care providers, residential care homes, and health care providers and organizations representing consumers on programs designed to provide information about health facilities to the public and to health facility residents.

Sec. 28. Minnesota Statutes 2016, section 144A.53, subdivision 4, is amended to read:

Subd. 4. **Referral of complaints.** (a) If a complaint received by the director relates to a matter more properly within the jurisdiction of law enforcement, an occupational licensing board or other governmental agency, the director shall forward the complaint ~~to that agency~~ appropriately and shall inform the complaining party of the forwarding. ~~The~~

(b) An agency shall promptly act in respect to the complaint, and shall inform the complaining party and the director of its disposition. If a governmental agency receives a complaint which is more properly within the jurisdiction of the director, it shall promptly forward the complaint to the director, and shall inform the complaining party of the forwarding.

(c) If the director has reason to believe that an official or employee, or client or resident, of an administrative agency, a home care provider, residential care home, or health facility has acted in a manner warranting criminal or disciplinary proceedings, the director shall refer the matter to the state commissioner of health, the commissioner of human services, an appropriate prosecuting authority, or other appropriate agency.

Sec. 29. Minnesota Statutes 2016, section 144D.01, subdivision 1, is amended to read:

Subdivision 1. **Scope.** As used in sections 144D.01 to ~~144D.06~~ 144D.095, the following terms have the meanings given them.

Sec. 30. Minnesota Statutes 2016, section 144D.02, is amended to read:

144D.02 REGISTRATION REQUIRED.

No entity may establish, operate, conduct, or maintain a housing with services establishment in this state without registering and operating as required in sections 144D.01 to 144D.06. By January 1, 2020, all registered housing with services establishments must

designate ten percent of rooms or beds for residents receiving medical assistance services. Nothing in this section prohibits a housing with services establishment from designating more than ten percent of rooms or beds for occupancy by residents receiving medical assistance services.

Sec. 31. Minnesota Statutes 2017 Supplement, section 144D.04, subdivision 2, is amended to read:

Subd. 2. **Contents of contract.** A housing with services contract, which need not be entitled as such to comply with this section, shall include at least the following elements in itself or through supporting documents or attachments:

(1) the name, street address, and mailing address of the establishment;

(2) the name and mailing address of the owner or owners of the establishment and, if the owner or owners is not a natural person, identification of the type of business entity of the owner or owners;

(3) the name and mailing address of the managing agent, through management agreement or lease agreement, of the establishment, if different from the owner or owners;

(4) the name and address of at least one natural person who is authorized to accept service of process on behalf of the owner or owners and managing agent;

(5) a statement describing the registration and licensure status of the establishment and any provider providing health-related or supportive services under an arrangement with the establishment;

(6) the term of the contract;

(7) a description of the services to be provided to the resident in the base rate to be paid by the resident, including a delineation of the portion of the base rate that constitutes rent and a delineation of charges for each service included in the base rate;

(8) a description of any additional services, including home care services, available for an additional fee from the establishment directly or through arrangements with the establishment, and a schedule of fees charged for these services;

(9) a conspicuous notice informing the tenant of the policy concerning the conditions under which and the process through which the contract may be modified, amended, or terminated, including whether a move to a different room or sharing a room would be required in the event that the tenant can no longer pay the current rent;

(10) a description of the establishment's complaint resolution process available to residents including the toll-free complaint line for the Office of Ombudsman for Long-Term Care;

(11) the resident's designated representative, if any;

(12) the establishment's referral procedures if the contract is terminated;

(13) requirements of residency used by the establishment to determine who may reside or continue to reside in the housing with services establishment;

(14) billing and payment procedures and requirements;

(15) a statement regarding the ability of a resident to receive services from service providers with whom the establishment does not have an arrangement;

(16) a statement regarding the availability of public funds for payment for residence or services in the establishment~~;~~ and the fact that at least ten percent of the rooms or beds in the housing with services establishment are to be used by residents whose payments are made under the medical assistance program;

(17) a statement regarding the availability of and contact information for long-term care consultation services under section 256B.0911 in the county in which the establishment is located~~.~~;

(18) a statement that a resident has the right to request a reasonable accommodation; and

(19) a statement describing the conditions under which a contract may be amended.

Sec. 32. **[144D.085] RELOCATION WITHIN FACILITY.**

Subdivision 1. **Notification prior to relocation.** A housing with services establishment or assisted living setting must:

(1) notify a resident and the resident's representative at least ten days prior to a proposed nonemergency relocation within the facility; and

(2) obtain consent from the resident or the resident's representative to the relocation.

Subd. 2. **Restriction on relocation.** A person who has been a private pay resident for at least one year, resides in a private room, and whose payments subsequently will be made under the medical assistance program may not be relocated to a shared room without the consent of the resident or the resident's representative.

Sec. 33. Minnesota Statutes 2016, section 144D.09, is amended to read:

144D.09 TERMINATION OF LEASE.

Subdivision 1. **Legislative intent.** ~~The housing with services establishment shall include with notice of termination of lease information about how to contact the ombudsman for long-term care, including the address and telephone number along with a statement of how to request problem-solving assistance.~~ It is the intent of the legislature to ensure to the greatest extent possible housing stability for persons residing in housing with services establishments or assisted living settings, and to avoid unnecessary moves either within or from the housing with services establishments or assisted living settings.

Subd. 2. **Permissible reasons to terminate lease.** (a) Notwithstanding chapter 504B, a housing with services establishment or assisted living setting may terminate a resident's lease only if:

(1) the resident breaches the lease, which includes failure to pay rent as required, and has not cured the breach within 30 days of receipt of the notice required under subdivision 3. A breach of a services contract does not constitute a breach of a lease;

(2) the resident holds over beyond the date to vacate mutually agreed upon in writing by the resident and the housing with services establishment or assisted living setting; or

(3) the resident holds over beyond the date provided by the resident in a notice of voluntary termination of the lease provided to the housing with services establishment or assisted living setting.

(b) Notwithstanding paragraph (a), a housing with services establishment or assisted living setting may immediately commence an eviction if the breach involves any of the acts listed in section 504B.171, subdivision 1.

Subd. 3. **Notice of lease termination.** A housing with services establishment or assisted living setting must provide at least 30 days' notice prior to terminating a residential lease, unless the resident commits a breach of the lease involving any of the acts listed in section 504B.171, subdivision 1.

Subd. 4. **Contents of notice.** The notice of lease termination required under subdivision 3 must include:

(1) the reason for the termination;

(2) the date termination shall occur;

(3) a statement that a lease cannot be terminated without providing the resident an opportunity to cure the breach of lease, including failure to pay rent;

(4) information on how to contact the Office of Ombudsman for Long-Term Care and a protection and advocacy agency, including the address and telephone number of both offices, along with a statement of how to request problem-solving assistance;

(5) a statement that the resident has the right to avoid termination of the lease by paying the rent in full or curing any breach prior to expiration of 30 days after receipt of the notice;

(6) a statement that the resident has the right to request a meeting with the owner or manager of the housing with services establishment or assisted living setting to discuss and attempt to resolve the alleged breach to avoid termination; and

(7) a statement that the resident has the right to appeal the termination of the lease to the Office of Administrative Hearings and provide the contact information for the Office of Administrative Hearings including the address, fax number, e-mail, and telephone number.

Subd. 5. **Right to appeal termination of lease.** (a) At any time prior to the expiration of the notice period provided under subdivision 3, a resident may appeal the termination by making a written request for a hearing to the Office of Administrative Hearings. The Office of Administrative Hearings must conduct the hearing no later than 14 days after the office receives the appeal request from the resident. The hearing must be held in the establishment in which the resident resides, unless impractical or the parties agree to a different place. Attorney representation is not required at the hearing, nor does appearing without an attorney constitute the unauthorized practice of law. The hearing shall not be construed as a formal evidentiary hearing. The hearing may also be attended by telephone as allowed by the administrative law judge. The hearing shall be limited to the amount of time necessary for the participants to expeditiously present the facts about the proposed termination. The administrative law judge shall issue a recommendation to the commissioner within ten business days after the hearing.

(b) A resident who timely appeals a notice of lease termination may not be evicted by the housing with services establishment or assisted living setting until the Office of Administrative Hearings has made a final determination on the appeal in favor of the housing with services establishment or assisted living setting.

(c) The commissioner of health may direct the housing with services establishment or assisted living setting to rescind the lease termination or readmit the resident if the Office of Administrative Hearings holds that the lease termination was in violation of state or federal law.

(d) The housing with services establishment or assisted living setting must readmit the resident following a hospitalization if the resident is hospitalized for medical necessity before resolution of the appeal.

(e) Residents are not required to request a meeting under subdivision 4, prior to submitting an appeal hearing request.

(f) Nothing in this section limits the right of a resident or the resident's representative to request or receive assistance from the Office of Ombudsman for Long-Term Care and the protection and advocacy agency concerning the proposed lease termination.

Subd. 6. **Discharge plan and transfer of information to new residence.** (a) A housing with services establishment or assisted living setting discharging a resident must prepare an adequate discharge plan that proposes a safe discharge location, is based on the resident's discharge goals, includes the resident and the resident's case manager and representative, if any, in discharge planning, and contains a plan for appropriate and sufficient postdischarge care. A housing with services establishment or assisted living setting may not discharge a resident if upon discharge the resident will become a homeless individual, as defined in section 116L.361, subdivision 5.

(b) A housing with services establishment or assisted living setting that proposes to discharge a resident must assist the resident with applying for and locating a new housing with services establishment, assisted living setting, or skilled nursing facility in which to live, including coordinating with the case manager, if any.

(c) Prior to discharge, a housing with services establishment or assisted living setting must provide to the receiving facility or establishment all information known to the housing with services establishment related to the resident that is necessary to ensure continuity of care and services, including at a minimum:

(1) the resident's full name, date of birth, and insurance information;

(2) the name, telephone number, and address of the resident's representative, if any;

(3) the resident's current documented diagnoses;

(4) the resident's known allergies, if any;

(5) the name and telephone number of the resident's physician and current physician orders;

(6) medication administration records;

(7) the most recent resident assessment; and

(8) copies of health care directives, "do not resuscitate" orders, and guardianship orders or powers of attorney, if any.

(d) For the purposes of this subdivision, "discharge" means the involuntary relocation of a resident due to a termination of a lease.

Subd. 7. **Final accounting; return of money and property.** Within 30 days of the date of discharge, the housing with services establishment or assisted living setting shall:

(1) provide to the resident or the resident's representative a final statement of account;

(2) provide any refunds due; and

(3) return any money, property, or valuables held in trust or custody by the establishment.

Sec. 34. **[144D.095] TERMINATION OF SERVICES.**

Subdivision 1. **Legislative intent.** It is the intent of the legislature to ensure to the greatest extent possible consistent and stable services for persons residing in housing with services establishments and assisted living settings.

Subd. 2. **Notice; permissible reasons to terminate services.** (a) Except as provided in paragraph (b), an arranged home care provider must provide at least 30 days' notice prior to terminating a service contract. Notwithstanding any other provision of law, an arranged home care provider may terminate services only if:

(1) the resident engages in conduct that interferes with the home care provider's ability to carry out the terms of the service plan and cannot be cured by updating or changing the terms of the service plan; or

(2) the resident breaches the services agreement, including failure to pay for services, provided the resident has not cured the breach within 30 days of receiving written notice of the nonpayment.

(b) Notwithstanding paragraph (a), the arranged home care provider may terminate services with ten days' notice if:

(1) the resident creates, and the provider documents, an abusive or unsafe work environment for the individual providing home care services; or

(2) a doctor or treating physician documents that an emergency or a significant change in the resident's condition has resulted in service needs that exceed the current service plan and that cannot be safely met by the home care provider.

Subd. 3. **Contents of service termination notice.** (a) If an arranged home care provider who is not also Medicare certified terminates a service agreement or service plan with a resident in a housing with services establishment and assisted living setting, the home care provider shall provide the resident and the legal or designated representatives of the resident, if any, with advance written notice of service termination according to subdivision 2, that must include:

(1) the effective date of service termination;

(2) the reason for service termination;

(3) without extending the termination notice period, an affirmative offer to meet with the resident or resident's representatives within no more than five business days of the date of the service termination notice to discuss the termination;

(4) contact information for other home care providers in the geographic area of the resident, as required by section 144A.4791, subdivision 10;

(5) a statement that the provider will participate in a coordinated transfer of the care of the client to another provider or caregiver, as required by section 144A.44, subdivision 1, clause (18);

(6) a statement that the resident has the right to request a meeting with the arranged home care provider to discuss and attempt to avoid the service termination;

(7) the name and contact information of a representative of the arranged home care provider with whom the resident may discuss the notice of service termination;

(8) a copy of the home care bill of rights;

(9) a statement that the notice of service termination of home care services by the home care provider does not constitute notice of termination of the housing with services establishment or assisted living setting lease; and

(10) a statement that the resident has the right to appeal the service termination to the Office of Administrative Hearings and provide the contact information for the Office of Administrative Hearings including the address, fax number, e-mail, and telephone number.

