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State of Minnesota

HOUSE OF REPRESENTATIVES

EIGHTY-EIGHTH SESSION

H. F. No. 662

02/18/2013 Authored by Laine
The bill was read for the first time and referred to the Committee on Health and Human Services Policy
03/11/2013 Adoption of Report: Pass as Amended and re-referred to the Committee on Judiciary Finance and Policy
03/13/2013 By motion, recalled and re-referred to the Committee on Civil Law

A bill for an act

relating to health; modifying a provision in the health professional education loan forgiveness program; requiring radon education disclosure for residential real property; changing provisions for tuberculosis standards; changing adverse health events reporting requirements; modifying a poison control provision; providing liability coverage for certain volunteer medical personnel and permitting agreements to conduct criminal background studies; defining occupational therapy practitioners; changing provisions for occupational therapy; amending prescribing authority for legend drugs; amending Minnesota Statutes 2012, sections 144.1501, subdivision 4; 144.50, by adding a subdivision; 144.55, subdivision 3; 144.56, by adding a subdivision; 144.7065, subdivisions 2, 3, 4, 5, 6, 7, by adding a subdivision; 144A.04, by adding a subdivision; 144A.45, by adding a subdivision; 144A.752, by adding a subdivision; 144D.08; 145.93, subdivision 3; 145A.04, by adding a subdivision; 145A.06, subdivision 7; 148.6402, by adding a subdivision; 148.6440; 151.37, subdivision 2; proposing coding for new law in Minnesota Statutes, chapters 144; 145A; repealing Minnesota Statutes 2012, sections 144.1487; 144.1488, subdivisions 1, 3, 4; 144.1489; 144.1490; 144.1491.

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

Section 1. Minnesota Statutes 2012, section 144.1501, subdivision 4, is amended to read:

Subd. 4. **Loan forgiveness.** The commissioner of health may select applicants each year for participation in the loan forgiveness program, within the limits of available funding. The commissioner shall distribute available funds for loan forgiveness proportionally among the eligible professions according to the vacancy rate for each profession in the required geographic area, facility type, teaching area, patient group, or specialty type specified in subdivision 2. The commissioner shall allocate funds for physician loan forgiveness so that 75 percent of the funds available are used for rural physician loan forgiveness and 25 percent of the funds available are used for underserved urban communities and pediatric psychiatry loan forgiveness. If the commissioner does not receive enough qualified applicants each year to use the entire allocation of funds for

any eligible profession, the remaining funds may be allocated proportionally among the other eligible professions according to the vacancy rate for each profession in the required geographic area, patient group, or facility type specified in subdivision 2. Applicants are responsible for securing their own qualified educational loans. The commissioner shall select participants based on their suitability for practice serving the required geographic area or facility type specified in subdivision 2, as indicated by experience or training. The commissioner shall give preference to applicants closest to completing their training. For each year that a participant meets the service obligation required under subdivision 3, up to a maximum of four years, the commissioner shall make annual disbursements directly to the participant equivalent to 15 percent of the average educational debt for indebted graduates in their profession in the year closest to the applicant's selection for which information is available, not to exceed the balance of the participant's qualifying educational loans. Before receiving loan repayment disbursements and as requested, the participant must complete and return to the commissioner ~~an affidavit~~ a confirmation of practice form provided by the commissioner verifying that the participant is practicing as required under subdivisions 2 and 3. The participant must provide the commissioner with verification that the full amount of loan repayment disbursement received by the participant has been applied toward the designated loans. After each disbursement, verification must be received by the commissioner and approved before the next loan repayment disbursement is made. Participants who move their practice remain eligible for loan repayment as long as they practice as required under subdivision 2.

Sec. 2. **[144.496] MINNESOTA RADON AWARENESS ACT.**

Subdivision 1. **Citation.** This section may be cited as the "Minnesota Radon Awareness Act."

Subd. 2. **Definitions.** (a) The following terms used in this section have the meanings given them.

(b) "Agent" means a licensed real estate broker or salesperson as defined in section 82.55, subdivisions 19 and 20, acting on behalf of a seller or buyer of residential real property.

(c) "Buyer" means any individual, partnership, corporation, or trustee entering into an agreement to purchase any residential real estate or interest in real property.

(d) "Department" means the Department of Health.

(e) "Mitigation" means measures designed to permanently reduce indoor radon concentrations.

(f) "Radon test" means a measurement of indoor radon concentrations according to established industry standards for residential real property.

(g) "Residential real property" means any estate or interest in a manufactured housing lot or a parcel of real property.

(h) "Seller" means any individual, partnership, corporation, or trustee transferring residential real property in return for consideration.

(i) "Elevated radon concentration" means a radon concentration above the United States Environmental Protection Agency's radon action level.

Subd. 3. **Radon testing and disclosure.** (a) Except as excluded by subdivision 4, the seller shall provide to the buyer of any interest in residential real property the department publication entitled "Radon Testing Guidelines for Real Estate Transactions" and the "Minnesota Disclosure of Information on Radon," which is specified in paragraph (b), stating that the property may present the potential for exposure to radon before the buyer is obligated under any contract to purchase residential real property.

(b) The following Disclosure of Information on Radon Hazards form must be provided to a buyer of residential real property as required by this section:

"DISCLOSURE OF INFORMATION ON RADON
(For Residential Real Property Sales or Purchases)

Radon Warning Statement

Every buyer of any interest in residential real property is notified that the property may present exposure to dangerous levels of indoor radon gas that may place the occupants at risk of developing radon-induced lung cancer. Radon, a Class A human carcinogen, is the leading cause of lung cancer in nonsmokers and the second leading cause overall. The seller of any interest in residential real property is required to provide the buyer with any information on radon test results of the dwelling.

The Minnesota Department of Health strongly recommends ALL homebuyers have an indoor radon test performed prior to purchase or taking occupancy, and recommends having the radon levels mitigated if elevated radon concentrations are found. Elevated radon concentrations can easily be reduced by a qualified, certified, or licensed, if applicable, radon mitigator.

Physical Address of Property including street address, city, and zip code.

A. Seller's Disclosure; initial each of the following items that apply:

(1) The seller has no knowledge of radon concentrations in the dwelling.

(2) A radon test has been conducted in the dwelling.

(3) The seller has provided the purchaser with the most current records and reports pertaining to radon concentrations within the dwelling.

(4) Radon concentrations above the United States Environmental Protection Agency radon action level are known to be present within the dwelling.

(5) Radon concentrations have been mitigated or remediated to concentrations below the United States Environmental Protection Agency radon action level.