Subd. 4. **Right to appeal service termination.** (a) At any time prior to the expiration of the notice period provided under subdivision 2 and section 144A.441, a resident may appeal the service termination by making a written request for a hearing to the Office of Administrative Hearings. The Office of Administrative Hearings must conduct the hearing no later than 14 days after the office receives the appeal request from the resident. The

hearing must be held in the place where the resident resides, unless it is impractical or the parties agree to a different place. Attorney representation is not required at the hearing, nor does appearing without an attorney constitute the unauthorized practice of law. The hearing shall not be construed as a formal evidentiary hearing. The hearing may also be attended by telephone as allowed by the administrative law judge. The hearing shall be limited to the amount of time necessary for the participants to expeditiously present the facts about the proposed termination. The administrative law judge shall issue a recommendation to the commissioner within ten business days after the hearing.

(b) The arranged home care provider may not discontinue services to a resident who timely appeals a notice of service termination until the Office of Administrative Hearings has made a final determination on the appeal in favor of the housing with services establishment or assisted living setting.

(c) Residents are not required to request a meeting under subdivision 3, clause (6), prior to submitting an appeal hearing request.

(d) The commissioner of health may direct the facility to rescind the service contract termination if the Office of Administrative Hearings holds that the proposed termination was in violation of state or federal law.

(e) Nothing in this section limits the right of a resident or the resident's representative to request or receive assistance from the Office of Ombudsman for Long-Term Care and the protection and advocacy agency concerning the proposed service termination.

Sec. 35. Minnesota Statutes 2017 Supplement, section 256.045, subdivision 3, is amended to read:

Subd. 3. **State agency hearings.** (a) State agency hearings are available for the following:

(1) any person applying for, receiving or having received public assistance, medical care, or a program of social services granted by the state agency or a county agency or the federal Food Stamp Act whose application for assistance is denied, not acted upon with reasonable promptness, or whose assistance is suspended, reduced, terminated, or claimed to have been incorrectly paid;

(2) any patient or relative aggrieved by an order of the commissioner under section 252.27;

(3) a party aggrieved by a ruling of a prepaid health plan;

(4) except as provided under chapter 245C~~,~~:

(i) any individual or facility determined by a lead investigative agency to have maltreated a vulnerable adult under section 626.557 after they have exercised their right to administrative reconsideration under section 626.557; and

(ii) any vulnerable adult who is the subject of a maltreatment investigation under section 626.557 or unless restricted by the vulnerable adult or by a court, an interested person as defined in section 144.651, subdivision 2, after the right to administrative reconsideration under section 626.557, subdivision 9d, has been exercised;

(5) any person whose claim for foster care payment according to a placement of the child resulting from a child protection assessment under section 626.556 is denied or not acted upon with reasonable promptness, regardless of funding source;

(6) any person to whom a right of appeal according to this section is given by other provision of law;

(7) an applicant aggrieved by an adverse decision to an application for a hardship waiver under section 256B.15;

(8) an applicant aggrieved by an adverse decision to an application or redetermination for a Medicare Part D prescription drug subsidy under section 256B.04, subdivision 4a;

(9) except as provided under chapter 245A, an individual or facility determined to have maltreated a minor under section 626.556, after the individual or facility has exercised the right to administrative reconsideration under section 626.556;

(10) except as provided under chapter 245C, an individual disqualified under sections 245C.14 and 245C.15, following a reconsideration decision issued under section 245C.23, on the basis of serious or recurring maltreatment; a preponderance of the evidence that the individual has committed an act or acts that meet the definition of any of the crimes listed in section 245C.15, subdivisions 1 to 4; or for failing to make reports required under section 626.556, subdivision 3, or 626.557, subdivision 3. Hearings regarding a maltreatment determination under clause (4) or (9) and a disqualification under this clause in which the basis for a disqualification is serious or recurring maltreatment, shall be consolidated into a single fair hearing. In such cases, the scope of review by the human services judge shall include both the maltreatment determination and the disqualification. The failure to exercise the right to an administrative reconsideration shall not be a bar to a hearing under this section if federal law provides an individual the right to a hearing to dispute a finding of maltreatment;

(11) any person with an outstanding debt resulting from receipt of public assistance, medical care, or the federal Food Stamp Act who is contesting a setoff claim by the Department of Human Services or a county agency. The scope of the appeal is the validity of the claimant agency's intention to request a setoff of a refund under chapter 270A against the debt;

(12) a person issued a notice of service termination under section 245D.10, subdivision 3a, from residential supports and services as defined in section 245D.03, subdivision 1, paragraph (c), clause (3), that is not otherwise subject to appeal under subdivision 4a;

(13) an individual disability waiver recipient based on a denial of a request for a rate exception under section 256B.4914; or

(14) a person issued a notice of service termination under section 245A.11, subdivision 11, that is not otherwise subject to appeal under subdivision 4a.

(b) The hearing for an individual or facility under paragraph (a), clause (4), (9), or (10), is the only administrative appeal to the final agency determination specifically, including a challenge to the accuracy and completeness of data under section 13.04. Hearings requested under paragraph (a), clause (4), apply only to incidents of maltreatment that occur on or after October 1, 1995. Hearings requested by nursing assistants in nursing homes alleged to have maltreated a resident prior to October 1, 1995, shall be held as a contested case proceeding under the provisions of chapter 14. Hearings requested under paragraph (a), clause (9), apply only to incidents of maltreatment that occur on or after July 1, 1997. A hearing for an individual or facility under paragraph (a), clauses (4), (9), and (10), is only available when there is no district court action pending. If such action is filed in district court while an administrative review is pending that arises out of some or all of the events or circumstances on which the appeal is based, the administrative review must be suspended until the judicial actions are completed. If the district court proceedings are completed, dismissed, or overturned, the matter may be considered in an administrative hearing.

(c) For purposes of this section, bargaining unit grievance procedures are not an administrative appeal.

(d) The scope of hearings involving claims to foster care payments under paragraph (a), clause (5), shall be limited to the issue of whether the county is legally responsible for a child's placement under court order or voluntary placement agreement and, if so, the correct amount of foster care payment to be made on the child's behalf and shall not include review of the propriety of the county's child protection determination or child placement decision.

(e) The scope of hearings under paragraph (a), clauses (12) and (14), shall be limited to whether the proposed termination of services is authorized under section 245D.10, subdivision 3a, paragraph (b), or 245A.11, subdivision 11, and whether the requirements of section 245D.10, subdivision 3a, paragraphs (c) to (e), or 245A.11, subdivision 2a, paragraphs (d) to (f), were met. If the appeal includes a request for a temporary stay of termination of services, the scope of the hearing shall also include whether the case management provider has finalized arrangements for a residential facility, a program, or services that will meet the assessed needs of the recipient by the effective date of the service termination.

(f) A vendor of medical care as defined in section 256B.02, subdivision 7, or a vendor under contract with a county agency to provide social services is not a party and may not request a hearing under this section, except if assisting a recipient as provided in subdivision 4.

(g) An applicant or recipient is not entitled to receive social services beyond the services prescribed under chapter 256M or other social services the person is eligible for under state law.

(h) The commissioner may summarily affirm the county or state agency's proposed action without a hearing when the sole issue is an automatic change due to a change in state or federal law.

(i) Unless federal or Minnesota law specifies a different time frame in which to file an appeal, an individual or organization specified in this section may contest the specified action, decision, or final disposition before the state agency by submitting a written request for a hearing to the state agency within 30 days after receiving written notice of the action, decision, or final disposition, or within 90 days of such written notice if the applicant, recipient, patient, or relative shows good cause, as defined in section 256.0451, subdivision 13, why the request was not submitted within the 30-day time limit. The individual filing the appeal has the burden of proving good cause by a preponderance of the evidence.

Sec. 36. Minnesota Statutes 2017 Supplement, section 256.045, subdivision 3b, is amended to read:

Subd. 3b. **Standard of evidence for maltreatment and disqualification hearings.** (a) The state human services judge shall determine that maltreatment has occurred if a preponderance of evidence exists to support the final disposition under sections 626.556 and 626.557. For purposes of hearings regarding disqualification, the state human services

judge shall affirm the proposed disqualification in an appeal under subdivision 3, paragraph (a), clause (10), if a preponderance of the evidence shows the individual has:

(1) committed maltreatment under section 626.556 or 626.557, which is serious or recurring;

(2) committed an act or acts meeting the definition of any of the crimes listed in section 245C.15, subdivisions 1 to 4; or

(3) failed to make required reports under section 626.556 or 626.557, for incidents in which the final disposition under section 626.556 or 626.557 was substantiated maltreatment that was serious or recurring.

(b) If the disqualification is affirmed, the state human services judge shall determine whether the individual poses a risk of harm in accordance with the requirements of section 245C.22, and whether the disqualification should be set aside or not set aside. In determining whether the disqualification should be set aside, the human services judge shall consider all of the characteristics that cause the individual to be disqualified, including those characteristics that were not subject to review under paragraph (a), in order to determine whether the individual poses a risk of harm. A decision to set aside a disqualification that is the subject of the hearing constitutes a determination that the individual does not pose a risk of harm and that the individual may provide direct contact services in the individual program specified in the set aside.

(c) If a disqualification is based solely on a conviction or is conclusive for any reason under section 245C.29, the disqualified individual does not have a right to a hearing under this section.

(d) For purposes of hearings under subdivision 4, if the state human services judge determines that maltreatment has occurred, the state human services judge shall recommend an order to the commissioner of health or human services that the lead investigative agency determines responsibility in accordance with section 626.557, subdivision 9c, who shall issue a final order.

~~(d)~~ (e) The state human services judge shall recommend an order to the commissioner of health, education, or human services, as applicable, who shall issue a final order. The commissioner shall affirm, reverse, or modify the final disposition. Any order of the commissioner issued in accordance with this subdivision is conclusive upon the parties unless appeal is taken in the manner provided in subdivision 7. In any licensing appeal under chapters 245A and 245C and sections 144.50 to 144.58 and 144A.02 to 144A.482, the

commissioner's determination as to maltreatment is conclusive, as provided under section 245C.29.

Sec. 37. Minnesota Statutes 2017 Supplement, section 256.045, subdivision 4, is amended to read:

Subd. 4. **Conduct of hearings.** (a) All hearings held pursuant to subdivision 3, 3a, 3b, or 4a shall be conducted according to the provisions of the federal Social Security Act and the regulations implemented in accordance with that act to enable this state to qualify for federal grants-in-aid, and according to the rules and written policies of the commissioner of human services. County agencies shall install equipment necessary to conduct telephone hearings. A state human services judge may schedule a telephone conference hearing when the distance or time required to travel to the county agency offices will cause a delay in the issuance of an order, or to promote efficiency, or at the mutual request of the parties. Hearings may be conducted by telephone conferences unless the applicant, recipient, former recipient, person, or facility contesting maltreatment objects. A human services judge may grant a request for a hearing in person by holding the hearing by interactive video technology or in person. The human services judge must hear the case in person if the person asserts that either the person or a witness has a physical or mental disability that would impair the person's or witness's ability to fully participate in a hearing held by interactive video technology. The hearing shall not be held earlier than five days after filing of the required notice with the county or state agency. The state human services judge shall notify all interested persons of the time, date, and location of the hearing at least five days before the date of the hearing. Interested persons may be represented by legal counsel or other representative of their choice, including a provider of therapy services, at the hearing and may appear personally, testify and offer evidence, and examine and cross-examine witnesses. The applicant, recipient, former recipient, person, or facility contesting maltreatment shall have the opportunity to examine the contents of the case file and all documents and records to be used by the county or state agency at the hearing at a reasonable time before the date of the hearing and during the hearing. In hearings under subdivision 3, paragraph (a), clauses (4), (9), and (10), either party may subpoena the private data relating to the investigation prepared by the agency under section 626.556 or 626.557 that is not otherwise accessible under section 13.04, provided the identity of the reporter may not be disclosed.

(b) The private data obtained by subpoena in a hearing under subdivision 3, paragraph (a), clause (4), (9), or (10), must be subject to a protective order which prohibits its disclosure for any other purpose outside the hearing provided for in this section without prior order of the district court. Disclosure without court order is punishable by a sentence of not more

than 90 days imprisonment or a fine of not more than $1,000, or both. These restrictions on the use of private data do not prohibit access to the data under section 13.03, subdivision 6. Except for appeals under subdivision 3, paragraph (a), clauses (4), (5), (9), and (10), upon request, the county agency shall provide reimbursement for transportation, child care, photocopying, medical assessment, witness fee, and other necessary and reasonable costs incurred by the applicant, recipient, or former recipient in connection with the appeal. All evidence, except that privileged by law, commonly accepted by reasonable people in the conduct of their affairs as having probative value with respect to the issues shall be submitted at the hearing and such hearing shall not be "a contested case" within the meaning of section 14.02, subdivision 3. The agency must present its evidence prior to or at the hearing, and may not submit evidence after the hearing except by agreement of the parties at the hearing, provided the petitioner has the opportunity to respond.

(c) In hearings under subdivision 3, paragraph (a), clauses (4), (9), and (10), involving determinations of maltreatment or disqualification made by more than one county agency, by a county agency and a state agency, or by more than one state agency, the hearings may be consolidated into a single fair hearing upon the consent of all parties and the state human services judge.