(6) The seller has provided the purchaser with information regarding the radon mitigation system installed in the dwelling including system description and documentation.

(7) The seller has no records or reports pertaining to radon concentrations within the dwelling.

B. Purchaser's Acknowledgment; initial each of the following items that apply:

(1) The purchaser has received copies of all information listed in A.

(2) The purchaser has received the department approved Radon Testing Guidelines for Real Estate Transactions.

C. Agent's Acknowledgement; initial if applicable:

The agent has informed the seller of the seller's obligation under Minnesota law.

D. Certification of Accuracy:

The following parties have reviewed the information above and each party certifies, to the best of his or her knowledge, that the information he or she provided is true and accurate.

Seller..... Date..... Purchaser..... Date.....

Seller..... Date..... Purchaser..... Date.....

Seller's Agent..... Date..... Purchaser's Agent..... Date....."

(c) If any of the disclosures required by this section occur after the buyer has made an offer to purchase the residential real property, the seller shall complete the required disclosure activities prior to accepting the buyer's offer and allow the buyer an opportunity to review the information and possibly amend the offer without penalty to the buyer.

Subd. 4. **Exclusions.** This section does not apply to the following:

(1) Transfers pursuant to court order, including, but not limited to, transfers ordered by a probate court in administration of an estate, transfers between spouses resulting from a judgment of dissolution of marriage or legal separation, transfers pursuant to an order of possession, transfers by a trustee in bankruptcy, transfers by eminent domain, and transfers resulting from a decree for specific performance.

(2) Transfers from a mortgagor to a mortgagee by deed in lieu of foreclosure or consent judgment, transfer by a judicial deed issued pursuant to a foreclosure sale to the successful bidder or the assignee of a certificate of sale, transfer by a collateral assignment

of a beneficial interest of a land trust, or a transfer by a mortgagee or a successor in interest to the mortgagee's secured position or a beneficiary under a deed in trust who has acquired the real property by deed in lieu of foreclosure, consent judgment, or judicial deed issued pursuant to a foreclosure sale.

(3) Transfers by a fiduciary in the course of the administration of a decedent's estate, guardianship, conservatorship, or trust.

(4) Transfers from one co-owner to one or more other co-owners.

(5) Transfers pursuant to testate or intestate succession.

(6) Transfers made to a spouse, or to a person or persons in the lineal line of consanguinity of one or more of the sellers.

(7) Transfers from an entity that has taken title to residential real property from a seller for the purpose of assisting in the relocation of the seller, so long as the entity makes available to all prospective buyers a copy of the disclosure form furnished to the entity by the seller.

(8) Transfers to or from any governmental entity.

(9) Transfers of any residential dwelling unit located on the third story or higher above ground level of any structure or building, including, but not limited to, condominium units and dwelling units in a residential cooperative.

Sec. 3. Minnesota Statutes 2012, section 144.50, is amended by adding a subdivision to read:

Subd. 8. **Supervised living facility provider; tuberculosis prevention and control.** (a) A supervised living facility provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines.

(b) Written compliance with this subdivision must be maintained by the provider.

Sec. 4. Minnesota Statutes 2012, section 144.55, subdivision 3, is amended to read:

Subd. 3. **Standards for licensure.** (a) Notwithstanding the provisions of section 144.56, for the purpose of hospital licensure, the commissioner of health shall use as minimum standards the hospital certification regulations promulgated pursuant to Title

XVIII of the Social Security Act, United States Code, title 42, section 1395, et seq. The commissioner may use as minimum standards changes in the federal hospital certification regulations promulgated after May 7, 1981, if the commissioner finds that such changes are reasonably necessary to protect public health and safety. The commissioner shall also promulgate in rules additional minimum standards for new construction.

(b) Each hospital and outpatient surgical center shall establish policies and procedures to prevent the transmission of human immunodeficiency virus and hepatitis B virus to patients and within the health care setting. The policies and procedures shall be developed in conformance with the most recent recommendations issued by the United States Department of Health and Human Services, Public Health Service, Centers for Disease Control. The commissioner of health shall evaluate a hospital's compliance with the policies and procedures according to subdivision 4.

(c) An outpatient surgical center provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines.

(d) Written compliance with this subdivision must be maintained by the provider.

Sec. 5. Minnesota Statutes 2012, section 144.56, is amended by adding a subdivision to read:

Subd. 2c. **Boarding care home provider; tuberculosis prevention and control.** (a) A boarding care home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines.

(b) Written compliance with this subdivision must be maintained by the provider.

Sec. 6. Minnesota Statutes 2012, section 144.7065, subdivision 2, is amended to read:

Subd. 2. **Surgical events.** Events reportable under this subdivision are:

(1) surgery or other invasive procedure performed on a wrong body part that is not consistent with the documented informed consent for that patient. Reportable events under this clause do not include situations requiring prompt action that occur in the course of surgery or situations whose urgency precludes obtaining informed consent;

(2) surgery or other invasive procedure performed on the wrong patient;

(3) the wrong surgical or other invasive procedure performed on a patient that is not consistent with the documented informed consent for that patient. Reportable events under this clause do not include situations requiring prompt action that occur in the course of surgery or situations whose urgency precludes obtaining informed consent;

(4) retention of a foreign object in a patient after surgery or other invasive procedure, excluding objects intentionally implanted as part of a planned intervention and objects present prior to surgery that are intentionally retained; and

(5) death during or immediately after surgery or other invasive procedure of a normal, healthy patient who has no organic, physiologic, biochemical, or psychiatric disturbance and for whom the pathologic processes for which the operation is to be performed are localized and do not entail a systemic disturbance.

Sec. 7. Minnesota Statutes 2012, section 144.7065, subdivision 3, is amended to read:

Subd. 3. **Product or device events.** Events reportable under this subdivision are:

(1) patient death or serious ~~disability~~ injury associated with the use of contaminated drugs, devices, or biologics provided by the facility when the contamination is the result of generally detectable contaminants in drugs, devices, or biologics regardless of the source of the contamination or the product;

(2) patient death or serious ~~disability~~ injury associated with the use or function of a device in patient care in which the device is used or functions other than as intended. "Device" includes, but is not limited to, catheters, drains, and other specialized tubes, infusion pumps, and ventilators; and

(3) patient death or serious ~~disability~~ injury associated with intravascular air embolism that occurs while being cared for in a facility, excluding deaths associated with neurosurgical procedures known to present a high risk of intravascular air embolism.