(d) For hearings under subdivision 3, paragraph (a), clause (4) or (10), involving a vulnerable adult, the human services judge shall notify: (1) the vulnerable adult who is the subject of the maltreatment determination and an interested person, as defined in section 144.651, subdivision 2, if known, ~~a guardian of the vulnerable adult appointed under section 524.5-310, or a health care agent designated by the vulnerable adult in a health care directive that is currently effective under section 145C.06 and whose authority to make health care decisions is not suspended under section 524.5-310,~~ of the hearing requested by the individual or facility determined to have maltreated a vulnerable adult under section 626.557; and (2) the facility or individual who is the alleged perpetrator of maltreatment of the hearing requested by the vulnerable adult who is the subject of the maltreatment determination or an interested person as defined in section 144.651, subdivision 2.

The notice must be sent by certified mail and inform the vulnerable adult, the facility, or the alleged perpetrator of the right to file a signed written statement in the proceedings. A guardian or health care agent who prepares or files a written statement for the vulnerable adult must indicate in the statement that the person is the vulnerable adult's guardian or health care agent and sign the statement in that capacity. The vulnerable adult, the guardian, or the health care agent may file a written statement with the human services judge hearing the case no later than five business days before commencement of the hearing. The human

services judge shall include the written statement in the hearing record and consider the statement in deciding the appeal. This subdivision does not limit, prevent, or excuse the vulnerable adult or alleged perpetrator from being called as a witness testifying at the hearing or grant the vulnerable adult, the guardian, the alleged perpetrator, or health care agent a right to participate in the proceedings or appeal the human services judge's decision in the case. The lead investigative agency must consider including the vulnerable adult victim of maltreatment as a witness in the hearing. If the lead investigative agency determines that participation in the hearing would endanger the well-being of the vulnerable adult or not be in the best interests of the vulnerable adult, the lead investigative agency shall inform the human services judge of the basis for this determination, which must be included in the final order. If the human services judge is not reasonably able to determine the address of the vulnerable adult, the guardian, the alleged perpetrator, or the health care agent, the human services judge is not required to send a hearing notice under this subdivision.

Sec. 38. Minnesota Statutes 2016, section 325F.71, is amended to read:

325F.71 SENIOR CITIZENS, VULNERABLE ADULTS, AND ~~DISABLED~~ PERSONS WITH DISABILITIES; ADDITIONAL CIVIL PENALTY FOR DECEPTIVE ACTS.

Subdivision 1. **Definitions.** For the purposes of this section, the following words have the meanings given them:

(a) "Senior citizen" means a person who is 62 years of age or older.

(b) "~~Disabled~~ Person with a disability" means a person who has an impairment of physical or mental function or emotional status that substantially limits one or more major life activities.

(c) "Major life activities" means functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

(d) "Vulnerable adult" has the meaning given in section 626.5572, subdivision 21.

Subd. 2. **Supplemental civil penalty.** (a) In addition to any liability for a civil penalty pursuant to sections 325D.43 to 325D.48, regarding deceptive trade practices; 325F.67, regarding false advertising; and 325F.68 to 325F.70, regarding consumer fraud; a person who engages in any conduct prohibited by those statutes, and whose conduct is perpetrated against one or more senior citizens, vulnerable adult, or ~~disabled~~ persons with a disability, is liable for an additional civil penalty not to exceed $10,000 for each violation, if one or more of the factors in paragraph (b) are present.

(b) In determining whether to impose a civil penalty pursuant to paragraph (a), and the amount of the penalty, the court shall consider, in addition to other appropriate factors, the extent to which one or more of the following factors are present:

(1) whether the defendant knew or should have known that the defendant's conduct was directed to one or more senior citizens, vulnerable adults, or ~~disabled~~ persons with a disability;

(2) whether the defendant's conduct caused one or more senior citizens, vulnerable adults, or ~~disabled~~ persons with a disability to suffer: loss or encumbrance of a primary residence, principal employment, or source of income; substantial loss of property set aside for retirement or for personal or family care and maintenance; substantial loss of payments received under a pension or retirement plan or a government benefits program; or assets essential to the health or welfare of the senior citizen, vulnerable adult, or ~~disabled~~ person with a disability;

(3) whether one or more senior citizens, vulnerable adults, or ~~disabled~~ persons with a disability are more vulnerable to the defendant's conduct than other members of the public because of age, poor health or infirmity, impaired understanding, restricted mobility, or disability, and actually suffered physical, emotional, or economic damage resulting from the defendant's conduct; ~~or~~

(4) whether the defendant's conduct caused senior citizens, vulnerable adults, or ~~disabled~~ persons with a disability to make an uncompensated asset transfer that resulted in the person being found ineligible for medical assistance~~.~~; or

(5) whether the defendant provided or arranged for health care or services that are inferior to, substantially different than, or substantially more expensive than offered, promised, marketed, or advertised.

Subd. 3. **Restitution to be given priority.** Restitution ordered pursuant to the statutes listed in subdivision 2 shall be given priority over imposition of civil penalties designated by the court under this section.

Subd. 4. **Private remedies.** A person injured by a violation of this section may bring a civil action and recover damages, together with costs and disbursements, including costs of investigation and reasonable ~~attorney's~~ attorney fees, and receive other equitable relief as determined by the court.

Sec. 39. Minnesota Statutes 2016, section 573.02, subdivision 2, is amended to read:

Subd. 2. **Injury action.** (a) When injury is caused to a person by the wrongful act or omission of any person or corporation and the person thereafter dies from a cause unrelated to those injuries, the trustee appointed in subdivision 3 may maintain an action for special damages arising out of such injury if the decedent might have maintained an action therefor had the decedent lived.

(b) When the injury is caused to a person who was a vulnerable adult, prior to the injury, the next of kin may maintain an action on behalf of the decedent for damages for pain and suffering, in addition to special damages as provided under paragraph (a). For purposes of this paragraph, "vulnerable adult" has the meaning given in section 626.5572, subdivision 21.

Sec. 40. Minnesota Statutes 2016, section 609.2231, subdivision 8, is amended to read:

Subd. 8. **Vulnerable adults.** (a) As used in this subdivision, "vulnerable adult" has the meaning given in section 609.232, subdivision 11.

(b) Whoever assaults ~~and inflicts demonstrable bodily harm on~~ a vulnerable adult, knowing or having reason to know that the person is a vulnerable adult, is guilty of a gross misdemeanor.

Sec. 41. Minnesota Statutes 2016, section 626.557, subdivision 3, is amended to read:

Subd. 3. **Timing of report.** (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall ~~immediately~~ within 24 hours report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless:

(1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or

(2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4).

(b) A person not required to report under the provisions of this section may voluntarily report as described above.

(c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.

(d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.

(e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c.

Sec. 42. Minnesota Statutes 2016, section 626.557, subdivision 4, is amended to read:

Subd. 4. **Reporting.** (a) Except as provided in paragraph (b), a mandated reporter shall immediately make an oral report to the common entry point. The common entry point may accept electronic reports submitted through a Web-based reporting system established by the commissioner. Use of a telecommunications device for the deaf or other similar device shall be considered an oral report. The common entry point may not require written reports. To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment, any evidence of previous maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment. A mandated reporter may disclose not public data, as defined in section 13.02, and medical records under sections 144.291 to 144.298, to the extent necessary to comply with this subdivision.

(b) A boarding care home that is licensed under sections 144.50 to 144.58 and certified under Title 19 of the Social Security Act, a nursing home that is licensed under section 144A.02 and certified under Title 18 or Title 19 of the Social Security Act, or a hospital that is licensed under sections 144.50 to 144.58 and has swing beds certified under Code of Federal Regulations, title 42, section 482.66, may submit a report electronically to the common entry point instead of submitting an oral report. ~~The report may be a duplicate of~~

~~the initial report the facility submits electronically to the commissioner of health to comply with the reporting requirements under Code of Federal Regulations, title 42, section 483.13.~~ The commissioner of health may modify these reporting requirements to include items required under paragraph (a) that are not currently included in the electronic reporting form.

(c) All reports shall be directed to the common entry point, including reports from federally licensed facilities, vulnerable adults, and interested persons.

Sec. 43. Minnesota Statutes 2016, section 626.557, subdivision 9, is amended to read:

Subd. 9. **Common entry point designation.** (a) Each county board shall designate a common entry point for reports of suspected maltreatment, for use until the commissioner of human services establishes a common entry point. Two or more county boards may jointly designate a single common entry point. The commissioner of human services shall establish a common entry point effective July 1, 2015. The common entry point is the unit responsible for receiving the report of suspected maltreatment under this section.

(b) The common entry point must be available 24 hours per day to take calls from reporters of suspected maltreatment. The common entry point staff must receive training on how to screen and dispatch reports efficiently and in accordance with this section. The common entry point shall use a standard intake form that includes:

(1) the time and date of the report;

(2) the name, address, and telephone number of the person reporting;

(3) the time, date, and location of the incident;

(4) the names of the persons involved, including but not limited to, perpetrators, alleged victims, and witnesses;

(5) whether there was a risk of imminent danger to the alleged victim;

(6) a description of the suspected maltreatment;

(7) the disability, if any, of the alleged victim;

(8) the relationship of the alleged perpetrator to the alleged victim;

(9) whether a facility was involved and, if so, which agency licenses the facility;

(10) any action taken by the common entry point;

(11) whether law enforcement has been notified;

(12) whether the reporter wishes to receive notification of the initial and final reports; and

(13) if the report is from a facility with an internal reporting procedure, the name, mailing address, and telephone number of the person who initiated the report internally.

(c) The common entry point is not required to complete each item on the form prior to dispatching the report to the appropriate lead investigative agency.

(d) The common entry point shall immediately report to a law enforcement agency any incident in which there is reason to believe a crime has been committed.

(e) If a report is initially made to a law enforcement agency or a lead investigative agency, those agencies shall take the report on the appropriate common entry point intake forms and immediately forward a copy to the common entry point.

(f) The common entry point staff must receive training on how to screen and dispatch reports efficiently and in accordance with this section.

(g) The commissioner of human services shall maintain a centralized database for the collection of common entry point data, lead investigative agency data including maltreatment report disposition, and appeals data. The common entry point shall have access to the centralized database and must log the reports into the database and immediately identify and locate prior reports of abuse, neglect, or exploitation.

(h) When appropriate, the common entry point staff must refer calls that do not allege the abuse, neglect, or exploitation of a vulnerable adult to other organizations that might resolve the reporter's concerns.

(i) A common entry point must be operated in a manner that enables the commissioner of human services to:

(1) track critical steps in the reporting, evaluation, referral, response, disposition, and investigative process to ensure compliance with all requirements for all reports;

(2) maintain data to facilitate the production of aggregate statistical reports for monitoring patterns of abuse, neglect, or exploitation;

(3) serve as a resource for the evaluation, management, and planning of preventative and remedial services for vulnerable adults who have been subject to abuse, neglect, or exploitation;

(4) set standards, priorities, and policies to maximize the efficiency and effectiveness of the common entry point; and

(5) track and manage consumer complaints related to the common entry point.

(j) The commissioners of human services and health shall collaborate on the creation of a system for referring reports to the lead investigative agencies. This system shall enable the commissioner of human services to track critical steps in the reporting, evaluation, referral, response, disposition, investigation, notification, determination, and appeal processes.

Sec. 44. Minnesota Statutes 2016, section 626.557, subdivision 9a, is amended to read:

Subd. 9a. **Evaluation and referral of reports made to common entry point.** (a) The common entry point must screen the reports of alleged or suspected maltreatment for immediate risk and make all necessary referrals as follows:

(1) if the common entry point determines that there is an immediate need for emergency adult protective services, the common entry point agency shall immediately notify the appropriate county agency;

(2) <u>if the common entry point determines immediate need exists for response by law enforcement, including but not limited to the urgent need to secure a crime scene, interview witnesses, remove the alleged perpetrator, or safeguard the vulnerable adult's property, or</u> if the report contains suspected criminal activity against a vulnerable adult, the common entry point shall immediately notify the appropriate law enforcement agency;

(3) the common entry point shall refer all reports of alleged or suspected maltreatment to the appropriate lead investigative agency as soon as possible, but in any event no longer than two working days;

(4) if the report contains information about a suspicious death, the common entry point shall immediately notify the appropriate law enforcement agencies, the local medical examiner, and the ombudsman for mental health and developmental disabilities established under section 245.92. Law enforcement agencies shall coordinate with the local medical examiner and the ombudsman as provided by law; and

(5) for reports involving multiple locations or changing circumstances, the common entry point shall determine the county agency responsible for emergency adult protective services and the county responsible as the lead investigative agency, using referral guidelines established by the commissioner.

(b) If the lead investigative agency receiving a report believes the report was referred by the common entry point in error, the lead investigative agency shall immediately notify the common entry point of the error, including the basis for the lead investigative agency's belief that the referral was made in error. The common entry point shall review the

information submitted by the lead investigative agency and immediately refer the report to the appropriate lead investigative agency.

Sec. 45. Minnesota Statutes 2016, section 626.557, subdivision 9b, is amended to read:

Subd. 9b. **Response to reports.** Law enforcement is the primary agency to conduct investigations of any incident in which there is reason to believe a crime has been committed. Law enforcement shall initiate a response immediately. If the common entry point notified a county agency for emergency adult protective services, law enforcement shall cooperate with that county agency when both agencies are involved and shall exchange data to the extent authorized in subdivision 12b, paragraph ~~(g)~~ (k). County adult protection shall initiate a response immediately. Each lead investigative agency shall complete the investigative process for reports within its jurisdiction. A lead investigative agency, county, adult protective agency, licensed facility, or law enforcement agency shall cooperate with other agencies in the provision of protective services, coordinating its investigations, and assisting another agency within the limits of its resources and expertise and shall exchange data to the extent authorized in subdivision 12b, paragraph ~~(g)~~ (k). The lead investigative agency shall obtain the results of any investigation conducted by law enforcement officials~~.~~ and law enforcement shall obtain the results of any investigation conducted by the lead investigative agency to determine if criminal action is warranted. The lead investigative agency has the right to enter facilities and inspect and copy records as part of investigations. The lead investigative agency has access to not public data, as defined in section 13.02, and medical records under sections 144.291 to 144.298, that are maintained by facilities to the extent necessary to conduct its investigation. Each lead investigative agency shall develop guidelines for prioritizing reports for investigation. Nothing in this subdivision alters the duty of the lead investigative agency to serve as the agency responsible for investigating reports made under this section.

Sec. 46. Minnesota Statutes 2016, section 626.557, subdivision 9c, is amended to read:

Subd. 9c. **Lead investigative agency; notifications, dispositions, determinations.** (a) ~~Upon request of the reporter,~~ The lead investigative agency shall notify the reporter that it has received the report, and provide information on the initial disposition of the report within five business days of receipt of the report, provided that the notification will not endanger the vulnerable adult or hamper the investigation.

(b) If the lead investigative agency is the Department of Health or the Department of Human Services according to section 626.5572, subdivision 13, the lead investigative agency

must provide the information in this paragraph to the vulnerable adult or the vulnerable adult's interested person, if identified in the report, within five days of receipt of the report, unless the lead investigative agency believes that notification would endanger the vulnerable adult or hamper the investigation. If the facility is federally certified, the lead investigative agency must comply with federal laws when releasing information. The information required to be provided is:

(1) the report of maltreatment with names, contact information, and identifying information redacted;

(2) the name of the facility or other location at which alleged maltreatment occurred;

(3) whether the alleged perpetrator was an employee of the facility;

(4) contact information for the investigator; and

(5) confirmation of whether the facility is investigating the matter, and if so, a statement that the lead investigative agency will provide periodic updates and a report when the investigation is concluded.

(c) The lead investigative agency may assign multiple reports of maltreatment for the same or separate incidences related to the same vulnerable adult to the same investigator, as deemed appropriate. Reports related to the same vulnerable adult must, at a minimum, be cross-referenced.

~~(b)~~ (d) Upon conclusion of every investigation it conducts, the lead investigative agency shall make a final disposition as defined in section 626.5572, subdivision 8.

~~(c)~~ (e) When determining whether the facility or individual is the responsible party for substantiated maltreatment or whether both the facility and the individual are responsible for substantiated maltreatment, the lead investigative agency shall consider at least the following mitigating factors:

(1) whether the actions of the facility or the individual caregivers were in accordance with, and followed the terms of, an erroneous physician order, prescription, resident care plan, or directive. This is not a mitigating factor when the facility or caregiver is responsible for the issuance of the erroneous order, prescription, plan, or directive or knows or should have known of the errors and took no reasonable measures to correct the defect before administering care;

(2) the comparative responsibility between the facility, other caregivers, and requirements placed upon the employee, including but not limited to, the facility's compliance with related regulatory standards and factors such as the adequacy of facility policies and procedures,

the adequacy of facility training, the adequacy of an individual's participation in the training, the adequacy of caregiver supervision, the adequacy of facility staffing levels, and a consideration of the scope of the individual employee's authority; and

(3) whether the facility or individual followed professional standards in exercising professional judgment.

~~(d)~~ (f) When substantiated maltreatment is determined to have been committed by an individual who is also the facility license holder, both the individual and the facility must be determined responsible for the maltreatment, and both the background study disqualification standards under section 245C.15, subdivision 4, and the licensing actions under section 245A.06 or 245A.07 apply.

~~(e)~~ (g) The lead investigative agency shall complete its final disposition within 60 calendar days. If the lead investigative agency is unable to complete its final disposition within 60 calendar days, the lead investigative agency shall notify the following persons provided that the notification will not endanger the vulnerable adult or hamper the investigation: (1) the vulnerable adult or ~~the vulnerable adult's guardian or health care agent~~ an interested person under section 144.651, subdivision 2, when known, if the lead investigative agency knows them to be aware of the investigation; and (2) the facility, where applicable. The notice shall contain the reason for the delay and the projected completion date. If the lead investigative agency is unable to complete its final disposition by a subsequent projected completion date, the lead investigative agency shall again notify the vulnerable adult or ~~the vulnerable adult's guardian or health care agent~~ an interested person under section 144.651, subdivision 2, when known if the lead investigative agency knows them to be aware of the investigation, and the facility, where applicable, of the reason for the delay and the revised projected completion date provided that the notification will not endanger the vulnerable adult or hamper the investigation. The lead investigative agency must notify the health care agent of the vulnerable adult only if the health care agent's authority to make health care decisions for the vulnerable adult is currently effective ~~under section 145C.06~~ and not suspended under section 524.5-310 ~~and the investigation relates to a duty assigned to the health care agent by the principal~~. A lead investigative agency's inability to complete the final disposition within 60 calendar days or by any projected completion date does not invalidate the final disposition.

~~(f)~~ (h) Within ten calendar days of completing the final disposition, the lead investigative agency shall provide a copy of the public investigation memorandum under subdivision 12b, paragraph ~~(b), clause (1)~~ (d), when required to be completed under this section, to the following persons: (1) the vulnerable adult, ~~or the vulnerable adult's guardian or health care~~

~~agent~~ an interested person, if known, unless the lead investigative agency knows that the notification would endanger the well-being of the vulnerable adult; (2) unless the reporter instructs otherwise, the reporter~~, if the reporter requested notification~~ when making the report, provided this notification would not endanger the well-being of the vulnerable adult; (3) the alleged perpetrator, if known; (4) the facility; ~~and~~ (5) the ombudsman for long-term care, or the ombudsman for mental health and developmental disabilities, as appropriate~~.~~; (6) law enforcement; and (7) the county attorney, as appropriate.

~~(g)~~ (i) If, as a result of a reconsideration, review, or hearing, the lead investigative agency changes the final disposition, or if a final disposition is changed on appeal, the lead investigative agency shall notify the parties specified in paragraph ~~(f)~~ (h).

~~(h)~~ (j) The lead investigative agency shall notify the vulnerable adult who is the subject of the report ~~or the vulnerable adult's guardian or health care agent~~ an interested person under section 144.651, subdivision 2, if known, and any person or facility determined to have maltreated a vulnerable adult, of their appeal or review rights under this section or section 256.021.

~~(i)~~ (k) The lead investigative agency shall routinely provide investigation memoranda for substantiated reports to the appropriate licensing boards. These reports must include the names of substantiated perpetrators. The lead investigative agency may not provide investigative memoranda for inconclusive or false reports to the appropriate licensing boards unless the lead investigative agency's investigation gives reason to believe that there may have been a violation of the applicable professional practice laws. If the investigation memorandum is provided to a licensing board, the subject of the investigation memorandum shall be notified and receive a summary of the investigative findings.

~~(j)~~ (l) In order to avoid duplication, licensing boards shall consider the findings of the lead investigative agency in their investigations if they choose to investigate. This does not preclude licensing boards from considering other information.

~~(k)~~ (m) The lead investigative agency must provide to the commissioner of human services its final dispositions, including the names of all substantiated perpetrators. The commissioner of human services shall establish records to retain the names of substantiated perpetrators.

Sec. 47. Minnesota Statutes 2016, section 626.557, subdivision 9d, is amended to read:

Subd. 9d. **Administrative reconsideration~~; review panel~~.** (a) Except as provided under paragraph ~~(e)~~ (d), any individual or facility which a lead investigative agency determines

has maltreated a vulnerable adult, or the vulnerable adult or an interested person acting on behalf of the vulnerable adult, regardless of the lead investigative agency's determination, who contests the lead investigative agency's final disposition of an allegation of maltreatment, may request the lead investigative agency to reconsider its final disposition. The request for reconsideration must be submitted in writing to the lead investigative agency within 15 calendar days after receipt of notice of final disposition or, if the request is made by an interested person who is not entitled to notice, within 15 days after receipt of the notice by the vulnerable adult or the vulnerable adult's guardian or health care agent. If mailed, the request for reconsideration must be postmarked and sent to the lead investigative agency within 15 calendar days of the individual's or facility's receipt of the final disposition. If the request for reconsideration is made by personal service, it must be received by the lead investigative agency within 15 calendar days of the individual's or facility's receipt of the final disposition. An individual who was determined to have maltreated a vulnerable adult under this section and who was disqualified on the basis of serious or recurring maltreatment under sections 245C.14 and 245C.15, may request reconsideration of the maltreatment determination and the disqualification. The request for reconsideration of the maltreatment determination and the disqualification must be submitted in writing within 30 calendar days of the individual's receipt of the notice of disqualification under sections 245C.16 and 245C.17. If mailed, the request for reconsideration of the maltreatment determination and the disqualification must be postmarked and sent to the lead investigative agency within 30 calendar days of the individual's receipt of the notice of disqualification. If the request for reconsideration is made by personal service, it must be received by the lead investigative agency within 30 calendar days after the individual's receipt of the notice of disqualification.

(b) Except as provided under paragraphs (d) and (e) ~~and (f)~~, if the lead investigative agency denies the request or fails to act upon the request within 15 working days after receiving the request for reconsideration, the person, including the vulnerable adult, or an interested person under section 144.651, subdivision 2, acting on behalf of the vulnerable adult, or facility entitled to a fair hearing under section 256.045, may submit to the commissioner of human services a written request for a hearing under that statute. ~~The vulnerable adult, or an interested person acting on behalf of the vulnerable adult, may request a review by the Vulnerable Adult Maltreatment Review Panel under section 256.021 if the lead investigative agency denies the request or fails to act upon the request, or if the vulnerable adult or interested person contests a reconsidered disposition.~~ The lead investigative agency shall notify persons who request reconsideration of their rights under this paragraph. The request must be submitted in writing to the review panel and a copy sent to the lead investigative agency within 30 calendar days of receipt of notice of a denial

of a request for reconsideration or of a reconsidered disposition. The request must specifically identify the aspects of the lead investigative agency determination with which the person is dissatisfied.

(c) If, as a result of a reconsideration or review, the lead investigative agency changes the final disposition, it shall notify the parties specified in subdivision 9c, paragraph ~~(f)~~ (h).

~~(d) For purposes of this subdivision, "interested person acting on behalf of the vulnerable adult" means a person designated in writing by the vulnerable adult to act on behalf of the vulnerable adult, or a legal guardian or conservator or other legal representative, a proxy or health care agent appointed under chapter 145B or 145C, or an individual who is related to the vulnerable adult, as defined in section 245A.02, subdivision 13.~~

~~(e)~~ (d) If an individual was disqualified under sections 245C.14 and 245C.15, on the basis of a determination of maltreatment, which was serious or recurring, and the individual has requested reconsideration of the maltreatment determination under paragraph (a) and reconsideration of the disqualification under sections 245C.21 to 245C.27, reconsideration of the maltreatment determination and requested reconsideration of the disqualification shall be consolidated into a single reconsideration. If reconsideration of the maltreatment determination is denied and the individual remains disqualified following a reconsideration decision, the individual may request a fair hearing under section 256.045. If an individual requests a fair hearing on the maltreatment determination and the disqualification, the scope of the fair hearing shall include both the maltreatment determination and the disqualification.

~~(f)~~ (e) If a maltreatment determination or a disqualification based on serious or recurring maltreatment is the basis for a denial of a license under section 245A.05 or a licensing sanction under section 245A.07, the license holder has the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. As provided for under section 245A.08, the scope of the contested case hearing must include the maltreatment determination, disqualification, and licensing sanction or denial of a license. In such cases, a fair hearing must not be conducted under section 256.045. Except for family child care and child foster care, reconsideration of a maltreatment determination under this subdivision, and reconsideration of a disqualification under section 245C.22, must not be conducted when:

(1) a denial of a license under section 245A.05, or a licensing sanction under section 245A.07, is based on a determination that the license holder is responsible for maltreatment or the disqualification of a license holder based on serious or recurring maltreatment;

(2) the denial of a license or licensing sanction is issued at the same time as the maltreatment determination or disqualification; and

(3) the license holder appeals the maltreatment determination or disqualification, and denial of a license or licensing sanction.

Notwithstanding clauses (1) to (3), if the license holder appeals the maltreatment determination or disqualification, but does not appeal the denial of a license or a licensing sanction, reconsideration of the maltreatment determination shall be conducted under sections 626.556, subdivision 10i, and 626.557, subdivision 9d, and reconsideration of the disqualification shall be conducted under section 245C.22. In such cases, a fair hearing shall also be conducted as provided under sections 245C.27, 626.556, subdivision 10i, and 626.557, subdivision 9d.