Sec. 8. Minnesota Statutes 2012, section 144.7065, subdivision 4, is amended to read:

Subd. 4. **Patient protection events.** Events reportable under this subdivision are:

(1) ~~an infant~~ a patient of any age, who does not have decision-making capacity, discharged to the wrong person;

(2) patient death or serious ~~disability~~ injury associated with patient disappearance, excluding events involving adults who have decision-making capacity; and

(3) patient suicide ~~or~~, attempted suicide resulting in serious ~~disability~~ injury, or self-harm resulting in serious injury or death while being cared for in a facility due to patient actions after admission to the facility, excluding deaths resulting from self-inflicted injuries that were the reason for admission to the facility.

Sec. 9. Minnesota Statutes 2012, section 144.7065, subdivision 5, is amended to read:

Subd. 5. **Care management events.** Events reportable under this subdivision are:

(1) patient death or serious ~~disability~~ injury associated with a medication error, including, but not limited to, errors involving the wrong drug, the wrong dose, the wrong patient, the wrong time, the wrong rate, the wrong preparation, or the wrong route of administration, excluding reasonable differences in clinical judgment on drug selection and dose;

(2) patient death or serious ~~disability~~ injury associated with ~~a hemolytic reaction due to the administration of ABO/HLA-incompatible~~ unsafe administration of blood or blood products;

(3) maternal death or serious ~~disability~~ injury associated with labor or delivery in a low-risk pregnancy while being cared for in a facility, including events that occur within 42 days postdelivery and excluding deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy, or cardiomyopathy;

(4) ~~patient death or serious disability directly related to hypoglycemia, the onset of which occurs while the patient is being cared for in a facility~~ death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy;

~~(5) death or serious disability, including kernicterus, associated with failure to identify and treat hyperbilirubinemia in neonates during the first 28 days of life. "Hyperbilirubinemia" means bilirubin levels greater than 30 milligrams per deciliter;~~

~~(6)~~ (5) stage 3 or 4 or unstageable ulcers acquired after admission to a facility, excluding progression from stage 2 to stage 3 if stage 2 was recognized upon admission;

~~(7) patient death or serious disability due to spinal manipulative therapy; and~~

~~(8)~~ (6) artificial insemination with the wrong donor sperm or wrong egg~~.~~;

(7) patient death or serious injury associated with a fall while being cared for in a facility;

(8) the irretrievable loss of an irreplaceable biological specimen; and

(9) patient death or serious injury resulting from the failure to follow up or communicate laboratory, pathology, or radiology test results.

Sec. 10. Minnesota Statutes 2012, section 144.7065, subdivision 6, is amended to read:

Subd. 6. **Environmental events.** Events reportable under this subdivision are:

(1) patient death or serious ~~disability~~ injury associated with an electric shock while being cared for in a facility, excluding events involving planned treatments such as electric countershock;

(2) any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances;

(3) patient death or serious ~~disability~~ injury associated with a burn incurred from any source while being cared for in a facility; and

~~(4) patient death or serious disability associated with a fall while being cared for in a facility; and~~

~~(5)~~ (4) patient death or serious ~~disability~~ injury associated with the use or lack of restraints or bedrails while being cared for in a facility.

Sec. 11. Minnesota Statutes 2012, section 144.7065, subdivision 7, is amended to read:

Subd. 7. **Potential criminal events.** Events reportable under this subdivision are:

(1) any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider;

(2) abduction of a patient of any age;

(3) sexual assault on a patient within or on the grounds of a facility; and

(4) death or ~~significant~~ serious injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of a facility.

Sec. 12. Minnesota Statutes 2012, section 144.7065, is amended by adding a subdivision to read:

Subd. 7a. **Radiologic events.** Death or serious injury of a patient associated with the introduction of a metallic object into the MRI area are reportable events under this subdivision.

Sec. 13. Minnesota Statutes 2012, section 144A.04, is amended by adding a subdivision to read:

Subd. 3b. **Nursing home providers; tuberculosis prevention and control.** (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality

Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines.

(b) Written compliance with this subdivision must be maintained by the provider.

Sec. 14. Minnesota Statutes 2012, section 144A.45, is amended by adding a subdivision to read:

Subd. 6. **Home care providers; tuberculosis prevention and control.** (a) A home care provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines.

(b) Written compliance with this subdivision must be maintained by the provider.

Sec. 15. Minnesota Statutes 2012, section 144A.752, is amended by adding a subdivision to read:

Subd. 5. **Hospice providers; tuberculosis prevention and control.** (a) A hospice provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and volunteers. For residential hospice facilities, the tuberculosis infection control plan must cover each hospice patient. The Department of Health shall provide technical assistance regarding implementation of the guidelines.

(b) Written compliance with this subdivision must be maintained by the provider.

Sec. 16. Minnesota Statutes 2012, section 144D.08, is amended to read:

144D.08 UNIFORM CONSUMER INFORMATION GUIDE.

All housing with services establishments shall make available to all prospective and current residents information consistent with the uniform format and the required

components adopted by the commissioner under section 144G.06. This section does not apply to an establishment registered under section 144D.025 serving the homeless.

Sec. 17. Minnesota Statutes 2012, section 145.93, subdivision 3, is amended to read:

Subd. 3. **Grant award; designation; payments under grant.** ~~Each odd-numbered~~ Every fifth year, the commissioner shall solicit applications for the poison information centers by giving reasonable public notice of the availability of money appropriated or otherwise available. The commissioner shall select from among the entities, whether profit or nonprofit, or units of government the applicants that best fulfill the criteria specified in subdivision 4. The grant shall be paid to the grantees quarterly beginning on July 1.

Sec. 18. Minnesota Statutes 2012, section 145A.04, is amended by adding a subdivision to read:

Subd. 6d. **Minnesota Responds Medical Reserve Corps; liability coverage.** A Minnesota Responds Medical Reserve Corps volunteer responding to a request for training or assistance at the call of a board of health must be deemed an employee of the jurisdiction for purposes of workers' compensation, tort claim defense, and indemnification.

Sec. 19. Minnesota Statutes 2012, section 145A.06, subdivision 7, is amended to read:

Subd. 7. **Commissioner requests for health volunteers.** (a) When the commissioner receives a request for health volunteers from:

(1) a local board of health according to section 145A.04, subdivision 6c;

(2) the University of Minnesota Academic Health Center;

(3) another state or a territory through the Interstate Emergency Management Assistance Compact authorized under section 192.89;

(4) the federal government through ESAR-VHP or another similar program; or

(5) a tribal or Canadian government;

the commissioner shall determine if deployment of Minnesota Responds Medical Reserve Corps volunteers from outside the requesting jurisdiction is in the public interest. If so, the commissioner may ask for Minnesota Responds Medical Reserve Corps volunteers to respond to the request. The commissioner may also ask for Minnesota Responds Medical Reserve Corps volunteers if the commissioner finds that the state needs health volunteers.