If the disqualified subject is an individual other than the license holder and upon whom a background study must be conducted under chapter 245C, the hearings of all parties may be consolidated into a single contested case hearing upon consent of all parties and the administrative law judge.

~~(g)~~ (f) Until August 1, 2002, an individual or facility that was determined by the commissioner of human services or the commissioner of health to be responsible for neglect under section 626.5572, subdivision 17, after October 1, 1995, and before August 1, 2001, that believes that the finding of neglect does not meet an amended definition of neglect may request a reconsideration of the determination of neglect. The commissioner of human services or the commissioner of health shall mail a notice to the last known address of individuals who are eligible to seek this reconsideration. The request for reconsideration must state how the established findings no longer meet the elements of the definition of neglect. The commissioner shall review the request for reconsideration and make a determination within 15 calendar days. The commissioner's decision on this reconsideration is the final agency action.

~~(1)~~ (g) For purposes of compliance with the data destruction schedule under subdivision 12b, paragraph ~~(d)~~ (h), when a finding of substantiated maltreatment has been changed as a result of a reconsideration under this paragraph, the date of the original finding of a substantiated maltreatment must be used to calculate the destruction date.

~~(2)~~ (h) For purposes of any background studies under chapter 245C, when a determination of substantiated maltreatment has been changed as a result of a reconsideration under this paragraph, any prior disqualification of the individual under chapter 245C that was based on this determination of maltreatment shall be rescinded, and for future background studies

under chapter 245C the commissioner must not use the previous determination of substantiated maltreatment as a basis for disqualification or as a basis for referring the individual's maltreatment history to a health-related licensing board under section 245C.31.

Sec. 48. Minnesota Statutes 2016, section 626.557, subdivision 10b, is amended to read:

Subd. 10b. **Investigations; guidelines.** (a) Each lead investigative agency shall develop guidelines for prioritizing reports for investigation. When investigating a report, the lead investigative agency shall conduct the following activities, as appropriate:

(1) interview of the alleged victim;

(2) interview of the reporter and others who may have relevant information;

(3) interview of the alleged perpetrator;

(4) examination of the environment surrounding the alleged incident;

(5) review of pertinent documentation of the alleged incident; and

(6) consultation with professionals.

(b) This paragraph only applies to the Departments of Health and Human Services performing duties as lead investigative agencies under section 626.5572, subdivision 13. The lead investigator must within five days after initiation of an investigation provide the vulnerable adult the investigator's name and contact information, and communicate upon request by the vulnerable adult or the interested person under section 144.651, subdivision 2, the status of the investigation, unless the lead investigative agency believes contact would be detrimental to the vulnerable adult if a family member is the alleged abuser.

Sec. 49. Minnesota Statutes 2016, section 626.557, subdivision 12b, is amended to read:

Subd. 12b. **Data management.** (a) In performing any of the duties of this section as a lead investigative agency, the county social service agency shall maintain appropriate records. Data collected by the county social service agency under this section are welfare data under section 13.46. Notwithstanding section 13.46, subdivision 1, paragraph (a), data under this paragraph that are inactive investigative data on an individual who is a vendor of services are private data on individuals, as defined in section 13.02. The identity of the reporter may only be disclosed as provided in paragraph ~~(c)~~ (g).

(b) Data maintained by the common entry point are ~~confidential~~ private data on individuals or ~~protected~~ nonpublic data as defined in section 13.02. Notwithstanding section 138.163, the common entry point shall maintain data for three calendar years after date of

receipt and then destroy the data unless otherwise directed by federal requirements. This paragraph only applies to the Departments of Health and Human Services performing duties as lead investigative agency under section 626.5572, subdivision 13. The lead investigative agency may provide to the vulnerable adult and an interested person under section 144.651, subdivision 2, if known from the report, a copy of any self-report submitted by the licensed care provider, appropriately redacted pursuant to this section, or state and federal laws.

~~(b)~~ (c) The commissioners of health and human services shall prepare an investigation memorandum for each report alleging maltreatment investigated under this section. County social service agencies must maintain private data on individuals but are not required to prepare an investigation memorandum. During an investigation by the commissioner of health or the commissioner of human services, data collected under this section are confidential data on individuals or protected nonpublic data as defined in section 13.02~~.~~, but may be considered private data on individuals or nonpublic data if the commissioner determines such data classification is needed to protect the health and safety of the vulnerable adult. Upon completion of the investigation, the data are classified as provided in ~~clauses (1) to (3) and paragraph (c)~~ paragraphs (d) to (g).

~~(1)~~ (d) The investigation memorandum must contain the following data, which are public:

~~(i)~~ (1) the name of the facility investigated;

~~(ii)~~ (2) a statement of the nature of the alleged maltreatment;

~~(iii)~~ (3) pertinent information obtained from medical or other records reviewed;

~~(iv)~~ (4) the identity of the investigator;

~~(v)~~ (5) a summary of the investigation's findings;

~~(vi)~~ (6) statement of whether the report was found to be substantiated, inconclusive, false, or that no determination will be made;

~~(vii)~~ (7) a statement of any action taken by the facility;

~~(viii)~~ (8) a statement of any action taken by the lead investigative agency; and

~~(ix)~~ (9) when a lead investigative agency's determination has substantiated maltreatment, a statement of whether an individual, individuals, or a facility were responsible for the substantiated maltreatment, if known.

The investigation memorandum must be written in a manner which protects the identity of the reporter and of the vulnerable adult and may not contain the names or, to the extent possible, data on individuals or private data listed in ~~clause (2)~~ paragraph (e).

~~(2)~~ (e) Data on individuals collected and maintained in the investigation memorandum are private data on individuals, including:

~~(i)~~ (1) the name of the vulnerable adult;

~~(ii)~~ (2) the identity of the individual alleged to be the perpetrator;

~~(iii)~~ (3) the identity of the individual substantiated as the perpetrator; and

~~(iv)~~ (4) the identity of all individuals interviewed as part of the investigation.

~~(3)~~ (f) Other data on individuals maintained as part of an investigation under this section are private data on individuals upon completion of the investigation.

~~(c)~~ (g) After the assessment or investigation is completed, the name of the reporter must be confidential~~.~~, except:

(1) the subject of the report may compel disclosure of the name of the reporter only with the consent of the reporter ~~or upon~~;

(2) upon a written finding by a court that the report was false and there is evidence that the report was made in bad faith~~.~~; or

(3) the mandated reporter may self-disclose to support a claim of retaliation that is prohibited under law, including under subdivisions 4a and 17 and section 144.651, subdivision 34.

This subdivision does not alter disclosure responsibilities or obligations under the Rules of Criminal Procedure, except that where the identity of the reporter is relevant to a criminal prosecution, the district court shall do an in-camera review prior to determining whether to order disclosure of the identity of the reporter.

~~(d)~~ (h) Notwithstanding section 138.163, data maintained under this section by the commissioners of health and human services must be maintained under the following schedule and then destroyed unless otherwise directed by federal requirements:

(1) data from reports determined to be false, maintained for three years after the finding was made;

(2) data from reports determined to be inconclusive, maintained for four years after the finding was made;

(3) data from reports determined to be substantiated, maintained for seven years after the finding was made; and

(4) data from reports which were not investigated by a lead investigative agency and for which there is no final disposition, maintained for three years from the date of the report.

~~(e)~~ (i) The commissioners of health and human services shall annually publish on their Web sites the number and type of reports of alleged maltreatment involving licensed facilities reported under this section, the number of those requiring investigation under this section, and the resolution of those investigations. On a biennial basis, the commissioners of health and human services shall jointly report the following information to the legislature and the governor:

(1) the number and type of reports of alleged maltreatment involving licensed facilities reported under this section, the number of those requiring investigations under this section, the resolution of those investigations, and which of the two lead agencies was responsible;

(2) trends about types of substantiated maltreatment found in the reporting period;

(3) if there are upward trends for types of maltreatment substantiated, recommendations for addressing and responding to them;

(4) efforts undertaken or recommended to improve the protection of vulnerable adults;

(5) whether and where backlogs of cases result in a failure to conform with statutory time frames and recommendations for reducing backlogs if applicable;

(6) recommended changes to statutes affecting the protection of vulnerable adults; and

(7) any other information that is relevant to the report trends and findings.

~~(f)~~ (j) Each lead investigative agency must have a record retention policy.

~~(g)~~ (k) Lead investigative agencies, prosecuting authorities, and law enforcement agencies may exchange not public data, as defined in section 13.02, if the agency or authority requesting the data determines that the data are pertinent and necessary to the requesting agency in initiating, furthering, or completing an investigation under this section. Data collected under this section must be made available to prosecuting authorities and law enforcement officials, local county agencies, and licensing agencies investigating the alleged maltreatment under this section. The lead investigative agency shall exchange not public data with the vulnerable adult maltreatment review panel established in section 256.021 if the data are pertinent and necessary for a review requested under that section. Notwithstanding section 138.17, upon completion of the review, not public data received by the review panel must be destroyed.

~~(h)~~ (l) Each lead investigative agency shall keep records of the length of time it takes to complete its investigations.

~~(i)~~ (m) A lead investigative agency may treat common entry point or investigative data as private data on individuals or nonpublic data and may notify other affected parties, including the vulnerable adult, an interested person under section 144.651, subdivision 2, and ~~their~~ the vulnerable adult's authorized representative if the lead investigative agency has reason to believe maltreatment has occurred and determines the information will safeguard the well-being of the affected parties or dispel widespread rumor or unrest in the affected facility.

~~(j)~~ (n) Under any notification provision of this section, where federal law specifically prohibits the disclosure of patient identifying information, a lead investigative agency may not provide any notice unless the vulnerable adult has consented to disclosure in a manner which conforms to federal requirements.

Sec. 50. Minnesota Statutes 2016, section 626.557, subdivision 14, is amended to read:

Subd. 14. **Abuse prevention plans.** (a) Each facility, except home health agencies and personal care attendant services providers and including a housing with services establishment under chapter 144D and an entity operating under assisted living title protection under section 144G.02, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency.

(b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse.

(c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section,

a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult.

(d) The commissioner of health must issue a correction order and fine upon a finding that the facility has failed to comply with this subdivision and shall calculate the fine amount according to section 144A.474, subdivision 11. Violation of this section must be no less than a Level 2 fine.

Sec. 51. Minnesota Statutes 2016, section 626.557, subdivision 17, is amended to read:

Subd. 17. **Retaliation prohibited.** (a) A facility or person shall not retaliate against any person, including the vulnerable adult or an interested person, who reports in good faith, or who the facility or person believes reported, suspected maltreatment pursuant to this section, or against a vulnerable adult with respect to whom a report is made, because of the report or a presumed report, whether mandatory or voluntary.

(b) In addition to any remedies allowed under sections 181.931 to 181.935, any facility or person which retaliates against any person because of a report of suspected maltreatment is liable to that person for actual damages, punitive damages up to $10,000, and attorney fees. A claim of retaliation may be brought upon showing that the claimant has a good faith reason to believe retaliation occurred as described under this subdivision. The claim may be brought regardless of whether or not there is confirmation that the name of the mandated reporter was known.

(c) There shall be a rebuttable presumption that any adverse action, as defined below, within 90 days of a report, is retaliatory. For purposes of this ~~clause~~ paragraph, the term "adverse action" refers to action taken by a facility or person involved in a report against the person making the report or the person with respect to whom the report was made because of the report, and includes, but is not limited to:

(1) discharge or transfer from the facility;

(2) discharge from or termination of employment;

(3) demotion or reduction in remuneration for services;

(4) restriction or prohibition of access to the facility or its residents; ~~or~~

(5) any restriction of rights set forth in section 144.651~~.~~;

(6) any restriction of access to or use of amenities or services;

(7) termination of services or lease agreement, or both;

(8) sudden increase in costs for services not already contemplated at the time of the maltreatment report;

(9) removal, tampering with, or deprivation of technology, communication, or electronic monitoring devices of the patient or resident;

(10) filing a maltreatment report in bad faith against the reporter; or

(11) oral or written communication of false information about the reporter.

Sec. 52. Minnesota Statutes 2016, section 626.5572, is amended by adding a subdivision to read:

Subd. 12a. **Interested person.** "Interested person" has the meaning given in section 524.5-102.

Sec. 53. **ASSISTED LIVING LICENSING AND DEMENTIA CARE TASK FORCE.**

Subdivision 1. **Creation.** (a) The Assisted Living Licensing and Dementia Care Task Force consists of 18 members, including the following:

(1) one senator appointed by the senate majority leader;

(2) one senator appointed by the senate minority leader;

(3) one member of the house of representatives appointed by the speaker of the house;

(4) one member of the house of representatives appointed by the minority leader of the house of representatives;

(5) the commissioner of health or a designee;

(6) the commissioner of human services or a designee;

(7) the ombudsperson for long-term care or a designee;

(8) the ombudsperson for mental health and developmental disabilities or a designee;

(9) one member appointed by Mid-Minnesota Legal Aid;

(10) one member appointed by the Minnesota Board on Aging;

(11) one member appointed by AARP Minnesota;

(12) one member appointed by the Alzheimer's Association Minnesota-North Dakota Chapter;

(13) one member appointed by Elder Voice Family Advocates;

(14) one member appointed by Minnesota Elder Justice Center;

(15) one member appointed by Care Providers of Minnesota;

(16) one member appointed by LeadingAge Minnesota;

(17) one member appointed by Minnesota HomeCare Association; and

(18) the executive director of the Minnesota Council on Disability.