(b) The commissioner may request Minnesota Responds Medical Reserve Corps volunteers to work on the Minnesota Mobile Medical Unit (MMU), or on other mobile or temporary units providing emergency patient stabilization, medical transport, or ambulatory care. The commissioner may utilize the volunteers for training, mobilization

or demobilization, inspection, maintenance, repair, or other support functions for the MMU facility or for other emergency units, as well as for provision of health care services.

(c) A volunteer's rights and benefits under this chapter as a Minnesota Responds Medical Reserve Corps volunteer is not affected by any vacation leave, pay, or other compensation provided by the volunteer's employer during volunteer service requested by the commissioner. An employer is not liable for actions of an employee while serving as a Minnesota Responds Medical Reserve Corps volunteer.

(d) If the commissioner matches the request under paragraph (a) with Minnesota Responds Medical Reserve Corps volunteers, the commissioner shall facilitate deployment of the volunteers from the sending Minnesota Responds Medical Reserve Corps units to the receiving jurisdiction. The commissioner shall track volunteer deployments and assist sending and receiving jurisdictions in monitoring deployments, and shall coordinate efforts with the division of homeland security and emergency management for out-of-state deployments through the Interstate Emergency Management Assistance Compact or other emergency management compacts.

(e) Where the commissioner has deployed Minnesota Responds Medical Reserve Corps volunteers within or outside the state, the provisions of paragraphs (f) and (g) must apply. Where Minnesota Responds Medical Reserve Corps volunteers were deployed across jurisdictions by mutual aid or similar agreements prior to a commissioner's call, the provisions of paragraphs (f) and (g) must apply retroactively to volunteers deployed as of their initial deployment in response to the event or emergency that triggered a subsequent commissioner's call.

(f) (1) A Minnesota Responds Medical Reserve Corps volunteer responding to a request for training or assistance at the call of the commissioner must be deemed an employee of the state for purposes of workers' compensation and tort claim defense and indemnification under section 3.736, without regard to whether the volunteer's activity is under the direction and control of the commissioner, the division of homeland security and emergency management, the sending jurisdiction, the receiving jurisdiction, or of a hospital, alternate care site, or other health care provider treating patients from the public health event or emergency.

(2) For purposes of calculating workers' compensation benefits under chapter 176, the daily wage must be the usual wage paid at the time of injury or death for similar services performed by paid employees in the community where the volunteer regularly resides, or the wage paid to the volunteer in the volunteer's regular employment, whichever is greater.

(g) The Minnesota Responds Medical Reserve Corps volunteer must receive reimbursement for travel and subsistence expenses during a deployment approved by the

commissioner under this subdivision according to reimbursement limits established for paid state employees. Deployment begins when the volunteer leaves on the deployment until the volunteer returns from the deployment, including all travel related to the deployment. The Department of Health shall initially review and pay those expenses to the volunteer. Except as otherwise provided by the Interstate Emergency Management Assistance Compact in section 192.89 or agreements made thereunder, the department shall bill the jurisdiction receiving assistance and that jurisdiction shall reimburse the department for expenses of the volunteers.

(h) In the event Minnesota Responds Medical Reserve Corps volunteers are deployed outside the state pursuant to the Interstate Emergency Management Assistance Compact, the provisions of the Interstate Emergency Management Assistance Compact must control over any inconsistent provisions in this section.

(i) When a Minnesota Responds Medical Reserve Corps volunteer makes a claim for workers' compensation arising out of a deployment under this section or out of a training exercise conducted by the commissioner, the volunteer's workers compensation benefits must be determined under section 176.011, subdivision 9, clause (25), even if the volunteer may also qualify under other clauses of section 176.011, subdivision 9.

Sec. 20. **[145A.061] CRIMINAL BACKGROUND STUDIES.**

Subdivision 1. **Agreements to conduct criminal background studies.** The commissioner of health may develop agreements to conduct criminal background studies on each person who registers as a volunteer in the Minnesota Responds Medical Reserve Corps and applies for membership in the Minnesota behavioral health or mobile medical teams. The background study is for the purpose of determining the applicant's suitability and eligibility for membership. Each applicant must provide written consent authorizing the Department of Health to obtain the applicant's state criminal background information.

Subd. 2. **Opportunity to challenge accuracy of report.** Before denying the applicant the opportunity to serve as a health volunteer due to information obtained from a background study, the commissioner shall provide the applicant with the opportunity to complete, or challenge the accuracy of, the criminal justice information reported to the commissioner. The applicant shall have 30 calendar days to correct or complete the record prior to the commissioner taking final action based on the report.

Subd. 3. **Denial of service.** The commissioner may deny any applicant who has been convicted of any of the following crimes:

Section 609.185 (murder in the first degree); section 609.19 (murder in the second degree); section 609.195 (murder in the third degree); section 609.20 (manslaughter in

the first degree); section 609.205 (manslaughter in the second degree); section 609.25 (kidnapping); section 609.2661 (murder of an unborn child in the first degree); section 609.2662 (murder of an unborn child in the second degree); section 609.2663 (murder of an unborn child in the third degree); section 609.342 (criminal sexual conduct in the first degree); section 609.343 (criminal sexual conduct in the second degree); section 609.344 (criminal sexual conduct in the third degree); section 609.345 (criminal sexual conduct in the fourth degree); section 609.3451 (criminal sexual conduct in the fifth degree); section 609.3453 (criminal sexual predatory conduct); section 609.352 (solicitation of children to engage in sexual conduct); section 609.352 (communication of sexually explicit materials to children); section 609.365 (incest); section 609.377 (felony malicious punishment of a child); section 609.378 (felony neglect or endangerment of a child); section 609.561 (arson in the first degree); section 609.562 (arson in the second degree); section 609.563 (arson in the third degree); section 609.749, subdivision 3, 4, or 5 (felony stalking); section 152.021 (controlled substance crimes in the first degree); section 152.022 (controlled substance crimes in the second degree); section 152.023 (controlled substance crimes in the third degree); section 152.024 (controlled substance crimes in the fourth degree); section 152.025 (controlled substance crimes in the fifth degree); section 243.166 (violation of predatory offender registration law); section 617.23, subdivision 2, clause (1), or subdivision 3, clause (1) (indecent exposure involving a minor); section 617.246 (use of minors in sexual performance); section 617.247 (possession of pornographic work involving minors); section 609.221 (assault in the first degree); section 609.222 (assault in the second degree); section 609.223 (assault in the third degree); section 609.2231 (assault in the fourth degree); section 609.224 (assault in the fifth degree); section 609.2242 (domestic assault); section 609.2247 (domestic assault by strangulation); section 609.228 (great bodily harm caused by distribution of drugs); section 609.23 (mistreatment of persons confined); section 609.231 (mistreatment of residents or patients); section 609.2325 (criminal abuse); section 609.233 (criminal neglect); section 609.2335 (financial exploitation of a vulnerable adult); section 609.234 (failure to report); section 609.24 (simple robbery); section 609.245 (aggravated robbery); section 609.255 (false imprisonment); section 609.322 (solicitation, inducement, and promotion of prostitution and sex trafficking); section 609.324, subdivision 1 (hiring or engaging minors in prostitution); section 609.465 (presenting false claims to a public officer or body); section 609.466 (medical assistance fraud); section 609.52 (felony theft); section 609.82 (felony fraud in obtaining credit); section 609.527 (felony identity theft); section 609.582 (felony burglary); section 609.611 (felony insurance fraud); section 609.625 (aggravated forgery); section 609.63 (forgery); section 609.631 (felony check forgery); section 609.66,

subdivision 1e (felony drive-by shooting); section 609.71 (felony riot); section 609.713 (terroristic threats); section 609.72, subdivision 3 (disorderly conduct by a caregiver against a vulnerable adult); section 609.821 (felony financial transaction card fraud); section 609.855, subdivision 4 (shooting at or in a public transit vehicle or facility); or aiding and abetting, attempting, or conspiring to commit any of the offenses in this subdivision.

Subd. 4. **Conviction.** For purposes of this section, an applicant is considered to have been convicted of a crime if the applicant was convicted, adjudicated delinquent, or otherwise found guilty, including by entering an Alford plea; was found guilty but the adjudication of guilt was stayed or withheld; or was convicted but the imposition or execution of a sentence was stayed.

Subd. 5. **Data practices.** All state criminal history record information or data used to match state health occupational licensing or national databases obtained by the commissioner from the Bureau of Criminal Apprehension is private data on individuals under section 13.02, subdivision 12, and restricted to the exclusive use of commissioner for the purpose of evaluating an applicant's eligibility for participation in the behavioral health or mobile field medical team.

Subd. 6. **Use of volunteers by commissioner.** The commissioner may deny a volunteer membership on a mobile medical team or behavioral health team for any reason, and is only required to communicate the reason when membership is denied as a result of information received from a criminal background study. The commissioner is exempt from the Criminal Offenders Rehabilitation Act under chapter 364 in the selection of volunteers for any position or activity including the Minnesota Responds Medical Reserve Corps, the Minnesota behavioral health team, and the mobile medical team.

Sec. 21. Minnesota Statutes 2012, section 148.6402, is amended by adding a subdivision to read:

Subd. 16a. **Occupational therapy practitioner.** "Occupational therapy practitioner" means any individual licensed as either an occupational therapist or occupational therapy assistant under sections 148.6401 to 148.6450.

Sec. 22. Minnesota Statutes 2012, section 148.6440, is amended to read:

148.6440 PHYSICAL AGENT MODALITIES.

Subdivision 1. **General considerations.** (a) Occupational ~~therapists~~ therapy practitioners who intend to use superficial physical agent modalities must comply with the requirements in subdivision 3. Occupational ~~therapists~~ therapy practitioners who intend to use electrotherapy must comply with the requirements in subdivision 4. Occupational

~~therapists~~ therapy practitioners who intend to use ultrasound devices must comply with the requirements in subdivision 5. Occupational therapy practitioners who are licensed as occupational therapy assistants and who intend to use physical agent modalities must also comply with subdivision 6.

(b) Use of superficial physical agent modalities, electrical stimulation devices, and ultrasound devices must be on the order of a physician.

(c) Prior to any use of any physical agent modality, ~~a licensee~~ an occupational therapy practitioner must obtain approval from the commissioner. The commissioner shall maintain a roster of persons licensed under sections 148.6401 to 148.6450 who are approved to use physical agent modalities.

(d) ~~Licensees~~ Occupational therapy practitioners are responsible for informing the commissioner of any changes in the information required in this section within 30 days of any change.

Subd. 2. **Written documentation required.** (a) An occupational ~~therapist~~ therapy practitioner must provide to the commissioner documentation verifying that the occupational ~~therapist~~ therapy practitioner has met the educational and clinical requirements described in subdivisions 3 to 5, depending on the modality or modalities to be used. Both theoretical training and clinical application objectives must be met for each modality used. Documentation must include the name and address of the individual or organization sponsoring the activity; the name and address of the facility at which the activity was presented; and a copy of the course, workshop, or seminar description, including learning objectives and standards for meeting the objectives. In the case of clinical application objectives, teaching methods must be documented, including actual supervised practice. Documentation must include a transcript or certificate showing successful completion of the coursework. Coursework completed more than two years prior to the date of application must be retaken. An occupational ~~therapist~~ therapy practitioner who is a certified hand therapist shall document satisfaction of the requirements in subdivisions 3 to 5 by submitting to the commissioner a copy of a certificate issued by the Hand Therapy Certification Commission. Occupational therapy practitioners are prohibited from using physical agent modalities under supervision or independently until granted approval as provided in subdivision 7, except under the provisions in paragraph (b).

(b) If ~~a~~ an occupational therapy practitioner has successfully completed a specific course previously reviewed and approved by the commissioner as provided for in subdivision 7, and has submitted the written documentation required in paragraph (a) within 30 calendar days from the course date, the occupational therapy practitioner awaiting written approval from the commissioner may use physical agent modalities

under the supervision of a ~~practitioner~~ licensed occupational therapist listed on the roster of persons approved to use physical agent modalities.

Subd. 3. **Requirements for use of superficial physical agent modalities.** (a) An occupational ~~therapist~~ therapy practitioner may use superficial physical agent modalities if the occupational ~~therapist~~ therapy practitioner has received theoretical training and clinical application training in the use of superficial physical agent modalities and been granted approval as provided in subdivision 7.

(b) Theoretical training in the use of superficial physical agent modalities must:

(1) explain the rationale and clinical indications for use of superficial physical agent modalities;

(2) explain the physical properties and principles of the superficial physical agent modalities;

(3) describe the types of heat and cold transference;

(4) explain the factors affecting tissue response to superficial heat and cold;

(5) describe the biophysical effects of superficial physical agent modalities in normal and abnormal tissue;

(6) describe the thermal conductivity of tissue, matter, and air;

(7) explain the advantages and disadvantages of superficial physical agent modalities; and

(8) explain the precautions and contraindications of superficial physical agent modalities.