(b) The appointing authorities must appoint members by July 1, 2018.

(c) The commissioner of health or a designee shall act as chair of the task force and convene the first meeting no later than August 1, 2018.

Subd. 2. **Legislative report on assisted living licensure and dementia care.** (a) The task force shall review existing state and federal laws and existing oversight of assisted living and providers serving people with dementia, and report to the legislature any regulatory gaps requiring improved state regulation and oversight to protect the health and safety of vulnerable adults.

(b) By January 1, 2019, the task force shall present recommendations regarding:

(1) an assisted living license as defined in section 55, subdivision 1;

(2) regulation and fine structure for licensed assisted living;

(3) dementia care core criteria and dementia care unit certification;

(4) serving residents on medical assistance elderly waiver and other waiver programs;

(5) licensing of executive directors and administrators for assisted living;

(6) all items listed in expedited rulemaking under section 55, subdivision 2; and

(7) the exclusion of providers and facilities currently licensed by the Department of Human Services from the requirements of the new assisted living license.

Subd. 3. **Administration.** (a) The task force must meet at least monthly.

(b) The commissioner of health shall provide meeting space and administrative support for the task force.

(c) The commissioner of health and the commissioner of human services shall provide technical assistance to the task force.

(d) Public members of the task force may be compensated as described in Minnesota Statutes, section 15.059, subdivision 3.

(e) A quorum is not required in order for the task force to meet or take testimony, but a quorum of 50 percent plus one member is required to make recommendations.

Subd. 4. **Expiration.** The task force expires on December 31, 2019.

Sec. 54. **ASSISTED LIVING LICENSURE AND DEMENTIA CARE CERTIFICATION.**

Subdivision 1. **Definitions.** (a) "Assisted living license" means a single license covering the provision of health and supportive services and housing provided in a multiunit residential dwelling.

(b) "Assisted living" means any multiunit residential dwelling, as defined by Minnesota Statutes, section 144D.01, subdivision 4, paragraph (a), clause (1), where health-related and supportive services, in combination with housing, are provided to adults.

(c) "Dementia care units" means a setting that provides services to persons with dementia in a secured unit or those settings that are required to disclose the special care status pursuant to Minnesota Statutes, section 325F.72.

(d) "Multiunit residential dwelling" means a residential dwelling containing two or more units intended for use as a residence.

Subd. 2. **Expedited rulemaking.** (a) By July 1, 2019, the commissioner shall adopt rules for assisted living licensure and dementia care unit certification using the expedited rulemaking process in Minnesota Statutes, section 14.389, conforming as much as possible with the recommendations proposed by the Assisted Living Licensure and Dementia Care Task Force, except that the rules under this section are exempt from Minnesota Statutes, section 14.389, subdivision 5.

(b) The rules may include, but are not limited to, the following:

(1) building design and physical plant;

(2) environmental health and safety;

(3) staffing and other standards of care, as appropriate, based on the acuity level of residents and the needs of persons with dementia;

(4) nutrition and dietary services;

(5) support services, social work, transportation, and quality of life;

(6) staffing requirements and number of residents;

(7) training and background checks for personnel;

(8) a single contract for both housing and services that complies with Minnesota Statutes, chapter 504B;

(9) discharge criteria, including discharge planning to a safe location and appeal rights reflecting the requirements of Minnesota Statutes, sections 144D.09 and 144D.095;

(10) required notices and disclosures;

(11) establishing resident and family councils;

(12) minimum requirements for all applications;

(13) requirements that support assisted living providers to comply with home and community-based settings requirements in Code of Federal Regulations, title 42, section 441.301(c);

(14) core dementia care criteria across all settings;

(15) care and health services, including coordination of care;

(16) admission criteria and assessments; and

(17) safety criteria.

(c) The rules adopted by the commissioner under this subdivision shall be effective on February 1, 2020, unless the legislature provides otherwise.

(d) After February 1, 2020, no one shall offer, advertise, or use the term "memory care unit" or "dementia care unit" in a multiunit residential dwelling, without first obtaining the dementia care unit certification required by the adopted rules required under this subdivision.

(e) After February 1, 2020, no one shall provide assisted living without first obtaining the license required by this section.

(f) After February 1, 2020, a home care provider licensed under Minnesota Statutes, chapter 144A, may not provide home care services in an assisted living setting that lacks the license required by this section.

(g) This section shall not be construed to modify the home care licensure required by Minnesota Statutes, chapter 144A, for providers serving consumers outside of assisted living settings.

(h) This section shall not be construed to modify the registration requirements for housing with services established under Minnesota Statutes, chapter 144D, for a housing with services establishment that is not assisted living.

Subd. 3. **Collaboration and consultation.** In developing the rules for the assisted living licensure and dementia care certification, the commissioner must:

(1) continue to engage and consult with the Assisted Living Licensure and Dementia Care Task Force;

(2) review and evaluate other states' licensing systems related to assisted living;

(3) solicit public comment on the proposed rules through a comment period of no less than 60 days; and

(4) consult with the commissioner of human services regarding:

(i) federal home and community-based service requirements necessary to preserve access to assisted living care and services for individuals who receive medical assistance-funded home and community-based services under Minnesota Statutes, sections 256B.0915 and 256B.49; and

(ii) consideration of changes by the commissioner of human services to the medical assistance elderly, community access for disability and inclusion, and brain injury waiver plans to ensure alignment with assisted living licensure standards.

Subd. 4. **Exceptions.** Rules adopted by the commissioner shall exclude providers and facilities currently licensed by the Department of Human Services from the requirements of the new assisted living license.

Subd. 5. **Fees; application, change of ownership, and renewal.** (a) An initial applicant seeking an assisted living license must submit an initial fee of $6,275 to the commissioner along with a completed application.

(b) An assisted living provider who is filing a change of ownership must submit a fee of $7,750 to the commissioner, along with documentation required for the change of ownership.

(c) An assisted living provider who is seeking to renew the provider's license shall pay a fee of $7,750 to the commissioner.

Sec. 55. **BACKGROUND STUDY RECOMMENDATIONS.**

By January 15, 2019, the commissioner of health shall, in consultation with the Task Force for Preventing Maltreatment of Vulnerable Adults, make recommendations to the chairs of the committees with jurisdiction over aging regarding the need for additional background study requirements for all staff working or volunteering in housing with services establishments and assisted living settings, in addition to any background studies already required by Minnesota Statutes, chapter 144A.

Sec. 56. **DIRECTION TO OFFICE OF HEALTH FACILITIES COMPLAINTS.**

Effective July 1, 2018, the Office of Health Facilities Complaints must publish all substantiated maltreatment reports on the department's Web site.

Sec. 57. **RECODIFICATION OF HEALTH CARE STATUTES; REVIEW OF HEALTH CARE RULES.**

(a) By February 1, 2020, the revisor of statutes in collaboration with the House Research Department, the Office of Senate Counsel, Research, and Fiscal Analysis, and the Departments of Health and Human Services shall provide a report to the legislature with proposed legislation to reorganize, consolidate, and recodify health care statutes governing the provision of care, services, and rights granted to patients, residents, clients, and other recipients of health care services, and the responsibilities imposed on providers of health care and services. Recodification of the health care statutes under this section shall:

(1) eliminate redundancy and confusion;

(2) improve readability, structure, and organization;

(3) ensure consistency of construction of provisions granting the same and similar rights to recipients;

(4) set forth the same and similar responsibilities of providers;

(5) consolidate, where appropriate, the Health Care Bill of Rights under Minnesota Statutes, section 144.651; Home Care Bill of Rights under Minnesota Statutes, section 144A.44; the Assisted Living Addendum under Minnesota Statutes, section 144A.441; patient rights under Minnesota Statutes, section 144.292; and Hospice Bill of Rights under Minnesota Statutes, section 144A.751; and

(6) eliminate or propose modification of ambiguous terms and construction in the statutes; identify and correct cross-references to repealed statutes and rules; and define and ensure

consistency in the use of terms that have the same or similar meanings, including but not limited to "administrator," "advocate," "consumer," "executor," "family member," "interested family member," "guardian," "legal guardian," "other individual," "involved party," "legal counsel," "legal representative," "designated legal representative," "representative," "designated representative," "authorized representative," "chosen representative," "outside representative of the resident's choice," "anyone properly authorized by the person," "others," "concerned others," "people receiving services," "recipient of services," and "near relatives."

(b) The following statutes and rules shall be included in the review:

(1) Minnesota Statutes, chapters 144, 144A, 144D, 144G, 245, 245A, 245D, 252, and 252A;

(2) Minnesota Statutes, sections 245.825; 256B.0615; 256B.0616; 256B.0621; 256B.0622; 256B.0623; 256B.0624; 256B.0651; 256B.0652 subdivision 12; 256B.0653; 256B.0654; 256B.0659; 256B.0911; 256B.0913; 256B.0915; 256B.0917; 256B.0922; 256B.092; 256B.0924; 256B.0926; 256B.093; 256B.0943; 256B.0944; 256B.0946; 256B.0947; and 256B.85; and

(3) Minnesota Rules, chapters 4640, 4655, 4658, 4664, 4665, 4675, 4680, 9520, 9525, 9544, 9555, and 9570.

(c) The Departments of Health and Human Services shall present the proposed legislation to legal and substantive experts who represent consumers and providers for input.

Sec. 58. **REPEALER.**

Minnesota Statutes 2016, sections 144G.01; 144G.02; 144G.03; 144G.04; 144G.05; and 144G.06, are repealed.

ARTICLE 8

HUMAN SERVICES FORECAST ADJUSTMENTS

Section 1. **HUMAN SERVICES APPROPRIATION.**

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

2018, or June 30, 2019, respectively. "The first year" is fiscal year 2018. "The second year" is fiscal year 2019. "The biennium" is fiscal years 2018 and 2019.

		APPROPRIATIONS Available for the Year Ending June 30	
		2018	**2019**
Sec. 2. **COMMISSIONER OF HUMAN SERVICES**			
Subdivision 1. **Total Appropriation**	**$**	**(208,963,000)**	**$** **(88,363,000)**
Appropriations by Fund			
General Fund		(210,083,000)	(103,535,000)
Health Care Access Fund		7,620,000	9,258,000
Federal TANF		(6,500,000)	5,914,000
Subd. 2. **Forecasted Programs**			
(a) **MFIP/DWP**			
Appropriations by Fund			
General Fund		(3,749,000)	(11,267,000)
Federal TANF		(7,418,000)	4,565,000
(b) **MFIP Child Care Assistance**		(7,995,000)	(521,000)
(c) **General Assistance**		(4,850,000)	(3,770,000)
(d) **Minnesota Supplemental Aid**		(1,179,000)	(821,000)
(e) **Housing Support**		(3,260,000)	(3,038,000)
(f) **Northstar Care for Children**		(5,168,000)	(6,458,000)
(g) **MinnesotaCare**		7,620,000	9,258,000
These appropriations are from the health care access fund.			
(h) **Medical Assistance**			
Appropriations by Fund			
General Fund		(199,817,000)	(106,124,000)
Health Care Access Fund		-0-	-0-
(i) **Alternative Care Program**		-0-	-0-

(j) **CCDTF Entitlements**	15,935,000	28,464,000
Subd. 3. **Technical Activities**	918,000	1,349,000

These appropriations are from the federal TANF fund.

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

ARTICLE 9

HEALTH AND HUMAN SERVICES APPROPRIATIONS

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

The sums shown in the columns marked "Appropriations" are added to or, if shown in parentheses, subtracted from the appropriations in Laws 2017, First Special Session chapter 6, article 18, to the agencies and for the purposes specified in this article. The appropriations are from the general fund and are available for the fiscal years indicated for each purpose. The figures "2018" and "2019" used in this article mean that the addition to or subtraction from the appropriation listed under them is available for the fiscal year ending June 30, 2018, or June 30, 2019, respectively. Base adjustments mean the addition to or subtraction from the base level adjustment set in Laws 2017, First Special Session chapter 6, article 18. Supplemental appropriations and reductions to appropriations for the fiscal year ending June 30, 2018, are effective the day following final enactment unless a different effective date is explicit.

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

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

Subdivision 1. **Total Appropriation**	**$**	**289,000**	**$** **26,498,000**

Appropriations by Fund

	2018	2019
General	289,000	23,807,000
Health Care Access	-0-	2,691,000
Opioid Stewardship	-0-	-0-

Subd. 2. **Central Office; Operations**

	Appropriations by Fund	
	2018	2019
General	289,000	6,291,000
Health Care Access	-0-	2,691,000
Opioid Stewardship	-0-	-0-

Base Adjustment. The general fund base is increased $6,055,000 in fiscal year 2020 and $5,511,000 in fiscal year 2021. The opioid stewardship fund base is increased $258,000 in fiscal year 2020 and $258,000 in fiscal year 2021.