(c) Clinical application training in the use of superficial physical agent modalities must include activities requiring the occupational therapy practitioner to:

(1) formulate and justify a plan for the use of superficial physical agents for treatment appropriate to its use and simulate the treatment;

(2) evaluate biophysical effects of the superficial physical agents;

(3) identify when modifications to the treatment plan for use of superficial physical agents are needed and propose the modification plan;

(4) safely and appropriately administer superficial physical agents under the supervision of a course instructor or clinical trainer;

(5) document parameters of treatment, patient response, and recommendations for progression of treatment for the superficial physical agents; and

(6) demonstrate the ability to work competently with superficial physical agents as determined by a course instructor or clinical trainer.

Subd. 4. **Requirements for use of electrotherapy.** (a) An occupational ~~therapist~~ therapy practitioner may use electrotherapy if the occupational ~~therapist~~ therapy

practitioner has received theoretical training and clinical application training in the use of electrotherapy and been granted approval as provided in subdivision 7.

(b) Theoretical training in the use of electrotherapy must:

(1) explain the rationale and clinical indications of electrotherapy, including pain control, muscle dysfunction, and tissue healing;

(2) demonstrate comprehension and understanding of electrotherapeutic terminology and biophysical principles, including current, voltage, amplitude, and resistance;

(3) describe the types of current used for electrical stimulation, including the description, modulations, and clinical relevance;

(4) describe the time-dependent parameters of pulsed and alternating currents, including pulse and phase durations and intervals;

(5) describe the amplitude-dependent characteristics of pulsed and alternating currents;

(6) describe neurophysiology and the properties of excitable tissue;

(7) describe nerve and muscle response from externally applied electrical stimulation, including tissue healing;

(8) describe the electrotherapeutic effects and the response of nerve, denervated and innervated muscle, and other soft tissue; and

(9) explain the precautions and contraindications of electrotherapy, including considerations regarding pathology of nerve and muscle tissue.

(c) Clinical application training in the use of electrotherapy must include activities requiring the occupational therapy practitioner to:

(1) formulate and justify a plan for the use of electrical stimulation devices for treatment appropriate to its use and simulate the treatment;

(2) evaluate biophysical treatment effects of the electrical stimulation;

(3) identify when modifications to the treatment plan using electrical stimulation are needed and propose the modification plan;

(4) safely and appropriately administer electrical stimulation under supervision of a course instructor or clinical trainer;

(5) document the parameters of treatment, case example (patient) response, and recommendations for progression of treatment for electrical stimulation; and

(6) demonstrate the ability to work competently with electrical stimulation as determined by a course instructor or clinical trainer.

Subd. 5. **Requirements for use of ultrasound.** (a) An occupational ~~therapist~~ therapy practitioner may use an ultrasound device if the occupational ~~therapist~~ therapy

practitioner has received theoretical training and clinical application training in the use of ultrasound and been granted approval as provided in subdivision 7.

(b) The theoretical training in the use of ultrasound must:

(1) explain the rationale and clinical indications for the use of ultrasound, including anticipated physiological responses of the treated area;

(2) describe the biophysical thermal and nonthermal effects of ultrasound on normal and abnormal tissue;

(3) explain the physical principles of ultrasound, including wavelength, frequency, attenuation, velocity, and intensity;

(4) explain the mechanism and generation of ultrasound and energy transmission through physical matter; and

(5) explain the precautions and contraindications regarding use of ultrasound devices.

(c) The clinical application training in the use of ultrasound must include activities requiring the practitioner to:

(1) formulate and justify a plan for the use of ultrasound for treatment appropriate to its use and stimulate the treatment;

(2) evaluate biophysical effects of ultrasound;

(3) identify when modifications to the treatment plan for use of ultrasound are needed and propose the modification plan;

(4) safely and appropriately administer ultrasound under supervision of a course instructor or clinical trainer;

(5) document parameters of treatment, patient response, and recommendations for progression of treatment for ultrasound; and

(6) demonstrate the ability to work competently with ultrasound as determined by a course instructor or clinical trainer.

Subd. 6. **Occupational therapy assistant use of physical agent modalities.** An occupational therapy practitioner licensed as an occupational therapy assistant may set up and implement treatment using physical agent modalities if the licensed occupational therapy assistant meets the requirements of this section, has applied for and received written approval from the commissioner to use physical agent modalities as provided in subdivision 7, has demonstrated service competency for the particular modality used, and works under the direct supervision of an occupational therapy practitioner licensed as an occupational therapist who has been granted approval as provided in subdivision 7. An occupational therapy practitioner licensed as an occupational therapy assistant who uses superficial physical agent modalities must meet the requirements of subdivision 3. An occupational therapy practitioner licensed as an occupational therapy assistant who uses

electrotherapy must meet the requirements of subdivision 4. An occupational therapy practitioner licensed as an occupational therapy assistant who uses ultrasound must meet the requirements of subdivision 5. An occupational therapy practitioner licensed as an occupational therapist may not delegate evaluation, reevaluation, treatment planning, and treatment goals for physical agent modalities to an occupational therapy practitioner licensed as an occupational therapy assistant.

Subd. 7. **Approval.** (a) The advisory council shall appoint a committee to review documentation under subdivisions 2 to 6 to determine if established educational and clinical requirements are met. If, after review of course documentation, the committee verifies that a specific course meets the theoretical and clinical requirements in subdivisions 2 to 6, the commissioner may approve practitioner applications that include the required course documentation evidencing completion of the same course.

(b) Occupational ~~therapists~~ therapy practitioners shall be advised of the status of their request for approval within 30 days. Occupational ~~therapists~~ therapy practitioners must provide any additional information requested by the committee that is necessary to make a determination regarding approval or denial.

(c) A determination regarding a request for approval of training under this subdivision shall be made in writing to the occupational ~~therapist~~ therapy practitioner. If denied, the reason for denial shall be provided.

(d) ~~A licensee~~ An occupational therapy practitioner who was approved by the commissioner as a level two provider prior to July 1, 1999, shall remain on the roster maintained by the commissioner in accordance with subdivision 1, paragraph (c).

(e) To remain on the roster maintained by the commissioner, ~~a licensee~~ an occupational therapy practitioner who was approved by the commissioner as a level one provider prior to July 1, 1999, must submit to the commissioner documentation of training and experience gained using physical agent modalities since the ~~licensee's~~ occupational therapy practitioner's approval as a level one provider. The committee appointed under paragraph (a) shall review the documentation and make a recommendation to the commissioner regarding approval.

(f) An occupational ~~therapist~~ therapy practitioner who received training in the use of physical agent modalities prior to July 1, 1999, but who has not been placed on the roster of approved providers may submit to the commissioner documentation of training and experience gained using physical agent modalities. The committee appointed under paragraph (a) shall review documentation and make a recommendation to the commissioner regarding approval.

Sec. 23. Minnesota Statutes 2012, section 151.37, subdivision 2, is amended to read:

Subd. 2. **Prescribing and filing.** (a) A licensed practitioner in the course of professional practice only, may prescribe, administer, and dispense a legend drug, and may cause the same to be administered by a nurse, a physician assistant, or medical student or resident under the practitioner's direction and supervision, and may cause a person who is an appropriately certified, registered, or licensed health care professional to prescribe, dispense, and administer the same within the expressed legal scope of the person's practice as defined in Minnesota Statutes. A licensed practitioner may prescribe a legend drug, without reference to a specific patient, by directing a nurse, pursuant to section 148.235, subdivisions 8 and 9, physician assistant, medical student or resident, or pharmacist according to section 151.01, subdivision 27, to adhere to a particular practice guideline or protocol when treating patients whose condition falls within such guideline or protocol, and when such guideline or protocol specifies the circumstances under which the legend drug is to be prescribed and administered. An individual who verbally, electronically, or otherwise transmits a written, oral, or electronic order, as an agent of a prescriber, shall not be deemed to have prescribed the legend drug. This paragraph applies to a physician assistant only if the physician assistant meets the requirements of section 147A.18.

(b) The commissioner of health, if a licensed practitioner, or a person designated by the commissioner who is a licensed practitioner, may prescribe a legend drug to an individual or by protocol for mass dispensing purposes where the commissioner finds that the conditions triggering section 144.4197 or 144.4198, subdivision 2, paragraph (b), exist. The commissioner, if a licensed practitioner, or a designated licensed practitioner, may prescribe, dispense, or administer a legend drug or other substance listed in subdivision 10 to control tuberculosis and other communicable diseases. The commissioner may modify state drug labeling requirements, and medical screening criteria and documentation, where time is critical and limited labeling and screening are most likely to ensure legend drugs reach the maximum number of persons in a timely fashion so as to reduce morbidity and mortality.

(c) A licensed practitioner that dispenses for profit a legend drug that is to be administered orally, is ordinarily dispensed by a pharmacist, and is not a vaccine, must file with the practitioner's licensing board a statement indicating that the practitioner dispenses legend drugs for profit, the general circumstances under which the practitioner dispenses for profit, and the types of legend drugs generally dispensed. It is unlawful to dispense legend drugs for profit after July 31, 1990, unless the statement has been filed with the appropriate licensing board. For purposes of this paragraph, "profit" means (1) any amount received by the practitioner in excess of the acquisition cost of a legend drug

for legend drugs that are purchased in prepackaged form, or (2) any amount received by the practitioner in excess of the acquisition cost of a legend drug plus the cost of making the drug available if the legend drug requires compounding, packaging, or other treatment. The statement filed under this paragraph is public data under section 13.03. This paragraph does not apply to a licensed doctor of veterinary medicine or a registered pharmacist. Any person other than a licensed practitioner with the authority to prescribe, dispense, and administer a legend drug under paragraph (a) shall not dispense for profit. To dispense for profit does not include dispensing by a community health clinic when the profit from dispensing is used to meet operating expenses.

(d) A prescription or drug order for the following drugs is not valid, unless it can be established that the prescription or order was based on a documented patient evaluation, including an examination, adequate to establish a diagnosis and identify underlying conditions and contraindications to treatment:

(1) controlled substance drugs listed in section 152.02, subdivisions 3 to 5;

(2) drugs defined by the Board of Pharmacy as controlled substances under section 152.02, subdivisions 7, 8, and 12;

(3) muscle relaxants;

(4) centrally acting analgesics with opioid activity;

(5) drugs containing butalbital; or

(6) phoshodiesterase type 5 inhibitors when used to treat erectile dysfunction.

(e) For the purposes of paragraph (d), the requirement for an examination shall be met if an in-person examination has been completed in any of the following circumstances:

(1) the prescribing practitioner examines the patient at the time the prescription or drug order is issued;

(2) the prescribing practitioner has performed a prior examination of the patient;

(3) another prescribing practitioner practicing within the same group or clinic as the prescribing practitioner has examined the patient;

(4) a consulting practitioner to whom the prescribing practitioner has referred the patient has examined the patient; or

(5) the referring practitioner has performed an examination in the case of a consultant practitioner issuing a prescription or drug order when providing services by means of telemedicine.

(f) Nothing in paragraph (d) or (e) prohibits a licensed practitioner from prescribing a drug through the use of a guideline or protocol pursuant to paragraph (a).

(g) Nothing in this chapter prohibits a licensed practitioner from issuing a prescription or dispensing a legend drug in accordance with the Expedited Partner Therapy

in the Management of Sexually Transmitted Diseases guidance document issued by the United States Centers for Disease Control.

(h) Nothing in paragraph (d) or (e) limits prescription, administration, or dispensing of legend drugs through a public health clinic or other distribution mechanism approved by the commissioner of health or a board of health in order to prevent, mitigate, or treat a pandemic illness, infectious disease outbreak, or intentional or accidental release of a biological, chemical, or radiological agent.

(i) No pharmacist employed by, under contract to, or working for a pharmacy licensed under section 151.19, subdivision 1, may dispense a legend drug based on a prescription that the pharmacist knows, or would reasonably be expected to know, is not valid under paragraph (d).

(j) No pharmacist employed by, under contract to, or working for a pharmacy licensed under section 151.19, subdivision 2, may dispense a legend drug to a resident of this state based on a prescription that the pharmacist knows, or would reasonably be expected to know, is not valid under paragraph (d).

(k) Nothing in this chapter prohibits the commissioner of health, if a licensed practitioner, or a person designated by the commissioner who is a licensed practitioner, from prescribing legend drugs for field-delivered therapy in the treatment of a communicable disease according to the Centers For Disease Control and Prevention Partner Services Guidelines.

Sec. 24. **REPEALER.**

Minnesota Statutes 2012, sections 144.1487; 144.1488, subdivisions 1, 3, and 4; 144.1489; 144.1490; and 144.1491, are repealed.