Subd. 3. **Central Office; Health Care**

	Appropriations by Fund	
General	-0-	873,000
Opioid Stewardship	-0-	-0-

Base Adjustment. The general fund base is increased $1,377,000 in fiscal year 2020 and $1,383,000 in fiscal year 2021. The health care access fund base is increased $10,234,000 in fiscal year 2020. The opioid stewardship fund base is increased $177,000 in fiscal year 2020 and $177,000 in fiscal year 2021.

Subd. 4. **Central Office; Continuing Care** -0- 2,917,000

(a) Investments in Personal Care Assistance Services, Consumer Directed Community Supports, and Consumer Support Grant Program. Of this appropriation, $1,920,000 in fiscal year 2019 is for administration, training, or grants for the personal care assistance, consumer directed community supports, and consumer support grant program. The commissioner may transfer funds between budget activities with the approval of the commissioner of management

and budget. The general fund base is $219,000 in fiscal year 2020 and $0 in fiscal year 2021. This paragraph expires June 30, 2020.

(b) Base Adjustment. The general fund base is increased $3,186,000 in fiscal year 2020 and $3,178,000 in fiscal year 2021.

Subd. 5. **Central Office; Community Supports**	-0-	5,723,000

Base Adjustment. The general fund base is increased $4,060,000 in fiscal year 2020 and $3,841,000 in fiscal year 2021.

Subd. 6. **Forecasted Programs; MFIP Child Care Assistance**	-0-	1,902,000
Subd. 7. **Forecasted Programs; Medical Assistance**	-0-	9,658,000
Subd. 8. **Forecasted Programs; Chemical Dependency Treatment Fund**	-0-	(14,243,000)
Subd. 9. **Grant Programs; Basic Sliding Fee Child Care Assistance Grants**	-0-	304,000

Base Adjustment. The general fund base is increased $900,000 in fiscal year 2020 and $940,000 in fiscal year 2021.

Subd. 10. **Grant Programs; Child Support Enforcement Grants**	-0-	382,000

(a) Child Support Enforcement Fees. $382,000 is appropriated in fiscal year 2019 from the general fund for payment of child support enforcement fees. The commissioner may transfer and administer the funds from the special revenue fund consistent with Minnesota Statutes, section 518A.51.

(b) Base Adjustment. The general fund base is increased $382,000 in fiscal year 2020 and $382,000 in fiscal year 2021.

Subd. 11. **Grant Programs; Children and Community Service Grants**	-0-	3,000,000

(a) County and Tribal Adult Protection Grants. $3,000,000 in fiscal year 2019 is appropriated from the general fund for grants to counties and tribes to provide adult protection services under Minnesota Statutes, section 256M.42. The general fund base is $3,500,000 in fiscal year 2020 and $4,000,000 in fiscal year 2021.

(b) Base Adjustment. The general fund base is increased $3,500,000 in fiscal year 2020 and $4,000,000 in fiscal year 2021.

Subd. 12. **Grant Programs; Health Care Grants**

Appropriations by Fund		
General	-0-	2,000,000
Opioid Stewardship	-0-	-0-

(a) Opioid Local Response Grants. $2,000,000 in fiscal year 2019 is appropriated from the general fund to contract with communities to design and implement integrated responses to the opioid crisis utilizing a community integration tool tailored to each community based on input from and collaboration with community partners in the areas each grant is intended to serve. This is a onetime appropriation.

(b) Base Adjustment. The opioid stewardship fund base in this activity is increased $2,000,000 in fiscal year 2020 and $2,000,000 in fiscal year 2021 to continue funding contracts with communities to design and implement integrated responses to the opioid crisis utilizing a community integration tool tailored to each community based on input from and collaboration with community partners in the areas each grant is intended to

serve. The opioid stewardship fund base is $2,000,000 in fiscal year 2022 and $0 in fiscal year 2023. This paragraph expires June 30, 2022.

Subd. 13. **Grant Programs; Child Mental Health Grants** -0- 5,000,000

Base Adjustment. The general fund base is increased $5,000,000 in fiscal year 2020 and $5,000,000 in fiscal year 2021.

Sec. 3. **COMMISSIONER OF HEALTH**

Subdivision 1. **Total Appropriation** **$** **-0-** **$** **17,416,000**

Appropriations by Fund

	2018	2019
General	-0-	12,483,000
State Government Special Revenue	-0-	4,933,000
Opioid Stewardship	-0-	-0-

Subd. 2. **Health Improvement**

Appropriations by Fund

General	-0-	6,969,000
State Government Special Revenue	-0-	1,259,000
Opioid Stewardship	-0-	-0-

(a) Opioid Treatment and Prevention. $6,000,000 in fiscal year 2019 is appropriated from the general fund to provide grants to American Indian communities to support opioid abuse prevention programs, to provide Naloxone kits and training to emergency medical service persons as defined under Minnesota Statutes, section 144.7401, and to fund local community prevention action teams. This is a onetime appropriation.

(b) Base Adjustments. The general fund base is increased $969,000 in fiscal year 2020 and

$969,000 in fiscal year 2021. The state government special revenue fund base is increased $1,759,000 in fiscal year 2020 and $2,259,000 in fiscal year 2021. The opioid stewardship fund base is increased $6,000,000 in fiscal year 2020 and $6,000,000 in fiscal year 2021.

Subd. 3. **Health Protection**

	Appropriations by Fund	
General	-0-	5,514,000
State Government Special Revenue	-0-	3,674,000

(a) Strengthen Protections for Vulnerable Adults. $1,500,000 in fiscal year 2019 and $3,000,000 in fiscal year 2020 are appropriated from the general fund to strengthen protections for vulnerable adults that use home care services.

(b) Assisted Living Licensure and Dementia Care Certification Rules. $1,557,000 in fiscal year 2019, $4,715,000 in fiscal year 2020, and $9,303,000 in fiscal year 2023 are appropriated from the state government special revenue fund to the commissioner of health for administering the assisted living licensure and dementia care certification rules under article 7, section 53.

(c) Base Adjustments. The general fund base is increased $5,483,000 in fiscal year 2020 and $2,398,000 in fiscal year 2021. The state government special revenue fund base is increased $8,949,000 in fiscal year 2020 and $13,537,000 in fiscal year 2021.

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

Subdivision 1. **Total Appropriation** **$** **-0-** **$** **2,383,000**

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

Subd. 2. **Board of Pharmacy**

Appropriations by Fund		
General	-0-	2,383,000
Opioid Stewardship	-0-	-0-

(a) Opioid Stewardship Fee and Prescription Monitoring Program Upgrade. $1,819,000 in fiscal year 2019 is appropriated from the general fund. This is a onetime appropriation. $1,430,000 in fiscal year 2020 and $1,430,000 in fiscal year 2021 are appropriated from the opioid stewardship fund for technology, implementation, and administration of the opioid stewardship fee program and upgrades to the prescription monitoring program.

(b) Vendor Contract for Health Care Provider Integration. $564,000 in fiscal year 2019 is appropriated from the general fund. This is a onetime appropriation. $814,000 in fiscal year 2020 and $1,061,000 in fiscal year 2021 are appropriated from the opioid stewardship fund for a vendor contract to securely integrate health care provider technology systems with the prescription monitoring program, according to Minnesota Statutes, section 152.126, subdivision 11. The value of the vendor contract is limited to the appropriations in this section.

(c) Base Adjustments. The opioid stewardship fund base is increased $2,244,000 in fiscal year 2020 and $2,491,000 in fiscal year 2021.

Sec. 5. Minnesota Statutes 2016, section 144.3831, subdivision 1, is amended to read:

Subdivision 1. **Fee setting.** The commissioner of health may assess an annual fee of ~~$6.36~~ $9.72 for every service connection to a public water supply that is owned or operated by a home rule charter city, a statutory city, a city of the first class, or a town. The commissioner of health may also assess an annual fee for every service connection served by a water user district defined in section 110A.02.

Sec. 6. Laws 2017, chapter 2, article 1, section 7, as amended by Laws 2017, First Special Session chapter 6, article 5, section 9, is amended to read:

Sec. 7. **APPROPRIATIONS.**

(a) $311,788,000 in fiscal year 2017 is appropriated from the general fund to the commissioner of management and budget for premium assistance under section 2. This appropriation is onetime and is available through August 31, 2018.

(b) $157,000 in fiscal year 2017 is appropriated from the general fund to the legislative auditor for purposes of section 3. This appropriation is onetime.

(c) $75,391,000 is canceled from the appropriation in paragraph (a) to the general fund upon enactment of this act.

~~(c)~~ (d) Any unexpended amount from the appropriation in paragraph (a) after June 30, 2018, shall be transferred no later than August 31, 2018, from the general fund to the budget reserve account under Minnesota Statutes, section 16A.152, subdivision 1a.

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

Sec. 7. **PREMIUM SECURITY PLAN ACCOUNT TRANSFERS.**

(a) The commissioner of commerce shall transfer $41,609,000 from the premium security plan account in Minnesota Statutes, section 62E.25, subdivision 1, to the MinnesotaCare Buy-In Option reserve fund established in Minnesota Statutes, section 256L.30, on July 1, 2019.

(b) The commissioner of commerce shall transfer $130,720,000 from the premium security plan account in Minnesota Statutes, section 62E.25, subdivision 1, to the general fund by June 30, 2020.

Sec. 8. **APPROPRIATION; MINNESOTACARE BUY-IN OPTION TRANSFER.**

$58,391,000 in fiscal year 2020 is appropriated from the general fund to the commissioner of human services. The commissioner of human services must transfer $58,391,000 from the general fund to the MinnesotaCare Buy-In Option reserve fund established in Minnesota Statutes, section 256L.30, by no later than December 31, 2019. This is a onetime appropriation and transfer.

Sec. 9. **APPROPRIATION; OPIOID STEWARDSHIP FUND TRANSFER.**

$8,000 in fiscal year 2020 and $12,000 in fiscal year 2021 are appropriated from the opioid stewardship fund to the commissioner of human services. The commissioner of human services must transfer $8,000 in fiscal year 2020 and $12,000 in fiscal year 2021 from the opioid stewardship fund to the general fund by no later than December 31, 2019. The purpose of this transfer is to pay for the cost of additional screenings under Minnesota Statutes, section 254A.03, subdivision 3.

Sec. 10. **EXPIRATION OF UNCODIFIED LANGUAGE.**

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

Sec. 11. **EFFECTIVE DATE.**

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

APPENDIX
Article locations in SF4014-0

119B.125 PROVIDER REQUIREMENTS.

Subd. 5. **Provisional payment.** After a county receives a completed application from a provider, the county may issue provisional authorization and payment to the provider during the time needed to determine whether to give final authorization to the provider.

119B.16 FAIR HEARING PROCESS.

Subd. 2. **Informal conference.** The county agency shall offer an informal conference to applicants and recipients adversely affected by an agency action to attempt to resolve the dispute. The county agency shall offer an informal conference to providers to whom the county agency has assigned responsibility for an overpayment in an attempt to resolve the dispute. The county agency or the provider may ask the family in whose case the overpayment arose to participate in the informal conference, but the family may refuse to do so. The county agency shall advise adversely affected applicants, recipients, and providers that a request for a conference with the agency is optional and does not delay or replace the right to a fair hearing.

144G.01 DEFINITIONS.

Subdivision 1. **Scope; other definitions.** For purposes of sections 144G.01 to 144G.05, the following definitions apply. In addition, the definitions provided in section 144D.01 also apply to sections 144G.01 to 144G.05.

Subd. 2. **Assisted living.** "Assisted living" means a service or package of services advertised, marketed, or otherwise described, offered, or promoted using the phrase "assisted living" either alone or in combination with other words, whether orally or in writing, and which is subject to the requirements of this chapter.

Subd. 3. **Assisted living client.** "Assisted living client" or "client" means a housing with services resident who receives assisted living that is subject to the requirements of this chapter.

Subd. 4. **Commissioner.** "Commissioner" means the commissioner of health.

144G.02 ASSISTED LIVING; PROTECTED TITLE; REGULATORY FUNCTION.

Subdivision 1. **Protected title; restriction on use.** No person or entity may use the phrase "assisted living," whether alone or in combination with other words and whether orally or in writing, to advertise, market, or otherwise describe, offer, or promote itself, or any housing, service, service package, or program that it provides within this state, unless the person or entity is a housing with services establishment that meets the requirements of this chapter, or is a person or entity that provides some or all components of assisted living that meet the requirements of this chapter. A person or entity entitled to use the phrase "assisted living" shall use the phrase only in the context of its participation in assisted living that meets the requirements of this chapter. A housing with services establishment offering or providing assisted living that is not made available to residents in all of its housing units shall identify the number or location of the units in which assisted living is available, and may not use the term "assisted living" in the name of the establishment registered with the commissioner under chapter 144D, or in the name the establishment uses to identify itself to residents or the public.