144.1487 LOAN REPAYMENT PROGRAM FOR HEALTH PROFESSIONALS.

Subdivision 1. **Definition.** (a) For purposes of sections 144.1487 to 144.1492, the following definition applies.

(b) "Health professional shortage area" means an area designated as such by the federal Secretary of Health and Human Services, as provided under Code of Federal Regulations, title 42, part 5, and United States Code, title 42, section 254E.

Subd. 2. **Establishment and purpose.** The commissioner shall establish a National Health Services Corps state loan repayment program authorized by section 388I of the Public Health Service Act, United States Code, title 42, section 254q-1, as amended by Public Law 101-597. The purpose of the program is to assist communities with the recruitment and retention of health professionals in federally designated health professional shortage areas.

144.1488 PROGRAM ADMINISTRATION AND ELIGIBILITY.

Subdivision 1. **Duties of commissioner of health.** The commissioner shall administer the state loan repayment program. The commissioner shall:

(1) ensure that federal funds are used in accordance with program requirements established by the federal National Health Services Corps;

(2) notify potentially eligible loan repayment sites about the program;

(3) develop and disseminate application materials to sites;

(4) review and rank applications using the scoring criteria approved by the federal Department of Health and Human Services as part of the Minnesota Department of Health's National Health Services Corps state loan repayment program application;

(5) select sites that qualify for loan repayment based upon the availability of federal and state funding;

(6) carry out other activities necessary to implement and administer sections 144.1487 to 144.1492;

(7) verify the eligibility of program participants;

(8) sign a contract with each participant that specifies the obligations of the participant and the state;

(9) arrange for loan repayment of qualifying educational loans for program participants;

(10) monitor the obligated service of program participants;

(11) waive or suspend service or payment obligations of participants in appropriate situations;

(12) place participants who fail to meet their obligations in default; and

(13) enforce penalties for default.

Subd. 3. **Eligible loan repayment sites.** Nonprofit private and public entities located in and providing health care services in federally designated primary care health professional shortage areas are eligible to apply for the program. The commissioner shall develop a list of Minnesota health professional shortage areas in greatest need of health care professionals and shall select loan repayment sites from that list. The commissioner shall ensure, to the greatest extent possible, that the geographic distribution of sites within the state reflects the percentage of the population living in rural and urban health professional shortage areas.

Subd. 4. **Eligible health professionals.** (a) To be eligible to apply to the commissioner for the loan repayment program, health professionals must be citizens or nationals of the United States, must not have any unserved obligations for service to a federal, state, or local government, or other entity, must have a current and unrestricted Minnesota license to practice, and must be ready to begin full-time clinical practice upon signing a contract for obligated service.

(b) Eligible providers are those specified by the federal Bureau of Health Professions in the policy information notice for the state's current federal grant application. A health professional selected for participation is not eligible for loan repayment until the health professional has an employment agreement or contract with an eligible loan repayment site and has signed a contract for obligated service with the commissioner.

144.1489 OBLIGATIONS OF PARTICIPANTS.

Subdivision 1. **Contract required.** Before starting the period of obligated service, a participant must sign a contract with the commissioner that specifies the obligations of the participant and the commissioner.

Subd. 2. **Obligated service.** A participant shall agree in the contract to fulfill the period of obligated service by providing primary health care services in full-time clinical practice. The

service must be provided in a nonprofit private or public entity that is located in and providing services to a federally designated health professional shortage area and that has been designated as an eligible site by the commissioner under the state loan repayment program.

Subd. 3. **Length of service.** Participants must agree to provide obligated service for a minimum of two years. A participant may extend a contract to provide obligated service for a third and fourth year, subject to approval by the commissioner and the availability of federal and state funding.

Subd. 4. **Affidavit of service required.** Before receiving loan repayment, annually thereafter, and as requested by the commissioner, a participant shall submit an affidavit to the commissioner stating that the participant is providing the obligated service and which is signed by a representative of the organizational entity in which the service is provided. Participants must provide written notice to the commissioner within 30 days of: a change in name or address, a decision not to fulfill a service obligation, or cessation of clinical practice.

Subd. 5. **Tax responsibility.** The participant is responsible for reporting on federal income tax returns any amount paid by the state on designated loans, if required to do so under federal law.

Subd. 6. **Nondiscrimination requirements.** Participants are prohibited from charging a higher rate for professional services than the usual and customary rate prevailing in the area where the services are provided. If a patient is unable to pay this charge, a participant shall charge the patient a reduced rate or not charge the patient. Participants must agree not to discriminate on the basis of ability to pay or status as a Medicare or medical assistance enrollee. Participants must agree to accept assignment under the Medicare program and to serve as an enrolled provider under medical assistance.

144.1490 RESPONSIBILITIES OF LOAN REPAYMENT PROGRAM.

Subdivision 1. **Loan repayment.** Subject to the availability of federal and state funds for the loan repayment program, the commissioner shall pay all or part of the qualifying education loans up to $20,000 annually for each primary care physician participant that fulfills the required service obligation. For purposes of this provision, "qualifying educational loans" are government and commercial loans for actual costs paid for tuition, reasonable education expenses, and reasonable living expenses related to the graduate or undergraduate education of a health care professional.

Subd. 2. **Procedure for loan repayment.** Program participants, at the time of signing a contract, shall designate the qualifying loan or loans for which the commissioner is to make payments. The participant shall submit to the commissioner proof that all payments made by the commissioner have been applied toward the designated qualifying loans. The commissioner shall make payments in accordance with the terms and conditions of the state loan repayment grant agreement or contract, in an amount not to exceed $20,000 when annualized. If the amount paid by the commissioner is less than $20,000 during a 12-month period, the commissioner shall pay during the 12th month an additional amount towards a loan or loans designated by the participant, to bring the total paid to $20,000. The total amount paid by the commissioner must not exceed the amount of principal and accrued interest of the designated loans.

144.1491 FAILURE TO COMPLETE OBLIGATED SERVICE.

Subdivision 1. **Penalties for breach of contract.** A program participant who fails to complete the required years of obligated service shall repay the amount paid, as well as a financial penalty specified by the federal Bureau of Health Professions in the policy information notice for the state's current federal grant application. The commissioner shall report to the appropriate health-related licensing board a participant who fails to complete the service obligation and fails to repay the amount paid or fails to pay any financial penalty owed under this subdivision.

Subd. 2. **Suspension or waiver of obligation.** Payment or service obligations cancel in the event of a participant's death. The commissioner may waive or suspend payment or service obligations in case of total and permanent disability or long-term temporary disability lasting for more than two years. The commissioner shall evaluate all other requests for suspension or waivers on a case-by-case basis.