Subd. 2. **Authority of commissioner.** (a) The commissioner, upon receipt of information that may indicate the failure of a housing with services establishment, the arranged home care provider, an assisted living client, or an assisted living client's representative to comply with a legal requirement to which one or more of the entities may be subject, shall make appropriate referrals to other governmental agencies and entities having jurisdiction over the subject matter. The commissioner may also make referrals to any public or private agency the commissioner considers available for appropriate assistance to those involved.

(b) In addition to the authority with respect to licensed home care providers under section 144A.45 and with respect to housing with services establishments under chapter 144D, the commissioner shall have standing to bring an action for injunctive relief in the district court in the district in which a housing with services establishment is located to compel the housing with services establishment or the arranged home care provider to meet the requirements of this chapter or other requirements of the state or of any county or local governmental unit to which the establishment or arranged home care provider is otherwise subject. Proceedings for securing an injunction may

be brought by the commissioner through the attorney general or through the appropriate county attorney. The sanctions in this section do not restrict the availability of other sanctions.

144G.03 ASSISTED LIVING REQUIREMENTS.

Subdivision 1. **Verification in annual registration.** A registered housing with services establishment using the phrase "assisted living," pursuant to section 144G.02, subdivision 1, shall verify to the commissioner in its annual registration pursuant to chapter 144D that the establishment is complying with sections 144G.01 to 144G.05, as applicable.

Subd. 2. **Minimum requirements for assisted living.** (a) Assisted living shall be provided or made available only to individuals residing in a registered housing with services establishment. Except as expressly stated in this chapter, a person or entity offering assisted living may define the available services and may offer assisted living to all or some of the residents of a housing with services establishment. The services that comprise assisted living may be provided or made available directly by a housing with services establishment or by persons or entities with which the housing with services establishment has made arrangements.

(b) A person or entity entitled to use the phrase "assisted living," according to section 144G.02, subdivision 1, shall do so only with respect to a housing with services establishment, or a service, service package, or program available within a housing with services establishment that, at a minimum:

(1) provides or makes available health-related services under a home care license. At a minimum, health-related services must include:

(i) assistance with self-administration of medication, medication management, or medication administration as defined in section 144A.43; and

(ii) assistance with at least three of the following seven activities of daily living: bathing, dressing, grooming, eating, transferring, continence care, and toileting.

All health-related services shall be provided in a manner that complies with applicable home care licensure requirements in chapter 144A and sections 148.171 to 148.285;

(2) provides necessary assessments of the physical and cognitive needs of assisted living clients by a registered nurse, as required by applicable home care licensure requirements in chapter 144A and sections 148.171 to 148.285;

(3) has and maintains a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by applicable home care licensure requirements in chapter 144A and sections 148.171 to 148.285;

(4) provides staff access to an on-call registered nurse 24 hours per day, seven days per week;

(5) has and maintains a system to check on each assisted living client at least daily;

(6) provides a means for assisted living clients to request assistance for health and safety needs 24 hours per day, seven days per week, from the establishment or a person or entity with which the establishment has made arrangements;

(7) has a person or persons available 24 hours per day, seven days per week, who is responsible for responding to the requests of assisted living clients for assistance with health or safety needs, who shall be:

(i) awake;

(ii) located in the same building, in an attached building, or on a contiguous campus with the housing with services establishment in order to respond within a reasonable amount of time;

(iii) capable of communicating with assisted living clients;

(iv) capable of recognizing the need for assistance;

(v) capable of providing either the assistance required or summoning the appropriate assistance; and

(vi) capable of following directions;

(8) offers to provide or make available at least the following supportive services to assisted living clients:

(i) two meals per day;

(ii) weekly housekeeping;

(iii) weekly laundry service;

(iv) upon the request of the client, reasonable assistance with arranging for transportation to medical and social services appointments, and the name of or other identifying information about the person or persons responsible for providing this assistance;

(v) upon the request of the client, reasonable assistance with accessing community resources and social services available in the community, and the name of or other identifying information about the person or persons responsible for providing this assistance; and

(vi) periodic opportunities for socialization; and

(9) makes available to all prospective and current assisted living clients information consistent with the uniform format and the required components adopted by the commissioner under section 144G.06. This information must be made available beginning no later than six months after the commissioner makes the uniform format and required components available to providers according to section 144G.06.

Subd. 3. **Exemption from awake-staff requirement.** A housing with services establishment that offers or provides assisted living is exempt from the requirement in subdivision 2, paragraph (b), clause (7), item (i), that the person or persons available and responsible for responding to requests for assistance must be awake, if the establishment meets the following requirements:

(1) the establishment has a maximum capacity to serve 12 or fewer assisted living clients;

(2) the person or persons available and responsible for responding to requests for assistance are physically present within the housing with services establishment in which the assisted living clients reside;

(3) the establishment has a system in place that is compatible with the health, safety, and welfare of the establishment's assisted living clients;

(4) the establishment's housing with services contract, as required by section 144D.04, includes a statement disclosing the establishment's qualification for, and intention to rely upon, this exemption;

(5) the establishment files with the commissioner, for purposes of public information but not review or approval by the commissioner, a statement describing how the establishment meets the conditions in clauses (1) to (4), and makes a copy of this statement available to actual and prospective assisted living clients; and

(6) the establishment indicates on its housing with services registration, under section 144D.02 or 144D.03, as applicable, that it qualifies for and intends to rely upon the exemption under this subdivision.

Subd. 4. **Nursing assessment.** (a) A housing with services establishment offering or providing assisted living shall:

(1) offer to have the arranged home care provider conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a service plan prior to the date on which a prospective resident executes a contract with a housing with services establishment or the date on which a prospective resident moves in, whichever is earlier; and

(2) inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a housing with services establishment or the date on which a prospective resident moves in, whichever is earlier.

(b) An arranged home care provider is not obligated to conduct a nursing assessment by a registered nurse when requested by a prospective resident if either the geographic distance between the prospective resident and the provider, or urgent or unexpected circumstances, do not permit the assessment to be conducted prior to the date on which the prospective resident executes a contract or moves in, whichever is earlier. When such circumstances occur, the arranged home care provider shall offer to conduct a telephone conference whenever reasonably possible.

(c) The arranged home care provider shall comply with applicable home care licensure requirements in chapter 144A and sections 148.171 to 148.285, with respect to the provision of a

nursing assessment prior to the delivery of nursing services and the execution of a home care service plan or service agreement.

Subd. 5. **Assistance with arranged home care provider.** The housing with services establishment shall provide each assisted living client with identifying information about a person or persons reasonably available to assist the client with concerns the client may have with respect to the services provided by the arranged home care provider. The establishment shall keep each assisted living client reasonably informed of any changes in the personnel referenced in this subdivision. Upon request of the assisted living client, such personnel or designee shall provide reasonable assistance to the assisted living client in addressing concerns regarding services provided by the arranged home care provider.

Subd. 6. **Termination of housing with services contract.** If a housing with services establishment terminates a housing with services contract with an assisted living client, the establishment shall provide the assisted living client, and the legal or designated representative of the assisted living client, if any, with a written notice of termination which includes the following information:

(1) the effective date of termination;

(2) the section of the contract that authorizes the termination;

(3) without extending the termination notice period, an affirmative offer to meet with the assisted living client and, if applicable, client representatives, within no more than five business days of the date of the termination notice to discuss the termination;

(4) an explanation that:

(i) the assisted living client must vacate the apartment, along with all personal possessions, on or before the effective date of termination;

(ii) failure to vacate the apartment by the date of termination may result in the filing of an eviction action in court by the establishment, and that the assisted living client may present a defense, if any, to the court at that time; and

(iii) the assisted living client may seek legal counsel in connection with the notice of termination;

(5) a statement that, with respect to the notice of termination, reasonable accommodation is available for the disability of the assisted living client, if any; and

(6) the name and contact information of the representative of the establishment with whom the assisted living client or client representatives may discuss the notice of termination.

144G.04 RESERVATION OF RIGHTS.

Subdivision 1. **Use of services.** Nothing in this chapter requires an assisted living client to utilize any service provided or made available in assisted living.

Subd. 2. **Housing with services contracts.** Nothing in this chapter requires a housing with services establishment to execute or refrain from terminating a housing with services contract with a prospective or current resident who is unable or unwilling to meet the requirements of residency, with or without assistance.

Subd. 3. **Provision of services.** Nothing in this chapter requires the arranged home care provider to offer or continue to provide services under a service agreement or service plan to a prospective or current resident of the establishment whose needs cannot be met by the arranged home care provider.

Subd. 4. **Altering operations; service packages.** Nothing in this chapter requires a housing with services establishment or arranged home care provider offering assisted living to fundamentally alter the nature of the operations of the establishment or the provider in order to accommodate the request or need for facilities or services by any assisted living client, or to refrain from requiring, as a condition of residency, that an assisted living client pay for a package of assisted living services even if the client does not choose to utilize all or some of the services in the package.

144G.05 REIMBURSEMENT UNDER ASSISTED LIVING SERVICE PACKAGES.

Notwithstanding the provisions of this chapter, the requirements for the elderly waiver program's assisted living payment rates under section 256B.0915, subdivision 3e, shall continue to be effective

and providers who do not meet the requirements of this chapter may continue to receive payment under section 256B.0915, subdivision 3e, as long as they continue to meet the definitions and standards for assisted living and assisted living plus set forth in the federally approved Elderly Home and Community Based Services Waiver Program (Control Number 0025.91). Providers of assisted living for the community access for disability inclusion (CADI) and Brain Injury (BI) waivers shall continue to receive payment as long as they continue to meet the definitions and standards for assisted living and assisted living plus set forth in the federally approved CADI and BI waiver plans.

144G.06 UNIFORM CONSUMER INFORMATION GUIDE.

The commissioner shall adopt a uniform format for the guide to be used by individual providers, and the required components of materials to be used by providers to inform assisted living clients of their legal rights, and shall make the uniform format and the required components available to assisted living providers.

245E.03 DUTY TO PROVIDE ACCESS.

Subd. 3. **Notice of denial or termination.** When a provider fails to provide access, a 15-day notice of denial or termination must be issued to the provider, which prohibits the provider from participating in the child care assistance program. Notice must be sent to recipients whose children are under the provider's care pursuant to Minnesota Rules, part 3400.0185.

245E.06 ADMINISTRATIVE SANCTIONS.

Subd. 2. **Written notice of department sanction; sanction effective date; informal meeting.** (a) The department shall give notice in writing to a person of an administrative sanction that is to be imposed. The notice shall be sent by mail as defined in section 245E.01, subdivision 11.

(b) The notice shall state:

(1) the factual basis for the department's determination;

(2) the sanction the department intends to take;

(3) the dollar amount of the monetary recovery or recoupment, if any;

(4) how the dollar amount was computed;

(5) the right to dispute the department's determination and to provide evidence;

(6) the right to appeal the department's proposed sanction; and

(7) the option to meet informally with department staff, and to bring additional documentation or information, to resolve the issues.

(c) In cases of determinations resulting in denial or termination of payments, in addition to the requirements of paragraph (b), the notice must state:

(1) the length of the denial or termination;

(2) the requirements and procedures for reinstatement; and

(3) the provider's right to submit documents and written arguments against the denial or termination of payments for review by the department before the effective date of denial or termination.

(d) The submission of documents and written argument for review by the department under paragraph (b), clause (5) or (7), or paragraph (c), clause (3), does not stay the deadline for filing an appeal.

(e) Notwithstanding section 245E.03, subdivision 4, the effective date of the proposed sanction shall be 30 days after the license holder's, provider's, controlling individual's, or recipient's receipt of the notice, unless timely appealed. If a timely appeal is made, the proposed sanction shall be delayed pending the final outcome of the appeal. Implementation of a proposed sanction following the resolution of a timely appeal may be postponed if, in the opinion of the department, the delay of sanction is necessary to protect the health or safety of children in care. The department may

consider the economic hardship of a person in implementing the proposed sanction, but economic hardship shall not be a determinative factor in implementing the proposed sanction.

(f) Requests for an informal meeting to attempt to resolve issues and requests for appeals must be sent or delivered to the department's Office of Inspector General, Financial Fraud and Abuse Division.

Subd. 4. **Consolidated hearings with licensing sanction.** If a financial misconduct sanction has an appeal hearing right and it is timely appealed, and a licensing sanction exists for which there is an appeal hearing right and the sanction is timely appealed, and the overpayment recovery action and licensing sanction involve the same set of facts, the overpayment recovery action and licensing sanction must be consolidated in the contested case hearing related to the licensing sanction.

Subd. 5. **Effect of department's administrative determination or sanction.** Unless a timely and proper appeal is received by the department, the department's administrative determination or sanction shall be considered a final department determination.

3400.0185 TERMINATION AND ADVERSE ACTIONS; NOTICE REQUIRED.

Subp. 5. **Notice to providers of actions adverse to the provider.** The county must give a provider written notice of the following actions adverse to the provider: a denial of authorization, a termination of authorization, a reduction in the number of hours of care with that provider, and a determination that the provider has an overpayment. The notice must include the following information:

A. a description of the adverse action;

B. the effective date of the adverse action; and

C. a statement that unless a family appeals the adverse action before the effective date or the provider appeals the overpayment determination, the adverse action will occur on the effective date. The notice must be mailed to the provider at least 15 calendar days before the effective date of the adverse action.